

**FROM BUREAUCRACY AND MARKET TO NETWORK  
IN THE UK NATIONAL HEALTH SERVICE**

**A Study of Emerging Collaborative Governance and Practice  
in Primary Health Care  
(1999-2003)**

A thesis submitted in fulfillment of the requirements for the Degree of  
Doctor of Philosophy (PhD) of the University of Wales

Cardiff Business School  
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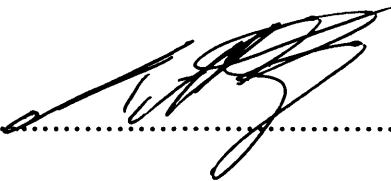


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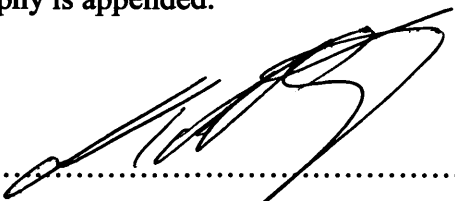
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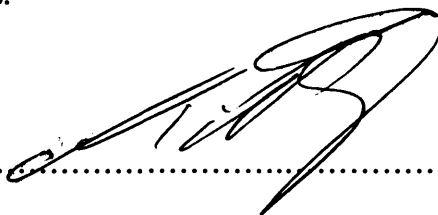
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## **THESIS SUMMARY**

Since the creation of the UK National Health Service in 1948, the question of how best to organise and administer this large and diverse institution has remained a central theme for governments, public sector managers and management scholars. Until recently, two models of governance, bureaucracy and market, dominated public sector management theory and reform strategies. Following the election of a Labour Government in 1997, health policy appears to have shifted towards an alternative mode of administration, centred on achieving a more integrated health care system, with better cooperation between health professionals, agencies and stakeholders. This study reports on the third-way approach to health service design and the recent move away from markets and bureaucracy to new network forms in the UK National Health Service.

The study focuses on emerging collaborative governance and practice in the commissioning and delivery of primary health care services. The study tracks and explores the reorganisation of the primary care sector and the development of new cooperative primary care groups introduced to integrate a range of health services, professions and agencies, within the community care setting. The study highlights the lack of research on networks in the public sector and seeks to address this deficiency by elaborating on the rationale behind recent collaborative policy; the significant processes involved in networking organisations and professionals; and the potential implications for the organisation and management of the Health Service.

The study applies a broad mix of research instruments to investigate networking at the national health sector level, the primary care level, the regional level of NHS Wales, and at the local level, within four Local Health Groups across one large Health Authority Area. Findings from the study provide original theoretic and empirical exploration of the contextual issues driving reform in health care and the salient factors influencing network relations.

# TABLE OF CONTENTS

<b>1</b>	<b>UNDERSTANDING THE NETWORK FORM .....</b>	<b>1</b>
1.1	INTRODUCTION .....	1
1.2	CHARACTERISTICS OF THE NETWORK ORGANISATION .....	1
1.3	IDENTIFYING A NETWORK ARCHETYPE .....	4
1.4	NETWORK THEORY: PRINCIPLE APPROACHES AND ANTECEDENTS .....	9
1.5	THE ECONOMICS OF NETWORKS .....	11
1.6	THE SOCIOLOGY OF NETWORKS.....	13
1.7	MANAGEMENT AND ORGANISATION THEORY OF NETWORKS .....	14
1.8	THE STRATEGIC NETWORK .....	18
1.9	THE EVOLUTION OF THE N-FORM: FROM MARKET TO HIERARCHY TO NETWORK .....	21
1.10	FROM MARKET TO NETWORK: A TRANSACTION COST THEORY PERSPECTIVE .....	25
1.11	NETWORK THEORY: LIMITATIONS AND OPPORTUNITIES .....	27
1.12	DEVELOPING AN ANALYTICAL FRAMEWORK.....	32
1.13	SUMMARY .....	36
<b>2</b>	<b>BUREAUCRACY AND MARKET TO NETWORK IN THE NHS .....</b>	<b>40</b>
2.1	INTRODUCTION .....	40
2.2	FROM QUASI-COMPETITION TO RELATIONAL-CONTRACTING .....	41
2.3	THE FAILURE OF THE INTERNAL-MARKET: A TRANSACTION COSTS APPRAISAL .....	42
2.4	THE UK PUBLIC SECTOR: FROM BUREAUCRACY AND MARKET TO NETWORK.....	45
2.5	THE NATIONAL HEALTH SERVICE: FROM BUREAUCRACY AND MARKET TO NETWORK.....	49
2.6	NETWORK NOT PANACEA .....	55
2.7	MANAGING PUBLIC HEALTH CARE NETWORKS .....	56
2.8	IMPLICATIONS FOR PUBLIC SECTOR MANAGEMENT IN THE NATIONAL HEALTH SERVICE.....	67
2.9	SUMMARY .....	72
<b>3</b>	<b>STUDY METHODOLOGY AND DESIGN.....</b>	<b>74</b>
3.1	INTRODUCTION .....	74
3.2	THE PHILOSOPHY OF SCIENTIFIC INQUIRY IN SOCIAL SCIENCE .....	75
3.3	THE METHODOLOGY OF SOCIAL SCIENCE.....	78
3.4	STUDY ONTOLOGY AND EPISTEMOLOGY .....	81
3.5	RESEARCH DESIGN .....	83
3.6	DATA AND SOURCES.....	88
3.7	DESIGN AIMS AND RESEARCH STRATEGY .....	89
3.8	DESIGN APPLICATION AND LEVELS OF ANALYSIS .....	90
3.9	RESEARCH INSTRUMENTS AND DATA ANALYSIS .....	94
3.10	A MULTI-LEVEL NETWORK ANALYTICAL FRAMEWORK.....	103
3.11	METHODOLOGICAL RELIABILITY AND CREDIBILITY.....	109
3.12	SUMMARY.....	114

<b>4</b>	<b>NETWORK ANALYSIS AT THE NATIONAL LEVEL.....</b>	<b>116</b>
4.1	INTRODUCTION .....	116
4.2	ANALYSING THE UK HEALTH SECTOR .....	116
4.3	THE SOCIO-POLITICAL CONTEXT OF THE NHS.....	118
4.4	THE LABOUR GOVERNMENT AND THE POLITICS OF THE 'THIRD-WAY' .....	120
4.5	THE MODERNISATION AGENDA AND THE NHS.....	124
4.6	THE 2000 NATIONAL HEALTH SERVICE PLAN: KEY FEATURES.....	129
4.7	CENTRAL THEMES IN HEALTH POLICY .....	134
4.8	SUMMARY .....	139
<b>5</b>	<b>NETWORK ANALYSIS AT THE PRIMARY CARE LEVEL .....</b>	<b>141</b>
5.1	INTRODUCTION .....	141
5.2	THE INTEGRATION OF SERVICES.....	141
5.3	THE NATIONAL HEALTH AS A PRIMARY-LED ORGANISATION.....	143
5.4	THE ANTECEDENTS OF PRIMARY CARE GROUPS .....	147
5.5	THE EMERGING ROLE OF PRIMARY CARE GROUPS AND TRUSTS.....	150
5.6	THE AGENDA FOR COOPERATIVE WORKING BETWEEN PROFESSIONALS AND AGENCIES .....	151
5.7	KEY CONSIDERATIONS IN THE MANAGEMENT OF PRIMARY CARE.....	155
5.8	OPPORTUNITIES FOR PRIMARY CARE TEAMS AND GROUPS .....	158
5.9	POTENTIAL BARRIERS TO JOINT-WORKING IN PRIMARY HEALTH CARE.....	160
5.10	ACHIEVING EFFECTIVE COLLABORATIVE-NETWORKING .....	165
5.11	SUMMARY .....	171
<b>6</b>	<b>NETWORK ANALYSIS AT THE REGIONAL LEVEL.....</b>	<b>173</b>
6.1	INTRODUCTION .....	173
6.2	THE NATIONAL HEALTH SERVICE OF WALES.....	173
6.3	HEALTH POLICY IN WALES: 1997-2003.....	176
6.4	NETWORKING: AN EMERGING THEME AND PRACTICE ACROSS NHS WALES.....	178
6.5	THE EMERGING ROLE OF LOCAL HEALTH GROUPS .....	181
6.6	DATA ON LOCAL HEALTH GROUPS IN WALES .....	186
6.7	MOVING FROM LOCAL HEALTH GROUPS TO LOCAL HEALTH BOARDS .....	195
6.8	SUMMARY .....	200
<b>7</b>	<b>NETWORK ANALYSIS AT THE LOCAL LEVEL .....</b>	<b>203</b>
7.1	INTRODUCTION .....	203
7.2	NETWORK SPECIFICATION AND ANALYSIS.....	204
7.3	PHASES OF FIELDWORK AND DATA COLLECTION PROTOCOLS.....	205
7.4	PROFILE OF HEALTH AUTHORITY ZONE-X .....	211
7.5	LOCAL HEALTH GROUPS OF HEALTH AUTHORITY ZONE-X.....	213
7.6	LOCAL HEALTH GROUP AREA-1.....	216
7.7	LOCAL HEALTH GROUP AREA-2.....	218

7.8	LOCAL HEALTH GROUP AREA-3.....	220
7.9	LOCAL HEALTH GROUP AREA-4.....	223
7.10	NETWORKING ACROSS LOCAL HEALTH GROUPS.....	224
7.11	VERTICAL AUTHORITY NETWORKING .....	227
7.12	INTER-AGENCY NETWORKING .....	230
7.13	INTER-SERVICE NETWORKING .....	235
7.14	NETWORKING ACROSS LOCAL HEALTH GROUPS: THE WORK OF LHG-2 .....	240
7.15	INTER-PROFESSIONAL NETWORKING .....	244
7.16	INVOLVING THE PUBLIC: THE ROLE OF LOCAL HEALTH GROUPS.....	253
7.17	THE ACCOUNTABILITY OF LOCAL HEALTH GROUPS .....	258
7.18	THE PERFORMANCE OF LOCAL HEALTH GROUPS .....	259
7.19	SUMMARY .....	261
<b>8</b>	<b>SUMMARY OF STUDY FINDINGS FROM MULTI-LEVEL NETWORK ANALYSIS..</b>	<b>265</b>
8.1	INTRODUCTION .....	265
8.2	THE STATUS OF NETWORK THEORY .....	265
8.3	PUBLIC SECTOR NETWORKS: AN EMERGING RESEARCH FIELD .....	268
8.4	APPLICATION OF METHODOLOGY .....	271
8.5	NETWORKING AT THE NATIONAL SECTOR LEVEL .....	275
8.6	NETWORKING AT THE PRIMARY CARE LEVEL.....	281
8.7	NETWORKING AT THE REGIONAL LEVEL OF NHS WALES.....	289
8.8	NETWORKING AT THE LOCAL LEVEL .....	298
<b>9</b>	<b>CONTRIBUTIONS TO NETWORK THEORY, PRACTICE AND HEALTH POLICY..</b>	<b>309</b>
9.1	INTRODUCTION .....	309
9.2	THE NATIONAL HEALTH SERVICE: FROM BUREAUCRACY AND MARKET TO NETWORK.....	309
9.3	CONTRIBUTIONS TO THE THEORY OF NETWORK MANAGEMENT IN HEALTH CARE.....	320
9.4	STUDY IMPLICATIONS FOR NHS RELATIONSHIPS AND PRACTICES .....	330
9.5	STUDY IMPLICATIONS FOR HEALTH POLICY .....	339
9.6	REFLECTING UPON METHODOLOGY AND METHODOLOGICAL ADVANCEMENT .....	344
9.7	DIRECTIONS FOR NETWORK RESEARCH IN THE NHS AND THE PUBLIC SECTOR.....	348
	<b>Bibliography.....</b>	<b>351</b>
	<b>Appendices.....</b>	<b>384</b>



## LIST OF TABLES

TABLE 1.1 CLASSIFICATION OF NETWORK FORMS.....	3
TABLE 1.2 NETWORK DESIGN FEATURES COMPARED WITH MARKETS AND HIERARCHIES .....	7
TABLE 1.3 SUMMARY OF NETWORK LITERATURE-BASED THEORETICAL LIMITATIONS .....	31
TABLE 1.4 NETWORK DIMENSIONS AND RESEARCH VARIABLES .....	34
TABLE 3.1 TABLE: SCIENTIFIC VERSUS NATURALISTIC PARADIGMS APPLIED TO THE RESEARCH STUDY	82
TABLE 3.2 PHASES OF DATA COLLECTION, ANALYSIS AND PRESENTATION .....	91
TABLE 3.3 STRENGTHS AND WEAKNESSES OF METHODOLOGICAL INSTRUMENTS .....	102
TABLE 3.4 OUTLINE OF RELATIONAL CONTENT AND RESEARCH FACTORS .....	106
TABLE 3.5 DIFFERENT LEVELS OF NETWORK ANALYSIS .....	108
TABLE 3.6 RESEARCH DOMAINS AND INDICATORS OF RESEARCH QUALITY.....	110
TABLE 4.1 TOTAL EXPENDITURE OF HEALTH CARE AS A PERCENTAGE OF TREND GDP 1997-2000 .....	122
TABLE 4.2 UNITED KINGDOM NATIONAL HEALTH SERVICE FUNDING POST-1997.....	123
TABLE 4.3 CORE PRINCIPLES FOR REFORM IN THE NHS 2000-2010 .....	130
TABLE 4.4 A CHRONOLOGY OF POLICY EVENTS IN THE NHS POST-1997 .....	135
TABLE 5.1 DIFFERENT LEVELS OF OPERATION FOR PRIMARY CARE GROUPS.....	146
TABLE 5.2 A TYPOLOGY OF VARIATION IN TOTAL PURCHASING PILOTS .....	166
TABLE 6.1 MAJOR POLICY PUBLICATIONS AND EVENTS IN WALES (CIRCA 1998-2002).....	177
TABLE 6.2 NATIONAL ASSEMBLY FOR WALES POLICY AIMS.....	178
TABLE 6.3 GENERAL PRACTICE LIST SIZES AS AT SEPTEMBER 2001.....	188
TABLE 6.4 BULLETIN REPORT ON LHGS IN WALES AS AT 30 SEPTEMBER 2002.....	189
TABLE 6.5 KEY ACCOUNTABILITIES FOR LOCAL HEALTH BOARDS .....	197
TABLE 7.1 LEVELS OF NETWORK ANALYSIS DURING FIELD INVESTIGATIONS AT THE LOCAL LEVEL.....	205
TABLE 7.2 NETWORK ATTRIBUTES AND DIMENSIONS AS GUIDES FOR FIELD INVESTIGATIONS.....	208
TABLE 7.3 KEY STATISTICS FOR HEALTH AUTHORITY ZONE-X .....	212
TABLE 7.4 POPULATION COVERAGE FOR HEALTH AUTHORITY ZONE-X.....	212
TABLE 7.5 LEVELS OF DEVELOPMENT WITHIN LHGS.....	229
TABLE 7.6 AREA-2 HEALTH STATUS AND CAUSES .....	240
TABLE 7.7 STAND-ALONE PRIMARY CARE RESOURCE CENTRE AREA-2 .....	242
TABLE 7.8 INTEGRATED PRIMARY CARE RESOURCE CENTRE AREA-2.....	243
TABLE 7.9 LHG BOARD MEMBERSHIP ACROSS LHGS IN HEALTH AUTHORITY ZONE-X .....	245
TABLE 7.10 CLINICAL GOVERNANCE PERFORMANCE FOR LHG-4 .....	260

## LIST OF FIGURES

FIGURE 1.1 FROM MARKET TO NETWORK ECOLOGY .....	21
FIGURE 1.2 A MATRIX OF ORGANISATIONAL FORMS .....	24
FIGURE 1.3 OVERVIEW OF A NETWORK ANALYTICAL FRAMEWORK MODEL .....	33
FIGURE 2.1 THE EVOLUTION OF COOPERATION IN HEALTH CARE .....	52
FIGURE 3.1 A LOGICAL AND CYCLICAL RESEARCH PROCESS .....	86
FIGURE 3.2 AN ADAPTATION OF BORUM'S MODEL OF RESEARCH.....	87
FIGURE 5.1 CHANGING STRUCTURE OF THE NATIONAL HEALTH SERVICE.....	142
FIGURE 5.2 THE RECONFIGURATION OF THE NATIONAL HEALTH SERVICE 1990-1999 .....	145
FIGURE 6.1 BOARD COMPOSITION OF LHGS AND PCGs .....	184
FIGURE 6.2 DATA ON THE COMPOSITION OF LHGS IN WALES COMPARED WITH PCGs .....	186
FIGURE 7.1 NETWORK FIELD INVESTIGATION PROCEDURES AND STAGES.....	206
FIGURE 7.2 OVERVIEW OF HEALTH AUTHORITY ZONE-X AND LOCAL HEALTH GROUPS.....	213
FIGURE 7.3 LOCAL HEALTH GROUP MEMBERSHIP AND PROFESSIONAL GROUPING.....	215
FIGURE 7.4 VERTICAL-LATERAL DIMENSIONS OF LHG NETWORKING ACTIVITIES .....	226
FIGURE 7.5 INTER-SERVICE NETWORKING VIA LHGS .....	235
FIGURE 7.6 STRUCTURE AND ORGANISATION OF SOCIAL SERVICES IN AREA-1 .....	238
FIGURE 7.7 INTER-PROFESSIONAL NETWORKING VIA LHGS .....	247
FIGURE 7.8 DIMENSIONS OF PUBLIC AND PATIENT INVOLVEMENT FOR LHGS.....	256

## LIST OF APPENDICES

APPENDIX 1 RESEARCH ANALYTICAL FRAMEWORK AND STRATEGY .....	384
APPENDIX 2 INTERVIEW QUESTIONNAIRE SCHEDULE .....	393
APPENDIX 3 LETTER TO LOCAL HEALTH GROUP MEMBERS .....	396
APPENDIX 4 LETTER TO ALLIED AGENCIES .....	397
APPENDIX 5 INTERVIEWEE DATABASE .....	398

## ACRONYMS AND ABBREVIATIONS

AT	Acute Trust
AWCHC	Association of Welsh Community Health Councils
BMA	British Medical Association
CCC	Community and Continuing Care
CCT	Compulsive Competitive Tendering
CEO	Chief Executive Officer
CHC	Community Health Care
CHD	Coronary Heart Disease
CHI	Commission for Health Improvement
CMHT	Community Mental Health Teams
CSR	Comprehensive Spending Review
CT	Community Trust
CSPRD	Centre for Social Policy Research and Development (University of Bangor)
DoH	Department of Health
DHA	District Health Authority
DPSD	Diabetes Peer Support Programme
DSS	Department of Social Services
ECAS	Elderly Care Assessment Service
EMA-LAT	Emergency Admissions Local Action Team
EPC	External Production Cost
ESRC	Economics and Social Research Council
FHSAS	Family Health Services Authorities
GDP	Gross Domestic Profit
GMC	General Medical Council
GMS	General Medical Services
GMP	General Medical Practitioner
GP	General Practitioner
HA	Health Authority
HAZ	Health Action Zone
HCHS	Hospital and Community Health Services
HIMP	Health Improvement Programme
NHS	National Health Service
NHSE	National Health Services Executive
HMO	Health Maintenance Organisation
HRM	Human Resource Management
NPHS	National Public Health Service (for Wales)
IPC	Internal Production Cost
IOR	Inter-Organisational Relationship
IT	Information Technology
LA	Local Authority
LHAP	Local Health Action Plan
LHB	Local Health Board
LHC	Local Health Co-operative
LHCC	Local Health Care Co-operative
LHG	Local Health Group
LSG	Locality Steering Group

MTC	Market Transaction Cost
MP	Member of Parliament
NAW	National Assembly for Wales
NCCSDO	National Coordinating Centre for NHS Service Delivery and Organisation Research and Development
NGO	Non-Governmental Organisation
NHS	National Health Service
NHSE	National Health Service Executive
NICE	National Institute of Clinical Excellence
NPM	New Public Management
NSF	National Service Framework
OECD	Organisation for Economic Cooperation and Development
ONS	Office of National Statistics
OPM	Office for Public Management (National Assembly for Wales)
PCG	Primary Care Group
PCRC	Primary Care Resource Centre
PCRT	Primary Care Resource Team
PCST	Primary Care Support Team
PCSU	Primary Care Support Unit
PCT	Primary Care Trust
PEARS	Primary Eye Care Acute Referral Scheme
PFI	Public Finance Initiative
PHCG	Primary Health Care Group
PHCT	Primary Health Care Team
PI	Performance Indicator
PPI	Public and Patient Involvement
PPP	Public Private Partnership
PSS	Personal Social Services
RCGP	Royal College of General Practitioners
RCS	Royal College of Surgeons
R&D	Research and Development
SHA	Strategic Health Authority
SHO	Senior House Officer
SSD	Social Service Department
SSIW	Social Services Inspectorate of Wales
TC	Transaction Cost
TCA	Transaction Cost Analysis
TCE	Transaction Cost Economics
TPP	Total Purchasing Pilot
UK	United Kingdom
UKCC	UK Central Council for Nursing, Midwifery and Health Visiting
US	United States
USA	United States of America
VAP	Value Adding Partnership
WHO	World Health Organisation

## INTRODUCTION

The integration and coordination of organisational actors in the delivery of publicly funded health and social services has remained an important issue since the creation of public welfare systems like the United Kingdom National Health Service. There has been considerable debate within management and organisational fields as to how best to deliver and coordinate such services. Two models of governance, bureaucracy and market, have dominated strategies and theories of public service provision and administration. More recently, an increasing body of knowledge on networks and cooperative relations has emerged that challenges traditional competition-based theories of exchange, and offers an alternative to the dogma of centralised departmentalised State provision. Until recently, economic theories of markets, predominantly neoclassical theories, and more sociological theories of bureaucracy (Weber, 1978), have dominated our understanding of organisational form, strategy and process: with conceptualisations of the competitive firm seeking utility and profit, bounded by production capabilities and resource constraints; to characterisations of the large bureaucracy with centralisation, hierarchy and authority. Within organisation and management studies, the bureaucracy has given rise to seminal works on organisational design and management (Chandler, 1962; Mintzberg, 1979), and sparked off more critical insights into the way organisations are portrayed and understood (Silverman, 1971, Reed, 1985). Environmental developments in the behaviour of large unitary firms, particularly during the 1980s and 1990s, such as increasing specialisation, sub-contracting, cooperation among competitors, knowledge and resource sharing, and organisational alliances, have raised many questions about the usefulness of existing economic and sociological bureaucracy-based conceptualisations of organisation. On the outside, the boundaries of an organisation are far less definable given the complex system dynamics in which organisations operate, such as legal, banking, national-cultural systems (Whitely, 1992), or given the web of alliances and relationships organisations form, buyer-supplier supply chains, knowledge-sharing collaboratives, or strategic alliances. On the inside, changes in the modernity of managerial strategies, in conjunction with new technologies, computer and telecommunications, have helped to redefine the inner hierarchy that once delineated the bureaucracy. Many organisations have stripped

away bureaucracy in place of flatter, more empowered and flexible arrangements. What lies behind many of these developments in organisational form and management, is a tacit and contemporary belief that new intra and inter-organisational relationships might yield benefits above and beyond those possible via more traditional competition-based strategies. Consequently, there has been a substantial rise in the number, frequency, and breath, of collaborative inter-organisational arrangements across private and public sectors over the past two decades.

In response, organisational researchers have become increasingly interested in modes and methods of collaboration between organisations. As an output of the resulting discourse and research on new collaborative forms, organisational theorists have put forward a more diverse range of organisational archetypes, such as the joint-venture (Harrigan, 1985), the value-adding partnership (Bresser and Hart, 1986), the strategic alliance (Kanter, 1990), or the networked organisation (Powell, 1991). What emerges is an array of different cooperative organisational forms, differentiated by the number of linkages, the degree of inter-dependence, and the nature of the relationship.

While the development and utilisation of cooperative relations between organisations has been the focus of management and organisational scholars since the 1960s (Levine and White, 1961); this early work tended to concentrate on dyadic lateral relationships and the impact on organisational structure and behaviour. Over the past decade, the focus within coordination research has moved upward to an examination of multiple interactions or more complete network systems (Alter and Hage, 1993; Ring and Van de Ven, 1994; Salancik, 1995; Provan, 1995, 1998). As a result, the network organisation has emerged as a new an alternative conceptualisation of organisational life. Network scholars suggest that organisations are more appropriately viewed as fluid and interconnected forms of social and economic interaction, involving a complex array of relational norms and strategic objectives: that seek to reduce uncertainty, increase legitimacy, innovate, and elicit a range of resources from knowledge and know-how, to capital and markets, from a range of loose and dense organisational ties with competitors and allies (Granovetter, 1990; Ring and Van de Ven, 1992; Pfeffer and Salancik, 1992).

In the public non-profit sector, there has been considerable support for the development of collaborative network-based relationships within and between organisations, particularly in health and social services (Powell, 1991); as a viable alternative to the divisive elements of market-based competition strategies, or the slow and costly bureaucracy-based modes. In the UK public sector, there is increasing argument among spectators that governance mechanisms can be seen to be moving away from more traditional bureaucratic and hierarchical modes, towards more decentralised and autonomous structures, more characteristic of the 'network organisation' (Ferlie, Ashburner, Fitzgerald and Pettigrew, 1996). Following the election of a Labour Government in 1997, UK public policy appears to have moved away from internal-markets and competition between public service providers. In health care, the emphasis has shifted to new initiatives based around achieving partnership, collaboration, joint-working and joined-up services. The 1997 White Paper on Health, *'The new NHS: modern, dependable'* (DoH, 1997), has been the blueprint document for an array of recent structural and procedural reforms in health care designed to create effective high performing service delivery systems. A major element of this modernisation agenda has been the reorganisation of the primary care sector and the development and implementation of new cooperative forms of multi-professional and multi-agency working. Of particular importance has been the creation of new primary care groups in England and local health groups in Wales; designed to redress the imbalances of quasi-markets and the purchaser-provider split.

Despite strong interest in the study of networks within the private sector, there has been relatively little empirical research on networks in the public sector. There have so far, been few studies which have taken the public sector as a context for an empirical examination of the network phenomena, or which have sought to link network theory to practice (Nohria and Eccles, 1992). Network theory remains predicated on studies of inter-firm exchange that focus on the structural and strategic dimensions of network ties in industrial markets. A review of three broad theoretical fields: economics, organisation/management studies, and sociology, including political science, strategy and business policy, reveals that network studies continue to focus more on the antecedent conditions that bring about networks, rather than on the internal processes at work, or how networks function and perform. From a research perspective, many unanswered questions remain concerning the viability and efficacy

of the network as a stable, high-performance, effective organisational governance mechanism. In particular, there has been scant examination of the factors affecting the longevity and performance of these new organisational structures. Relatively little is known about the processes of relationship building or network failure (Ring and Van de Ven, 1992; Park, 1996).

The lack of research insight into the procedural and functional aspects of networks is exacerbated in the public non-profit sector. The majority of research on networks and cooperative relations among organisations originates from organisational and management research in the private sector. In addition, the limited number of empirical-based studies of networking in the public sector, are more often based on localised case studies of unitary organisations, rather than on more complete network systems, where networks are often treated as a metaphor, a conceptual scheme, or a managerial technique (Milward and Provan, 1998: 387). In response, this study seeks to add to the developing theory on network organisation and to contribute to the limited research on networks in the non-profit sector, by reporting on the development and implementation of new collaborative governance and practice in the UK National Health Service. This study explores the recent policy drive in health towards increased cooperation and service integration, and investigates the emergence of the network as an alternative mode of service delivery and coordination. While the study does not explicitly attempt to measure the overall effectiveness of networks in health care, it does seek to increase our understanding of the link between network processes and network performance. It also considers the organisational and managerial implications of networking and aims to provide original theoretic and empirical exploration of the environmental and contextual issues driving public sector reform, and to explore in a more robust and holistic way, the salient factors impacting upon network relations within the unique and complex setting of health care. This study is principally guided by three broad research questions: what evidence is there of a move away from market and hierarchy to new network forms in the National Health Service?; what are the important factors and processes involved in the integration of agencies in health care, and how might these factors be linked to network outcomes and performance?; and, what are the potential implications of networks for the organisation and management of the National Health Service?



The following chapters of this thesis present a structured account of research that has sought to qualitatively report on recent moves away from bureaucracy and market in the UK National Health Service. The research aim is to ascertain what factors need to be considered when entering into, operating, and maintaining, multi-agency organisational networks in a public health sector context. Particular attention is paid to the challenges that public sector managers and professionals might face in developing and maintaining network relations within the complex organisational setting of the National Health Service, and on understanding the potential barriers to effective networking and performance. In pursuit of these aims, this study provides a detailed and descriptive account of developments in the public sector and the NHS following the election of a Labour Government in 1997. The study's temporal or political context is the post 'internal-market' era of the Labour Government's White Paper, *'The new NHS: modern, dependable'* (DoH, 1997). The study tracks the Government's policy aim to develop a primary care-led NHS and the subsequent move towards new collaborative governance and networking practices in the commissioning and delivery of primary health care services.

## **Chapter 1**

This chapter reviews the literature on the network organisation as an alternative philosophy of governance (Harrison, 1997: 27). The chapter begins by highlighting the distinctive characteristics of the network organisation and addresses the development of a network archetype. The chapter moves on to outline the driving forces behind network development and goes some way to explain why networks exist. The chapter reviews the principal economic and strategic incentives for network involvement and accounts for the major theoretical perspectives in network research, drawing from the fields of economics, organisational studies, sociological studies and strategic approaches to network research. The chapter moves forward by presenting a theory of networks that looks at the progression, or evolutionary adaptation of organisational governance modes, from markets to hierarchies, and from hierarchies to networks. The final sections of the chapter present a classification of different network forms and discusses the importance of network processes as a research topic, and puts forward a tentative analytical framework for understanding and researching networks. Chapter 1 draws a number of conclusions about the weaknesses of current network research, namely the scant attention paid to network function and outcomes.

Within network research, network processes and network-level components are often scantily addressed and there appears to be little empirical or theoretical treatment of relational processes, particularly any attempt to identify and explain significant input factors. In particular, existing theory and empirical research is weak in linking network inputs to network outputs.

## **Chapter 2**

This chapter moves discussions of networking away from more established debates concerning markets and inter-firm relationships, to the comparatively under-researched setting of the UK public sector, by reporting on recent moves away from internal-markets and classical bureaucracy to new collaborative governance and network relationships. This second chapter brings together important findings from a variety of literature sources to examine recent structural and procedural developments in the National Health Service. The chapter addresses current speculation that the NHS, like other public sector services, is becoming more characteristic of a network archetype institution. The chapter details some of the principal forces influencing change in the sector. The chapter applies a transaction cost logic to explain a contemporary critique of internal-markets, and reports on recent moves away from quasi-competition and obligational-contracting, to more relational-contracting and collaborative working between public sector contractors. The chapter moves on by exploring the concept of the National Health Service as network organisation and discusses the important issue of network management. The chapter identifies a number of recurrent factors influencing network performance, including: trust, opportunism, stability and uncertainty, goal congruence, and innovative ability. The chapter also explores the potential implications of networks for the NHS, particularly issues of managing tasks, the potential for network failure, the longevity of network forms, and network performance and accountability.

## **Chapter 3**

This chapter presents and reflects upon the development and application of the research design and methods employed to pursue the study's aims and objectives. The chapter discusses the philosophical biases underlying the choice of research design, strategy, and methods: particularly the implications of these assumptions with respect to an interpretation and evaluation of findings. The chapter sets out the three dominant

philosophical schools or research paradigms: *positivism*, *realism*, and *naturalism*, and goes on to depict how these different philosophical traditions have influenced research in the social sciences, particularly in management and organisational fields. The chapter details the epistemological and ontological position taken to undertake this study: illustrating how the study is influenced by a realist approach to the study of social behaviour, but how the study is guided by a broad multi-paradigm preference to scientific inquiry. The chapter presents an overview of the research process followed and the research strategy adopted, to pursue the objectives of the study. The subsequent section professes a rationale and justification for the use of an exploratory-descriptive research design that encompasses a pluralist mix of methods. The study's research design is divided by three levels of network analysis: a national level review and analysis of change in the UK health care sector; a review and analysis of developments at the regional level in the National Health Service in Wales; and an investigation of networking and collaboration at the local level, within four Local Health Groups across a Health Authority area. The chapter also establishes the research protocols used to guide data collection and analysis, and goes on to examine in more detail the application of methods: accounting for how the methodological approach required adjustment, refinement, and evaluation, at different stages during the research process. The penultimate section addresses issues arising from the conceptualisation of the network phenomenon and sets out an analytical framework to guide network analysis and theoretic-empiric interaction. The chapter ends by reflecting upon the strengths and weaknesses of methods employed in terms of establishing research quality and credibility.

#### **Chapter 4**

This chapter analyses the broad environment of health care in the UK. The goal of the chapter is to review change at the wider sector level and to account for recent developments in the organisation and management of the National Health Service. The chapter identifies the major impetus for change in Governmental health policy, including social, economic, and political pressures, and presents data that supports the suggestion of an archetypal shift away from traditional hierarchical and market mechanisms in health care administration. The chapter identifies and explores the significant developments shaping change in the UK health sector. This task is supported by an array of data sources, including an extensive and detailed review of

public policy publications. The chapter reviews the Government's modernisation agenda and provides detailed insight into changing governance patterns in the public sector. The chapter substantiates analysis with evidence and argument from public management literature and a range of secondary research. Overall, this chapter reports on the status of the organisational or institutional setting in which the research takes place using a meta-analysis of change at the sector level.

## **Chapter 5**

This chapter takes the research agenda forward by exploring issues of networking and organisational integration in primary health care. Primary health care has undergone considerable change and restructuring following the implementation of the White Paper on health, '*The new NHS, modern and dependable*' (DoH, 1997). The development and reorganisation of primary health care has been a central feature of the reform agenda over the period, whereby the NHS has become more primary care focused. The chapter reports on the major impetus for change, drawing on a wide range of specialist practitioner and academic literatures. The chapter seeks to draw out the rationale for the recent move away from markets to new primary care groups, as well as the recent emphasis placed on cooperative working and collaboration in primary health care. The chapter outlines the new role of primary care organisations, primary care groups (PCGs) in England and local health groups (LHGs) in Wales, in delivering a primary-led NHS. A critical aim of the chapter is to interpret the potential implications of network-type organisational and managerial changes, in particular, implications for service provision, professional cooperation, collaborative management, and more generally, for service improvement. The chapter highlights the potential opportunities created by recent changes and reflects on the barriers to implementing collaborative-networking in primary care.

## **Chapter 6**

This chapter reports on the next stage of the research design, an investigation of change and policy implementation at the regional level of the National Health Service of Wales. The chapter focuses on the development and application of health policy in primary health care in Wales. The chapter presents and interprets data extracted from an extensive review of secondary data and primary policy sources, and is informed and supported by field investigations, including specialist interviews with

practitioners and policy makers. The aim of this review is to record and evaluate the application of central policy at the regional level, and to identify key amendments and additions to national level health policy. The chapter presents an extensive overview of change at the regional level of NHS Wales and reports on the application of reforms in primary health care, specifically the role of local health groups in the commissioning and delivery of primary care services.

## **Chapter 7**

This chapter presents findings drawn from a major phase of the research design, a local level investigation of networking activities in primary care. The chapter draws on data collected and analysed from field investigations of networking activities within and across four Local Health Groups within a unitary Health Authority area of NHS Wales. The purpose of such local or community level analysis is largely exploratory, seeking to generate informative insights into network processes and practices as they take place in a real-life setting. There is also a significant descriptive element to this research stage. The chapter maps out the array of network ties at work and reports on relational norms that have developed in the research setting following the creation of LHGs. Importantly, the Local Health Groups, strategically situated within this locality context of the National Health Service, are the focal point, or central node and coordination mechanism, for a study of networking activity. The chapter reports on the relational norms at work and on how health professionals have responded to these new forms of collaborative working. The chapter also details the depth and breath of relationships across professions and agencies, and how network actors have responded within these new organisational forms.

## **Chapter 8**

This chapter draws together the significant outcomes to emerge from the different stages of the study and seeks to relate outputs to the theoretical field, the policy, institutional, and managerial contexts, in which the study takes place. The chapter begins by restating the guiding aims and objectives of the study. Findings from the extensive literature review conducted in the initial stages of the project are presented and discussed in terms of the status of current network research, and are used to establish a rationale for the study in relation to the weaknesses in network logic exposed during the literature review. A discussion on shifting patterns of governance

in health and public services is presented, to position the study within the relatively under-researched area of networking and collaborative governance in health care. The chapter also reflects on the methodology crafted and utilised to address the main objectives of the study. The chapter goes on to present the important outcomes from the multi-level analysis of network activities across the national sector level, primary care level, regional level, and the local level contexts of health care.

## **Chapter 9**

This chapter, the final chapter of the thesis, reflects on the outcomes and contributions of the study. The chapter addresses the principal research questions posed by the study by drawing a number of conclusions based on the findings to emerge from the different phases of data collection and analysis, as summarised in chapter 8. As such, this final chapter concludes that recent changes in policy and practice in health care reveal an archetypal shift away from markets and hierarchy, to a more network model in the UK National Health Service. The chapter draws out the salient processes and factors involved in the integration of agencies in health care, as uncovered by this study, and the potential implications of networks for the management and organisation of the National Health Service. The chapter goes on to present the important implications for Health Service design and development, management and professional practices. The chapter presents a number of relevant observations and recommendations concerning current and future health policy, particularly the need to support collaborative relationship building and network embedding over the long-term. The chapter also reflects on the methodology applied during the study and presents an agenda for future research on networks in health care, and more widely across the public sector.

## **1.1 Introduction**

This first chapter explores the organisational form known as the 'network'. The aim of the chapter is both informative and synoptic, seeking to define the field of inquiry, review the relevant theoretical literature, specify the main themes of the research and identify potential areas for contribution to the field of study. A prime objective of the chapter is to draw out theoretical and conceptual issues relating to the activity, or formalisation of activities, within or between organisations, known as networking, and to view such derivatives in relation to the overall focus of the study, an exploration and evaluation of the salient features and functions of management and organisation under network conditions. The chapter begins by summarising an abstract view of networks and contrasts this with established interpretations of the network phenomena. The chapter then presents a summary of the different antecedent approaches taken to the study of networks and comments on the relative influence and contribution different theoretical approaches have made to the field of inquiry. A rationale for organisational networking is presented and positioned in terms of discussions of markets, hierarchies and network modes of governance. The chapter goes on to present a classification of different types of inter-organisational arrangements; highlighting the varied depth and breadth of relationships that exist within and between organisations, making the network a generic term for a variety of different relationships. The chapter goes on to highlight areas of conceptual and empirical weakness in network theory and justifies the need for research that compares and contrasts networks with more established forms of organising, research that provides more understanding of network processes and how to manage networks, and research that evaluates the effectiveness and outcomes derived from networking.

## **1.2 Characteristics of the Network Organisation**

The term network is so widely used by academics and others that it has arguably lost a precise meaning (Nohria and Eccles, 1992). The density and breadth of the term has widened in recent years, to include a range of labels such as: organisational sets

(Aldrich and Whetten, 1981); vertical disaggregation (Miles and Snow, 1984); quasi-firm (Eccles, 1981); cooperative arrangements or strategic alliances (Contractor and Lorange, 1988); and strategic network (Thorelli, 1986; Jarillo, 1988). This variance in the terminology used to describe network activities is understandable given the complexity of the phenomenon, however it is still surprising that the term network has not yet produced a more detailed description and that the network organisation continues to elicit a significant degree of ambiguity.

The term network is most often referred to as ‘an abstract notion referring to a set of nodes and relationships that connect them’ (Fombrun, 1982), and is frequently cited in a variety of scientific disciplines, including, artificial intelligence, social psychology, management and organisational studies. Michell (1969: 2-4) talking on the subject of social interaction, defines the network as, “*a specific type of relation that links a specified set of persons, objects, or events*”. Different types of relations define and help identify different types of networks; for example, in an organisation the network of authority may be different from the network of power and influence. In society people often form multiple relations or networks, such as strong family ties, friendship ties or professional relationships. The persons, objects or events, represent the actors or nodes within a given network. The commonalties or attributes actors exhibit, are often used to delineate the network, whereby the form these relations take is often used to differentiate between network typologies (table 1). Network analysis would not be complete without some recognition of the relations that occur, but also those that do not exist. As such, Knoke and Kukliniski, 1991: 175) state that, “*The configuration of present and absent ties between the network actors reveals a specific network structure*”. The structure and form a network takes is often illustrated according to degree, frequency and depth of interactions, from the isolated or fragmented structure in which no actors are connected, to more dense or embedded structures in which all actors are strongly linked. In addition, the conceptualisation of the network form by different research perspectives has eluded an array of network types (Easton, 1992). There are three broad definitional groups: one describes the network as the total pattern of relationships within a group of organisations working to achieve a common goal (Van de Ven and Ferry, 1980); the second focuses on the social relationships that link connected organisations (Aldrich, 1979); the third looks



at the exchange dimensions, where the components of exchange can include products, services, information, or knowledge (Anderson et al., 1994). These definitions reflect different levels of network analysis.

**Table 1 Classification of Network Forms**

Classification Variable	Classification of Network	Classification Base
Type of governance structure: level of risk and reliance on trust for instance	<ul style="list-style-type: none"> <li>▪ Recurrent contract</li> <li>▪ Relational contract</li> </ul>	Ring & Van de Ven (1992)
Formal versus informal co-operation	<ul style="list-style-type: none"> <li>▪ Hard networks</li> <li>▪ Soft networks</li> </ul>	Rosenfeld (1996)
Network orientation and direction	<ul style="list-style-type: none"> <li>▪ Internal networks</li> <li>▪ Vertical networks</li> <li>▪ Horizontal networks</li> <li>▪ Diagonal networks</li> </ul>	Hinterhuber & Levin (1994)
Structural autonomy and joint creation	<ul style="list-style-type: none"> <li>▪ Social networks</li> <li>▪ Value-creation networks</li> <li>▪ Market-based transactions</li> <li>▪ Vertical integration</li> </ul>	Van de Ven, Walker & Liston (1979) Burt (1990)
Degree of ownership and degree of outsourcing	<ul style="list-style-type: none"> <li>▪ Internal networks</li> <li>▪ Stable networks</li> <li>▪ Dynamic networks</li> </ul>	Miles & Snow (1992)
Degree of ownership integration and coordination integration	<ul style="list-style-type: none"> <li>▪ Marshallian districts</li> <li>▪ Japanese Kaisha networks</li> <li>▪ Venture capital networks</li> <li>▪ Third Italian districts</li> <li>▪ Chandlerian firms</li> <li>▪ Holding companies</li> </ul>	Robertson & Langlois (1995)
Network actors and task orientation	<ul style="list-style-type: none"> <li>▪ Business networks</li> <li>▪ Infrastructure networks</li> </ul>	Halleng (1992)
Type of relationship and environmental fluctuations	<ul style="list-style-type: none"> <li>▪ Flexible networks</li> <li>▪ Virtual networks</li> <li>▪ Hollow networks</li> </ul>	Cravens et al. (1996)

Table 1 presents a list of the different network characterisations to emerge from across the three broad areas and the classifications given to different forms of networking behaviours. A classification or typology of networks is important for a number of reasons. As Easton (1992) points out, *'the way networks are defined and perceived will have an effect on the way we think about them and also on the way we focus our interest and delimit problems'*. Table 1 not only demonstrates the diversity of the meaning attached to the term network, it also shows how different researchers from different theoretical perspectives have addressed the network phenomenon. This review and study is primarily interested in networks as modes of governance for managing organisational activities through the processes of coordination and cooperation between separate organisations. In particular, the focus of this study is on organisations or organisational sub-units during cooperation and on networks as the nexuses of integration. Following on from discussions presented above it is recognised that networking, or collaborative integrative cross-organisational processes, include all the range of organisational coordination devices from lateral communication, to inter-dependent information and planning systems, to complex integrated structures, building and maintenance, trust, reciprocity, opportunism and commitment (Grandori and Soda, 1995; Ring and Van de Ven, 1996).

### **1.3 Identifying a Network Archetype**

Contributions from institutional economics and behavioural/sociological-based organisational theory present two very different interpretations of the network organisation. Institutional economists often characterise the network as an intermediate or hybrid form of organisation (Williamson, 1991). Williamson (1975) refers to the network as *'some form of intermediary compromise between either market or firm'*. Williamson's view of cooperative behaviour between firms contrasts with organisational representations that view the network organisation as a 'third-type' of organisational arrangement, qualitatively different from both markets and firms (Powell, 1990; Johansson, 1987a). While economics, particularly from the neoclassical tradition, tend to address network arrangements in terms of their temporal properties, probable longevity and stability, organisational studies take a more socio-psychological approach to the study of these alternative governance structures

(section 1.4 for a more detailed explanation). Grandori and Soda (1995: 183) writing on networks offer the following definition:

*“An inter-firm network is a mode of regulating inter-dependence between firms which is different from the aggregation of these units within a single firm and from coordination through market signals (prices, strategic moves, tacit collusion) and which is based on a co-operative game with partner-specific communication”.*

Grandori and Soda’s terminology evokes sentiments from game theory, such as the bargaining powers often cited in economics, but also allude to the relational basis of networking. There remains a need for a more flexible definition of networks, one that recognises the different magnitudes and nature of cooperation among organisations. For instance, the term ‘inter-organisational network’ often refers to a number of connections, commonly referred to as relationships, between different organisations (Easton, 1992). These network organisations can take the form of businesses, associations, institutions, or agencies, and can be located in either the profit or non-profit sectors. As such, inter-organisational networks generally refer to external cooperation between separate organisations, as opposed to intra-organisational cooperation, which takes place between units of a single organisation. Definitions are in some sense, visions based on perception. The way networks are perceived highlights the problem that exists when attempting to draft a universal definition of any organisational form, or more appropriately, an organisational phenomenon, that by its very nature, is multi-dimensional and multi-faceted.

While many studies tackle the problem of demarcating the boundaries of the hierarchical organisation in a competitive environment, studies of network organisations under conditions of reciprocal collaboration, also find it difficult to mark out organisational boundaries. For instance, in large institutions such as multi-national corporations, or public sector services that encompass multiple unitary organisations that fall under the umbrella of one larger institution, it is often difficult to distinguish simple boundaries. Similarly, for large multinational corporations with multiple subsidiaries, unit subsidiaries often compete with each other over resources and investments, as would be the case for independent firms in a competitive market place. In this example, each component organisation can exhibit similar characteristics to that of stand-alone organisations. In such instances, relationships

between organisational units can justifiably be classified in terms of external-type collaborative forms. The former highlight the complexities of network structural features and demonstrate the constraints on efforts to define a network as a finite structure, rather a network is a far more pervasive form, a myriad of inter and intra-organisational ties.

The inter-organisational network is most often differentiated from the vertically integrated organisation by the independence maintained by partners within the network (Park, 1996). Accordingly, the network in the profit sector is based on the price mechanism of markets and on the authority relationship of hierarchies. As Park (1996: 796) points out, '*market forces remain in existence while network members exercise operational dependence, as within a hierarchy*'. In the not-for-profit sector, independence may be viewed in terms of operational control and accountability.

Whether the network is understood according to behavioural characteristics, strategic objectives or economic indicators, the network organisation is most commonly defined and investigated through one of three key dimensions, of *structure*, *process* or *strategy*. Structurally, a network combines co-specialisation, the sharing of control over assets. In terms of process and purpose, the network relationship refers to a level of joint ownership over the production of assets, either tangible or intangible, through some form of integration, according to a form of mutual arrangement between partners. Networks are also often characterised by flexibility. Participating agents are allowed influence in procedural matters, but are free to develop or dissolve ties. A network, as an organisation, presupposes a unifying purpose and thus, holds some sense of shape and identify needed to bound and share resources, with useful action that concludes a strategy or goal of purpose. The network is arguably distinguished from more centralised less flexible hierarchies, by eliciting higher elements of *joint-specialisation*, *joint-control*, and *joint-purpose*, features derived from the extant literature on networks and cooperative behaviour.

The vast and multidimensional literature relevant to the network organisation provides a number of recurrent themes or design features associated with these complex and flexible organisational forms. Specifically, the network organisation preserves

permeable boundaries, either internally among business units, or externally with other firms (Doz and Prahalad, 1991; Nolan and Croson, 1995; Snow and Miles, 1992). Management tends to be less hierarchical, deriving authority more from expertise than rank (Jarvenpaa and Ives, 1994; Kanter, 1989). This feature stems from network functions demanding a high degree of intangible, specialised, or local knowledge and know-how (Drucker, 1992). The type and form of communication in network relations appear to be more un-directed or ad-hoc, as apposed to the official channels of hierarchy. Of significant importance is the way in which knowledge is transferred via multiple loose associations or weak ties (Nohria and Eccles, 1992; Granovetter, 1983). Resources are more specialized and customisable across product and services ranges, but are far less vertically integrated (Johnston and Lawrence, 1988). Another unique feature is that tasks are more often project driven and less functional, with shorter business cycles, leading to better quality and more differentiated outputs (Aldrich, 2000). The division of labour is readdressed, so that problems are dealt with at line or operational level, or more locally (Kanter, 1989). Cooperative partnerships generally expose agents to risk from opportunistic behaviour (Williamson, 1975; 1985) resulting in network relations requiring a high degree of trust and commitment from members (Ring and Van de Ven, 1992; 1994). This in turn allows members involved in high-commitment high-trust networks to take risks or partake in ventures normally deemed too risky for stand-alone firms (Harrigan, 1988). The archetypal features of networks are summarised in table 2, and are contrasted with similar design features for markets and hierarchies.

**Table 2 Network Design Features Compared with Markets and Hierarchies**

Attribute	Market	Network	Hierarchy
Purpose	Provide a forum for transacting	Advance the interests of a cooperative	Advance the interests of a central executive
Vertical Integration	None: complete decentralisation of ownership of inputs to production	Variable: moderate for stable networks; low for dynamic networks	High: centralised ownership of inputs to production

<b>Assets and Resources</b>	<ul style="list-style-type: none"> <li>▪ Low asset specificity</li> <li>▪ Easily traded</li> </ul>	<ul style="list-style-type: none"> <li>▪ Moderate to high asset specificity</li> <li>▪ Few slack resources</li> <li>▪ Flexible, more intangible assets</li> </ul>	<ul style="list-style-type: none"> <li>▪ High asset specificity</li> <li>▪ Not easily traded</li> <li>▪ Slack resources, buffer stocks</li> <li>▪ Fixed assets, mostly tangible</li> </ul>
<b>Products and/or Services</b>	Spot contracts with high variation	Customised, economies of scale and scope	Mass produced, economies of scale
<b>Transactions</b>	Short-term, low likelihood of repetition	Less-fixed time frame, variable likelihood of repetition	Long-term, high likelihood of repetition
<b>Property Rights Transfers</b>	Wage or revenue claims incurred at time of sale, conferred by property rights	Sustained property rights transfers, negotiated or shared claim to future revenue	Wage claims incurred at time of production, little claim to future revenue
<b>Boundaries</b>	<ul style="list-style-type: none"> <li>▪ Discrete, entirely atomic</li> <li>▪ Distant, arms-length, once-off associations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Flexible, permeable, relative or latent</li> <li>▪ Loose ties, dynamic in nature</li> </ul>	<ul style="list-style-type: none"> <li>▪ Fixed, rigid</li> <li>▪ Stable ties or associations</li> </ul>
<b>Trust</b>	Low	High	Low to Moderate
<b>Conflict Resolution</b>	Market norms and legal system	Relational norms and recurrent contracts	Detailed contracts and administrative fiat
<b>Communications</b>	Direct, brief, and complex	Direct, as required	Via vertical channels, constant, up-down
<b>Task Basis</b>	Unitary	Project	Functional
<b>Incentives</b>	High sales base, quick sale or exit	Performance orientated with multiple transactions	Low, process steps and output pre-specified, reliance on fixed-wages
<b>Decision Locus</b>	Complete autonomy	Locally negotiated	Top-down

Knowledge Acquisition and Transfer	Information conveyed by prices via market channels	From partners via relational ties, wider scope and access to external environment	From the external environment via specialised internal offices e.g. marketing, or via external collaborators
Control / Authority / Influence	Persuasion achieved via a pricing mechanism	Expertise and reputation based, high level of persuasion, control achieved by relational norms	Status and rule based, command and obedience relationship

Source: Entries taken from multiple sources, principally; Powell (1991), Galbraith (1974), Van de Ven and Walker (1984), Thompson *et al.*, (1991)

The design features summarised in table 2 illustrate the relative differences between market, hierarchy, and network forms. This table is particularly useful for the development, or for the distinction, of a network organisational archetype. One of the principal concerns of the network literature is whether or not networks represent some intermediate compromise between markets and hierarchies, or that they represent a new organisational form. Along the axes of *vertical integration*, networks clearly fall between market and hierarchy. However, as introduced in section 1.2, there is considerable support in the literature for networks as a new and distinctive governance mechanism (Nohria and Eccles, 1993). Table 1 presents a useful, yet simplified, abstraction from which to compare networks against the well-established ideas of market and hierarchy.

#### 1.4 Network Theory: Principle Approaches and Antecedents

This section examines some of the central factors and influences relevant to network entry and network formation decisions. Importantly, understanding why organisations decide to network reveals some clues as to why networks exist, and perhaps most importantly, why some networks succeed, while others fail. The principal motivations for network formation are documented under two main headings; economic

imperatives and strategic imperatives. It is clear from the following accounts that the economic and strategic are very much inter-linked, where strategic decision-making is fundamentally premised on economic principles.

The concept of the network is well documented in many social science disciplines, particularly in sociology (Park, 1996). The term network has often been used as a metaphor to describe the inter-personal relationships that have existed in society. The recent proliferation and acceleration of corporate (organisational) networking in the private sector has stimulated renewed interest in this social phenomenon. Social scientists within the management field are now examining the inter-organisational network as an analytical tool rather than a metaphor, in an attempt to explain its activities (Thorelli, 1986; Jarillo, 1988). Networking and new processes of organisational collaboration are interesting from a theoretical perspective as the network represents a unique area of common interest that brings together various branches of the social sciences (Grandori and Soda, 1995: 183). The eclectic range of empirical research in this area has resulted in network studies being rooted in multidisciplinary sources which date as far back as theories of market failure (Coase, 1937), to individual problem solving (March and Simon, 1958), game theory (Axelrod, 1984; Parkhe, 1993), institutional legitimisation theory (Selznick, 1949; Galaskiewicz and Wasserman, 1989), resource dependency and social exchange theory (Pfeffer and Salancik, 1978; Provan, 1984), and transaction-cost economic theory (Williamson, 1985, 1991; Hennart, 1988; Kogut, 1988). While many of these approaches have documented the propensity for network formation, less has been articulated about the processes of networking post-formation (Grandori and Soda, 1995), and there exists scarce theoretical or empirical research concerning network performance, in particular how and why networks succeed or fail? A review of the relevant literature from economics, organisational studies and sociology, reveals several major lines of inquiry in the study of networks. The principal approaches of economics, organisational studies, sociology and management, are presented here and are viewed in relation to the major antecedent theoretical contributions of these contrasting perspectives. Findings from different fields and disciplines are outlined below and are reviewed in terms of their relevance to the study at hand.



## 1.5 The Economics of Networks

The majority of writers on inter-organisational networks cite economic incentive as the main driving force for network formation (Contractor and Lorange, 1988; Kogut, 1988). Economic interpretations of cooperative behaviour between firms dominate network theory. For many economists the network form is viewed as a cartel of independent organisations working together to achieve a desired collective benefit. According to Park, the economic rationale is simple, “*the network can establish collective strengths beyond those of single firms*” (1996: 797). The division of labour allows network members to specialise in adding-value to the product, service, or innovation, by tapping into each member’s specific and distinctive competencies (Miles and Snow, 1986). Networks are commonly formed to achieve synergy (Luke et al., 1989). Member companies act like chains of competencies, each specialising in core competencies with the chain linked as an extended production operation, thus increasing efficiency and maximising economies of scale and scope.

Economic uncertainty remains a critical element in the organisation of industrial firms. Macmillan and Farmer (1979) comment that the reduction of uncertainty is the most significant motivator for the increase in buyer-supplier networks during the 1970s and 1980s; such as the upsurge in inter-firm networks during the 1970s oil crisis. High levels of environmental instability or uncertainty, prompts firms to seek out secure relationships with suppliers.

Barnard’s (1968) explanation for the existence of organisations poses the technological imperative, suggesting that informal collaborative arrangements originate when technological conditions demand physical power, speed, endurance, mechanical adaptation, or continuity beyond the capacity of the single individual (1968: 27-8). Significantly, each organisation is viewed as a medium for cooperation, where tasks are complex or beyond the technological capacity of an individual. Technological and strategic resource issues are well documented in international business texts (Dunning, 1988).

Economic approaches to the study of networks remain centred around markets and inter-firm competition. The network represents an unusual governance mechanism for

economists, as it repudiates much of the neo-classical ideas of competition. To address this evolving organisational form and process, economics has tended to concentrate on the objectives of inter-firm cooperation, citing rationale motivations of technology acquisition, information exchange or access to markets (economic and strategic imperatives section 1.3) for example, and relating these precursors back to more traditional notions of competitive behaviour.

Industrial economics offers a special insight into network behaviour and has long been concerned with the subject of industry organisation (Richardson, 1971; Mariti and Smiley, 1983). Research into vertical and horizontal integration has broadened out to examine mixed forms of quasi-integration (Blois, 1972), for example, and the processes of internationalisation (Dunning, 1982; Mariotti, 1984). Core explanatory variables used to assess the efficiency properties of firms include economies of scale, scope, specialisation and experience. As such, economies of specialisation and experience are important factors in explaining why, even in the presence of significant inter-dependence, a network (of separate firms) may be superior to an integrated enterprise, as is the case in subcontracting (Eccles, 1981). The pooling of resources in coalitions aimed at the provision of common services, such as in joint production agreements between care producers (Turati, 1990) show how economies of scale also play an important role. Economies of scope can form the basis for agreements, such as the joint utilisation of resources or know-how agreements (Teece, 1980). More historical or evolutionary economic-strategic approaches have often stressed the role of technology in relation to costs and learning problems, and in the formation of inter-firm networks. These approaches have built extensively on the work of Chandler (1962; 1977) and discussions of strategy and structure, by aligning cooperation and coordination to the process of technological innovation (Nelson, 1993).

Economics adds to the explanation for the relative success of inter-firm cooperative arrangements, the reduction of governance costs to that of production costs, and is currently one of the most widely used approaches for the analysis of networks. Importantly, organisational economics advances a theory of networks by combining traditional economic thinking to organisational explanations of inter-firm behaviour, striking a balance between the properties of markets and hierarchies (Williamson,

1985; Powell, 1987; Thorelli, 1986; Bradach and Eccles, 1989). The most frequently used variables, or sources of increasing costs under market conditions are: asset specificity, contextual uncertainty, the frequency of transaction costs (Williamson, 1981), the measurability of performance and the difficulties of detecting and controlling it (Barney and Ouchi, 1984), and the presence of agents characterised by risk aversion (McGuire, 1988; Davis, 1991).

## **1.6 The Sociology of Networks**

In contrast to the rationale logic of economics, explanations and research on cooperative alliances between organisations in a societal context from the general field of sociology provide distinctively different interpretations of the network organisation. Of particular prominence is the concept of social embeddedness. Granovetter (1983, 1985) coined the terms 'social embeddedness' and 'cultural embeddedness'. Granovetter argues that all economic relations between firms take place within a web of pre-existing social and cultural relationships. According to Granovetter (1983), complex inter-organisational networks develop from 'weak social ties'. Social acquaintances act as predictors of network development. Analysts of organisational culture view institutionalised social norms and the values internalised by economic actors as an important motivation for inter-firm cooperative behaviour (Ring, 1993). Here trust between partners and organisational culture are highlighted as necessary ingredients of cooperation, where entities are viewed as having an identity, with specific characteristics, and where effective cooperation is the marrying of complementary organisations with similar or compatible identities and cultures.

Another important area of study on networks is that of social network theory. Originating from small-group research, this form of analysis has been applied to the study of inter-firm coordination in particular, the emergence and change of informal structures (Burt, 1990), network boundaries (Burt and Minor, 1983; Laumann, Marsden and Prensky, 1980), the processes of corporate cooptation (Burt, 1983), inter-locking directorates (Burt 1979, 1980), and patterns of relations among small firms (Lomi and Grandi, 1993). One of the main contributions of social network analysis has been in understanding the role of the individual organisation within the

network (Burt 1979; 1990). Lastly, at the more grand-theory level is the radical-Marxist perspective, which spans both sociology and economics. The strategic behaviour of networks is driven by power and dominance, manifest in notions of efficiency or effectiveness (Whitt, 1980). Empirical work in this area, from this radical perspective, has mainly originated from sociological studies of informal power networks and associations (Moore, 1979; Perucci and Potter, 1989), and contrasts the more segmented theories outlined above. This perspective adds a more macro-economic-sociological level from which to view organisations such as networks, particularly against ideas of exploitation, alienation, and capitalism.

### **1.7 Management and Organisation Theory of Networks**

The organisational perspective on networks is arguably situated somewhere between economic and sociological approaches. Studies of inter-firm cooperation tend to be prescriptive and descriptive in terms of theory development. Principal findings derive mainly from studies of inter-organisational processes such as: the achievement of desirable results; reaching and stabilising agreements (Schermerhorn, 1975; Schmidt and Kochan, 1977; Van de Ven and Walker, 1984); design, structuring and formalisation (Van de Ven, Walker and Liston, 1979); choosing an effective power distribution (Gray, 1987); and the methodological considerations of researching the network form (Fombrun, 1982). Importantly, contributions from organisational studies include the degree of differentiation within markets, industries, sectors, and organisational units, as an explanatory variable in network formation. The diversity of firms and the resources they control act as an incentive to collaborate and is considered a predictor of network formation, especially in relation to technology acquisition and innovation (Teece, 1986; Richardson, 1971). Conversely, there is some argument that the degree of differentiation can also lead to network failure. Inter-unit differentiation is a major source of coordination costs (Harrigan, 1985; Miles and Snow, 1992). The literature on mergers and acquisitions and multinational companies cites an excessive degree of differentiation as a cause of bureaucratic failure, resulting in the disintegration of the organisation (Porter, 1987; Franck, 1990; Olie, 1990).

The intensity or degree of dependence that exists between organisations, particularly firms in a market environment, has been highlighted by organisational studies as an indicator or catalyst for network formation, and as a factor in the efficiency and performance of networks post-formation (Oliver, 1990). Dependency or inter-dependency, are commonly related to a number of factors such as, asset specificity, uncertainty and the intensity of resource exchange. Dependency is defined in terms of the depth of relationship that exists between partner organisations, and is directly related to the availability of alternative partners, as well as the ease and costs associated with switching partners. For example, where a firm requires inputs, such as raw materials, and these resources are only available for one supplier, the contracting firm is heavily dependent. In another way, when one firm invests substantial resources into a partner organisation, the level of dependency increases, as does risk. Thus, dependency is a central measurement variable, and as such, has been applied extensively in organisational approaches to network studies.

The number of separate but inter-dependent firms requiring coordination has been shown to be a predictor of network formalisation (Van de Ven, Walker and Liston, 1979). As the numbers of organisational sub-units increase this places limits on the capabilities of hierarchies, in terms of coordination (Williamson, 1970). Conversely, it is suggested that the network allows firms to expand their activities beyond traditional structural limits (Vacca, 1986), by forming alliances with external organisations, where activities are shared and where individual units can specialise, but where the network acts as one coordinated unit to the benefit of all partners. In a related vein, the complexity of inter-dependent activities has long been considered a predictor of organisational arrangements and has also been positively related to the complexity of inter-organisational relationships (Osborn and Baughn, 1990; Killing, 1988). Asymmetry in the resources controlled by different firms, for example information and know-how, have added to this type of organisational analysis of networks as a predictor of their degree of centralisation.

The fact that economic exchange very often involves negotiation has resulted in an exploration of the processes of negotiation and exchange as an area of organisational studies that has been beneficial in refining our understanding of how interactions are

regulated between organisations. It is argued that:

*“in order to understand the fine structure of an inter-firm co-ordination agreement, the specific utilities of the partner firm should also be considered, as well as the type of negotiation process that is likely to emerge”* (Grandori and Soda, 1995: 186).

It is also suggested that the sustainability of a network is dependent upon the negotiation process as it is defined by ‘the underlying game structure’ (1995: 186). For example, transaction-cost economics mainly addresses the particular problem, or game, of effectively regulating buyer-seller exchanges in varying conditions of risk, specificity, or uncertainty. In this case, the game involves the negotiation of two opposing interests, which often requires complex contracts and safeguards. Thus, the negotiation approach raises the issue of games as a predictor of both network formation and shape. The game represents an uncertain process of bargaining and risk-taking, that goes far beyond more established or accepted theories of transaction costs and related opportunistic behaviour (Coase, 1937), by introducing notions of pareto-efficiency and fairness of devised arrangements. Finally, a negotiation approach has helped in appraising the effects of processes in enhancing the probability of parties reaching an agreement and in shaping organisational form (Schmidt and Kochan, 1977; O’Toole and O’Toole, 1981).

One of the most prominent explanations for network formation is that of resource dependency (Pfeffer and Salancik, 1978). The idea that the firm is subject to forces outside or beyond its control and dependent on a number of internal and external agents (sources), is very important to the notion of a network organisation (Aldrich, 1979; Benson, 1975; Jacobs, 1974; Evan, 1966). The resource dependency perspective has emerged as one of the most influential or most cited explanatory theories of inter-firm cooperation (Pfeffer and Salancik, 1978). While this approach offers similar antecedent conditions to those presented by organisational economics, particularly with respect to core explanatory variables like critical uncertainty and inter-dependence, it arguably represents an independent perspective by offering a universal explanation for network formation and network processes as: *“...the strategic manipulation of transactions and games aimed at changing the relationship of interdependence”* (Grandori and Soda, 1995: 187). As such, the origins of this

perspective are clearly linked with organisational studies of environmental factors and negotiation analysis of games and inter-dependence.

Resource dependency theory distinguishes between types of dependence as possible predictors of network formation and structure, both in quantitative and qualitative terms. Quantitative studies often examine the variance in relationship types and the quasi-casual link between level of dependence, strength of relationship and network performance (Gillet, 2000; Alter and Hage, 1993). Qualitative studies highlight the process of relationship building and maintenance (Pfeffer and Salancik, 1978) as an important factor in network performance, and suggest that horizontal inter-dependence, such as that stemming from resource-pooling or symbiotic arrangements, result in a very different type of coordination mechanism; one based on relational values rather than economic precedents, such as contracting against opportunistic behaviour. Grandori and Soda, citing the work of Aldrich and Whetten (1981) state that:

*“...alliances are mostly regulated by associational agreements (e.g. trade associations, cartels and consortia); while complex resource-transferring alliances have been shown to be mostly regulated by agreements based on various forms of relational and obligational contracting” (1995: 187).*

Institutional approaches to cooperative behaviour between firms in a market place also consider dependence as a central concept, but dependence does not only refer to material resources or transactions, but includes a new resource, that of legitimisation (Grandori and Soda, 1995: 187). The social aspects of the organisation, from the personal to formal relationships, are deemed important in terms of understanding a firm's desire to survive by means of seeking recognition and avoiding isolation. In this way, the organisation forms networks of relationships to survive in a social sense (Di Maggio, 1986; Baum and Oliver, 1991). In addition, an organisation's social skills thus become a predictor of survival. The institutional perspective also suggests that inter-firm network formation is shaped or affected by 'institutional embeddedness', *“the relative effectiveness and ease of formation of various inter-firm co-operative structures is contingent to the larger social institutions in which these relationships are embedded” (Grandori and Soda, 1995: 188).* These social institutions, similarly described by resource dependency theory, include the legal system, the banking

system, the structure of labour markets and the political system (Whitley, 1990, 1991; Grabher, 1993; Dore, 1983). The institutional context is shown to be an important aspect of collaboration, incentive and restriction.

Organisational studies have also indicated flexibility as a major property of inter-firm networks. *“Flexibility in this context does not only mean capacity to change firms’ output according to contingencies but also capacity to change the organisational arrangement itself”* (Grandori and Soda, 1995: 1986). In this sense, networks are seen as being more conducive to organisational restructuring and more able to respond to environmental changes, as the network can reconfigure itself by disposing of unproductive partnerships or by integrating new partners (Pfeffer and Salancik, 1978; Gadde and Mattsson, 1987).

## **1.8 The Strategic Network**

The concept of the ‘strategic network’ has been used to define the inter-organisational network as a purposeful and conscious arrangement among related profit-seeking firms, to gain or sustain competitive advantage *vis-à-vis*, their competitors outside the network (Miles and Snow, 1986; Jarillo, 1988). Strategic networks are often setup by a ‘hub firm’ that proactively manages the network from the centre (Jarillo, 1988). By cooperating with other economic agents, network members hope to exchange the indirect influence that economic systems and actors place upon them, for increased stability and a reduction in uncertainty and risk (Pfeffer and Salancik, 1978). Park (1996: 17) writes,

*“...the inter-organisational network is viewed as a strategic mechanism to improve a firm’s competitive advantage through cost minimisation while maintaining flexibility”.*

The strategic network allows firms to lower information costs and to accelerate innovation, both technological and non-technological. Teece (1992) illustrates how networks are used as connecting and transferring mechanisms for complementary and inter-dependent competencies between firms. Powell (1987) adds that organisational and technological competencies are not always easily transferable, but that the network facilitates the transfer of codified knowledge and technology, that are



commonly difficult to trade in a market, or communicate through the hierarchy. In addition, networks offer members a unique form of operational flexibility. While individual firms maintain the standard hierarchical shape, network-based relationships allow the firm to access extended sources of assets. For example, in high-tech industries where the pace and cost of innovations is high, and where product life cycles are significantly shortened, unitary firms might find it difficult to reconfigure operations to react rapidly to changing and dynamic market conditions. In such instances, collaboration offers increased support and asset sharing. Consequently, members have more freedom to enter or exit innovative networks, as compared with 'closed' hierarchical arrangements (Park, 1996).

Reve (1990) highlights the importance of defining the boundaries of the network firm. Reve suggests that organisations should focus on unique resources or core competencies, and should outsource complementary skills through external contracts: a move towards a flexible model of the firm where, "*the properties of the transaction determine what constitutes the efficient boundary of the firm*" (1990: 144). This conceptualisation reflects the important role of inter-organisational relationships for a firm to obtain sustainable competitive advantage.

The strategic management perspective has tended to concentrate on the development of inter-organisation alliances, commonly strategic alliances and joint-ventures (Harrigan, 1985; Killing, 1983; Turati, 1990). Drawing on the offerings of economics, sociology, social psychology and organisational theory, business policy or strategic management approaches have generally tackled the study of inter-firm networks under the heading of 'strategic alliances' (Porter and Fuller, 1986; Ohmae, 1989; Contractor and Lorange, 1988). The distinctive focus of this research has been eclectic, using all available tools, often to examine one focal firm attempting to enhance its position. In particular, business policy has focused on the variable of specificity/unsubstitutability, in relation to core and distinctive competencies, as something to be manipulated. Among strategic marketing perspectives of inter-firm coalitions and alliances, is the work of a group of Swedish scholars on long-term buyer-seller relationships of industrial goods (Hakanasson, 1982; Ford, 1980; Ford, Hakanasson and Johanson, 1986; Forsgren and Johanson, 1992). The Swedish

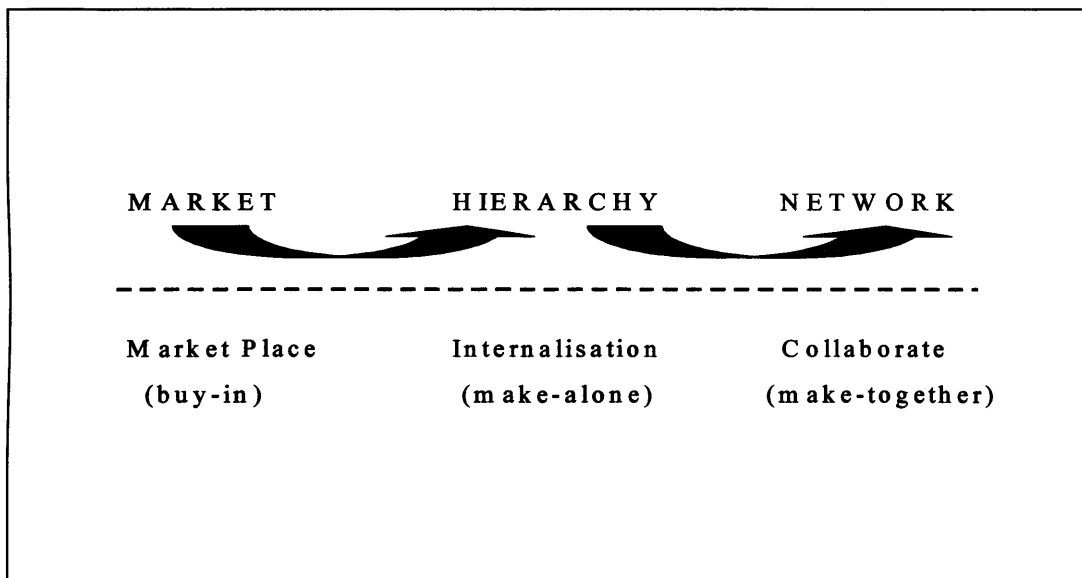
approach has principally analysed the social-exchange aspects of inter-firm networks (Johanisson, 1987b) and the dynamics of network, rather than structural form (Gadde and Mattson, 1987). Emerging from this approach has been an emphasis on the role of individual skills (Grieco and Hosking, 1987) and entrepreneurship (Johanisson, 1987c). The work of the International Marketing and Purchasing (IMP) research group, referred to as the 'Swedish Network School', has been particularly influential in the field of business-to-business relationships (Ford, 1990; Hakansson and Johanson, 1987). One of the central features of the IMP group is reflected in the title of a book by Hakansson and Snehota (1990), *'No Business is an Island'*. Conceptually, IMP industrial network theory is grounded in behavioural theories of decision making and in a strategic resource dependency perspective. According to Hakansson and Johanson (1987) *'to understand how networks work, it is crucial to understand relationship characteristics as well as the interaction processes within which relationships develop'*.

Lastly, some mention must be given to the population ecology perspective, an adaptation of the Darwinian concept of evolution, that brings together much of the knowledge generated by earlier network approaches. Ecological theories tend to be concerned with the concept of organisational survival and longevity. The focus is on the factors responsible for the emergence, sustainability, or decline of organisations (as organisms) in an environment (eco-system), most often a competitive market place situation. More recently, population and organisational ecologists have begun to examine new organisational forms, particularly the emergence of the network form. Much of the work in this area has focused on the relationship between form and economic viability, particularly a comparison of unitary-competitive organisations with pluralist-collaborative organisations in terms of longevity and performance (Barley, Freeman and Hybels, 1991; Lomi and Grandi, 1993). Contributions from population organisational ecology to network theory have helped position existing explanatory theory of network formation and post-formation process. As discussed above, many factors influence network cognition, resource dependency, legitimacy (Carrol et al., 1988), economic uncertainty (Williamson, 1975) and social exchange, all play an important role in determining the 'network entry decision' (figure 1), and in determining the viability, longevity, or survival, of the network organisation.

## 1.9 The Evolution of the N-Form: From Market to Hierarchy to Network

Much of the debate that surrounds the network form relates to more established theories of organisation. Very often, intellectual wrangling is aimed at the development of a generic 'theory of the firm'. Specifically, much of the literature on cooperation between competitive firms focuses attention on the conditions that influence a market-hierarchy-network relationship (Ring and Van de Ven, 1992). It is sometimes that an evolutionary process occurs, whereby hierarchical or bureaucratic organisations (firms) emerge from the imperfections of markets. Similarly, the network organisation emerges as a response to the imperfections or limitations of hierarchy (figure 1 below). This triad evolutionary theory is important in relation to network formation, existence and behaviour. The focus of this section is on understanding how governance mechanisms, networks in particular, emerge, grow, and dissolve over time.

Figure 1 From Market to Network Ecology



### 1.9.1 Markets

The market is sometimes viewed as '*a spontaneous coordination mechanism that imparts rationality and consistency to the self-interested actions of individuals and firms*' (Powell, 1991: 270). Transactions take place between two or more parties and are mediated through a price mechanism, where competitive market forces reassure parties that the terms of the exchange are equitable. Benefits to be exchanged are

clearly specified, no trust is required, and agreements are secured with the backing of a legal sanction. While traditional economics asserts that markets offer choice, flexibility and opportunity, organisational and strategic managerial studies suggest that any system based around price fails to capture the intricacies of idiosyncratic complex economic exchange. As Powell (1991: 271) states, markets are “...a *poor device for learning and the transfer of technological know-how*”. In the ideal market, where information is freely available, where demand and supply are non-problematic, and where there are no carry-over effects from one transaction to another, the need for controls and safeguards are almost non-existent. However, it is widely accepted that firms exist as entities that profit from the failure or imperfection of markets. The utopia of the market represents a theoretical ideal rather than an empirical reality to some extent, in terms of behaviours frequently observed. In existing world markets firms exist to capitalise on the imperfections of markets. For instance, rather than accepting the problems of opportunism and limited information, firms internalise production and reduce uncertainty by contracting a relationship with labour. By internalising the production of goods or the delivery of services, firms seek to decrease uncertainty. As such, the imperfections and uncertainties of markets give rise to hierarchy and organisations.

### 1.9.2 Hierarchy

In a hierarchy, each party contributes labour to a cooperative body, which mediates the relationship by placing a value on each contribution, and then compensates parties equitably. Equity depends on a social agreement that a bureaucratic hierarchy has legitimate authority to provide this mediation (Thompson, et al., 1994). Organisations, or hierarchies, arise to internalise transactions and resources that were previously conducted in the market place (Dunning, 1988). According to Powell (1991), the hierarchical structure, with clear departmental boundaries, clean lines of authority, detailed reporting mechanisms, and formal decision making procedures, is particularly well suited for mass production and distribution: for instance companies such as Ford automobiles or McDonalds. The strength of the hierarchical organisation lies in its ability to produce goods *en masse* and to record how resources have been used to improve efficiency (DiMaggio and Powell, 1983). However, when firms internalise production to circumvent the problems associated with markets, a new set

of challenges are created, for example how to control labour, how to maximise production, how to innovate, how to gain access to consumer markets, or how to become informed of, and respond to, environmental change? Powell (1991) comments that one major problem faced by hierarchies concerns their ability to respond quickly to sharp fluctuations in demand. Given these obstacles, hierarchies are constantly seeking ways of minimising the risk of unforeseen changes in environmental conditions, and new ways of reducing risk and uncertainty. It is this motivation that has arguably resulted in firms (hierarchies) seeking out collaborative partnerships with other hierarchies (network formation).

### 1.9.3 Network

In attempting to address collaborative forms of organising, Ouchi (1991) poses a theory of socialisation. Ouchi (1991: 248), referring to the Japanese system of employee socialisation, argues that the basis of reciprocity may be altered by engaging employees (contracted parties) to identify with the goals of the organisation. In this scenario, the emphasis moves away from performance measurement, to control management. Ouchi (1991) refers to an organisation that mediates transactions through a socialisation mechanism as a 'clan' (taken from Durkheim, 1933:155). The socialisation of employees is not a new concept and it is one that has grown in popularity in recent times. Ouchi's (1991) clan is no different from a traditional bureaucratic organisation that has successfully socialised its employees (if this is realistically possible in the first instance). Indeed, Durkheim's (1933: 365) theory of solidarity, from which Ouchi's clan is formulated, suggests that any group which has organic or '*natural dependent solidarity*' can be called a clan. This includes professions, unions, and corporations. Accordingly, professional bureaucracies can be both clans and hierarchies.

According to Thompson (1991: 243-4) there are two possible approaches to economic relationships, *competitive* and *cooperative*, and there are two unit organisational forms, hierarchical and independent. Thompson suggests that if networks were to be introduced into Ouchi's framework (1991: 246-255), it would be possible to construct a matrix of organisational forms and relationships (See figure 2). Ouchi's bureaucracy might be classified as *hierarchical-competitive* and *hierarchical-cooperative* systems

respectively. The classical market form is defined as an *independent-competitive* combination, while the network structure is viewed as *independent-cooperative*. While markets and hierarchies have been identified as two possible mechanisms for mediating economic transactions, Ouchi (1991) suggests a third. “...if the objectives of individuals are congruent (not mutually exclusive), then the conditions of reciprocity and equity can be met quite differently” (1991: 248). As seen in figure 2, the network offers an alternative to the limitations of hierarchy, by building trust-based relationships the firm is able to reduce opportunism and uncertainty (Powell, 1991). There is a degree of agreement in organisational and strategic orientated literature, that networks are an emerging trend, facilitated by the inter-linking of separate organisational entities via technology such as the internet, computer networks and email. The technology revolution has reduced or removed traditional geographical or physical barriers between firms. In addition, increasing volatility, risk and uncertainty, across many business sectors, accounts for the increased incentive for single firms to network themselves to competitors, facilitated by technology.

**Figure 2 A Matrix of Organisational Forms**

		APPROACH TO RELATIONSHIPS	
		Competitive	Co-operative
UNIT OF ORGANISATIONAL FORM	Independent	Market	Network
	Hierarchical	Bureaucracy	Clan

Source: Thompson et al (1994: 244)

There is a growing body of knowledge and support, particularly from organisational and behavioural perspectives, that the network organisation represents a distinct governance structure or mode of coordination, different from either pure market or hierarchy. These alternative forms of governance have been identified in the

management and organisational literatures as a unique organisational solution to the problems of markets and inter-firm competition (Thompson et al., 1991). To understand why this might be the case, it is important to set out the main arguments concerning transaction costs made by institutional economics.

### **1.10 From Market to Network: A Transaction Cost Theory Perspective**

One general theory to emerge from institutional economics is that hierarchies exist as a result of the imperfections of markets (Williamson, 1985). For example, if there is insufficient competition, or where information is not clearly transparent (Le Grand and Barlett, 1993). When market exchange becomes too costly, organisations emerge through the internalisation of production. In a similar vein, networks emerge where the costs of hierarchical exchange (inter-firm) are high. The central theoretical elaboration of this concept originates from the transaction cost perspective. The work of Ronald H. Coase, '*The Theory of the Firm*' (1937), and Oliver E. Williamson, '*The Economic Institutions of Capitalism: Firms, Markets, Relational Contracting*' (1985), have been central to the development of transaction cost economic explanations of inter-firm behaviour. As organisations engage each other, particularly during contractual relationships, they experience transaction costs, for example, *ex-ante* contract negotiation and specification, in addition to *ex-post* contract monitoring and (if required) enforcement and arbitration. Transaction costs increase where there are a small number of providers, when assets are highly specific, and when the complexity of the contract is such that any criteria or method of evaluation is ambiguous (Williamson, 1985).

Transaction cost theory is often utilised to explain the existence of intermediate or hybrid organisational forms (Williamson, 1985). Networks remedy the problems of markets and hierarchy by reducing transaction costs through the development of trust-based relational contracts (Park, 1996: 804). Park (1996: 801) suggests that the network is an intermediate form of governance mechanism between market and hierarchy, concurring with the institutional economic view expressed in section 1.2.. According to Park (1996), the network acts as a governance structure based on transactional reciprocity, where the presence of reciprocity helps the network to

overcome the risks of opportunism. Accordingly, Sako (1992) notes that network forms of organisation are characterised by obligational-style contract-relations; whereas traditional hierarchies are founded on more arms-length relations. The latter involves discrete economic exchange and impersonal relations between agents governed by formal, legal contracts, that seek to specify all future expectations and outcomes. In contrast, obligational or reciprocal contractual relations are embedded in social relationships between parties, that evolve over time and that allow for transactions to emerge and develop where no contractual safe-guards exist, other than good-will and trust (Aldrich and Whetten, 1981). The network operates by aligning incentives to reveal information, to share firm-specific know-how and technology (Kogut, 1988). The level or degree of faith that is required goes beyond that found in arms-length relationships (contractual and competence) and involves mutuality and commitment (Sako, 1992: 37-40). The importance of such goodwill trust is that it facilitates an environment where participants are less likely to adopt a short-term view, or act opportunistically. As a result, partners can reduce transaction costs by removing the need for detailed contract specification and *ex-post* monitoring and enforcement.

Theories of transaction costs, formal contracting and informal contracting, have most recently been applied to exchange and contractual relations in public sector settings. Williamson's work on transaction costs has been widely used as a framework for examining policy initiatives, such as the competitive contracting of public services to external private sector tenders. The literature on quasi-market approaches to UK public sector management, raise a number of concerns regarding increasing transaction costs, in particular, problems of moral hazard, asset specificity and contingency are commonly cited in the contracting of public services (Walsh et al., 1997: 37), where it is often difficult to draft or monitor contracts, and where it is difficult to specify all requirements without incurring significant costs (Kirkpatrick, 2000).

Park (1996: 801-802) summarises the market-to-hierarchy-to-network transaction cost theory as follows. Joining a network may be beneficial when the costs of internal production (IPC) are higher than that of external production (EPC), where the market



transaction cost (ETC) is high to the extent that internal production (make) is cheaper than external transaction (buy). This can be expressed as:

$$IPC > EPC, IPC < EPC + ETC$$

Market transaction costs (ETC) stem from contractual stipulations that govern behaviour. This involves the costs of acquiring and processing information, monitoring contractual promises, enforcing contractual breaches of agreement, particularly during conditions of asset specificity, uncertainty, transaction continuity and information constraints. If the market transaction cost is not a serious factor, as in the case of the 'flawless economy' assumed by neoclassical economics, then the market becomes the most efficient governance mechanism. However, where ETC is significant, the internalisation of transactions presents a superior option (Williamson, 1985). The important point to note here, is that while internalising production reduces market transaction costs (ETC), hierarchies merely replace one type of transaction cost (ETC) with others, such as bureaucratic and coordination costs, problems of monitoring and measurement or internal transaction costs (ITC). Significantly, the network emerges as a more efficient mode where ITCs are high. While transaction cost theory is uniquely placed within contemporary network theory, such economic explanations for social relationship development (networking) have attracted considerable criticism from behavioural and organisational theorists (Thompson et al., 1991).

### **1.11 Network Theory: Limitations and Opportunities**

This section raises some concerns about the limitations or weaknesses of current network theory, at both the empirical and conceptual levels. This section further explores the actions and processes of networking. The later part of the section raises some concerns about current network logic, suggesting that network theory is weak in explaining network processes and in linking network activities to organisational performance. The section concludes by identifying areas where research is required, but also considers some of the problems faced in researching the network.

As outlined above, the network organisation is founded on the development and maintenance of relationships between partners. Networking generally involves *information exchange processes, adaptation processes, routinisation and social exchange processes* (Hakansson and Johanson, 1987). As referenced earlier, the coordination costs involved in networking tend to be higher than those experienced by hierarchies. According to Achrol (1991:77), to promote effective networking it is important to evolve and elaborate 'relational norms', such as sharing, trust, culture, commitment, and sophisticated information, political and quasi-judicial systems. Lorange (1988) stresses the explicit role and responsibilities of network members in terms of value-creation, as one of the most critical dimensions when considering the planning and control of cooperative alliances. Miles and Snow (1992b) identify three broker roles as important to the success of network organisations: architect, lead-operator, and caretaker. Key individual managers act as core coordinators and designers of the network. Lead-operators link up organisations with complementary capabilities, while the caretaker role involves the monitoring of relationships, knowledge creation and organisational learning functions. This draws attention to the relationship between network actors' roles and network outcomes. Network outcomes are very important to network theory as they represent the proposed incentives for organisations entering into collaborative partnerships, including economic and strategic incentives, as outlined in section 1.8. These may be '*objective*', including financial performance, market position, market share, sales, and productivity, or more '*subjective*', including a range of outputs that are more difficult to observe or quantify, such as organisational flexibility, risk reduction, or customer satisfaction (Jarillio, 1988). The full range of performance indicators demonstrates how both network inputs and outputs are multi-dimensional, including economic, strategic, and behavioural components.

The identification of factors that influence network outcomes is as an important area of research that has arguably been neglected by the network literature. While network studies have tended to focus on dyadic relationships between buyer-supplier firms, there is a growing recognition of the need to assess the performance of the network in terms of the overall effect, rather than some evaluation of the singular changes in the performance of individual members' outputs. There is also growing recognition of the

need to compare the viability of the network, against more established organisational forms, notably hierarchy (Mintzberg et al., 1996). One important area where more research is expected, is in linking network input factors (NIFs), to network outputs, and in understanding the processes that effect network performance. Writers in this area continue to highlight the importance of trust, commitment, goal congruence, stability, leadership, control and accountability, as important input process factors (IPFs) (Provan, 1995, 1996). However, researchers have found it difficult to explicitly link input processes to objective outcomes, such as financial performance and productivity, and have also found it problematic linking IPFs to more subjective measures, such as increases in product/service quality, or knowledge base. Indeed, the rationale for entering into networks is often to access intangible assets such as knowledge or know-how (Powell, 1987; 1991), that by their very nature, are difficult phenomena to measure. In addition, few writers have been able to link relational dimensions, such as depth and breath of relationships, to outcomes such as cultural development, or improvements in employee motivation and morale.

While there is a growing awareness and support for inter-organisational networking among academics, practitioners, and policy-makers, there appears to be a general lack of awareness among such groups, of the potential costs and difficulties associated with networking. It is possible to expose a number of theoretical-conceptual limitations in existing network theory. Mintzberg et al., commenting on the general subject of collaboration write:

*“...while collaboration is a good concept, in both specific application and general spirit...it will eventually prove to be no more a panacea than hierarchy or market ever were, for there is good and bad in all ideas” (1996: 60).*

In relation to what is understood about traditional systems or modes of organisation, namely markets and hierarchies, there is comparatively little known about network processes, such as explanations of reciprocity or collaboration. Ring and Van de Ven (1992: 90) state that, in particular, ‘relatively little scholarly attention has been devoted to studying the developmental processes of inter-organisational relationships’. Ring and Ven de Ven also suggest that:

*“...although knowing the inputs, structures, and desired outputs of a relationship, provides a useful context for studying process, these factors do not*

*tell us how the relationship might unfold over time ” (1992: 91).*

Provan (1998: 453) and Larson (1992) confirm that there has been a lack of emphasis on understanding network properties. Most research on networks, both in the profit and not-for-profit contexts, has failed to address network processes; focusing instead on the antecedent conditions of networking, and on such issues as structure and governance (Larson, 1992). Transaction cost or agency theory perspectives have concentrated work on comparisons of alternative governance structures (Armour and Teece, 1978; Coase, 1937; Williamson, 1975, 1991), while organisational studies have examined the environmental conditions and contingent factors influencing network formation and structure (Aldrich and Whetten, 1981; Galaskiewicz, 1985; Oliver, 1990). Consequently, less attention has been prescribed to understanding network processes, specifically post-formation, and there has been little empirical or theoretical treatment of the task of ‘managing collaboration’. While commentators continue to profess the benefits of networking (Powell, 1990), there remains a lack of empirical evidence on why some networks succeed while others fail.

There are many unanswered questions about network governance, management, stability, and performance. As agents of the firm, managers are often responsible for creating, maintaining, and dissolving inter-organisational arrangements (Ring and Van de Ven, 1992: 90-91). However, given what is known, or more appropriately what is not known, about networking, it is arguable that organisations enter into collaborative relationships with little prior knowledge of what is involved, and without a clear strategy for managing the relationship throughout the lifetime of the network (Ring and Van de Ven, 1992). One suggestion is that managers are making important strategic decisions based more on instinct rather than on rational, objective, knowledge or experience (Pollitt, 1995: 150). There is some indication in the literature that recent moves towards network forms, both in the private and public sector, is as a result of management ‘fashion’, rather than as a result of confirmed performance and track record. It appears the network organisation, like traditional hierarchies, remains a black-box of activities little understood by either scholars or practitioners (Jenson and Meckling, 1976). Table 3 below presents a range of expert views, and arguably a consensus opinion, taken from the network literature.

**Table 3 Summary of Network Literature-Based Theoretical Limitations**

<p>‘Network studies, while documenting the propensity for network formation, have focused comparatively less attention on the processes of networking post-formation’</p>	<p>(Grandori and Soda, 1995)</p>
<p>‘Relatively little is known about networking, in particular how and why networks fail or succeed’</p>	<p>(Park, 1996)</p>
<p>‘Little scholarly attention has been devoted to studying the developmental processes of inter-organisational relationships’</p>	<p>(Ring and Van de Ven, 1992: 90)</p>
<p>‘There is a lack of empirical knowledge/understanding on how to manage network processes’</p>	<p>(Jenson and Meckling, 1970)</p>
<p>‘While collaboration is a good concept, in both specific application and general spirit, it will eventually prove to be no more a panacea than hierarchy or market ever were’</p>	<p>(Mintzberg et al., 1996: 60)</p>
<p>‘Despite strong interest in the study of inter-organisational networks, very little attention has been devoted to assessing the effectiveness of multi-organisational networks’</p>	<p>(Provan, 1998)</p>
<p>‘Evidence indicates that networks often fail to achieve intended goals, and that the obstacles facing them are formidable’</p>	<p>(Parkhe, 1993; Ring and Van de Ven, 1994)</p>

The above concerns expose the limitations of contemporary network theory, as well as an identification of opportunities for research. There is increasing need for a holistic

conceptualisation and empirical evaluation of network process issues, particularly research that balances the potential benefits of networking against the potential risks and costs<sup>1</sup>.

### **1.12 Developing an Analytical Framework**

There are a number of research incentives for the development of a conceptual framework for inter-organisational networking. Firstly, there is a continuing need to define the organisational network (as shown in sections 1.2). Secondly, there are clear theoretical benefits to clarify and address current limited conceptual or empirical work in this area. This might involve the identification of factors involved in networking; understanding the relational processes involved; or making linkages between input and relational factors on network performance and effectiveness. Within this study, the focus is on the process of collaboration between service organisations and professional groups in the UK public sector. The network is the focal point for an examination of collaboration, for exploring the formal adoption and implementation of new network type structures and processes in health care.

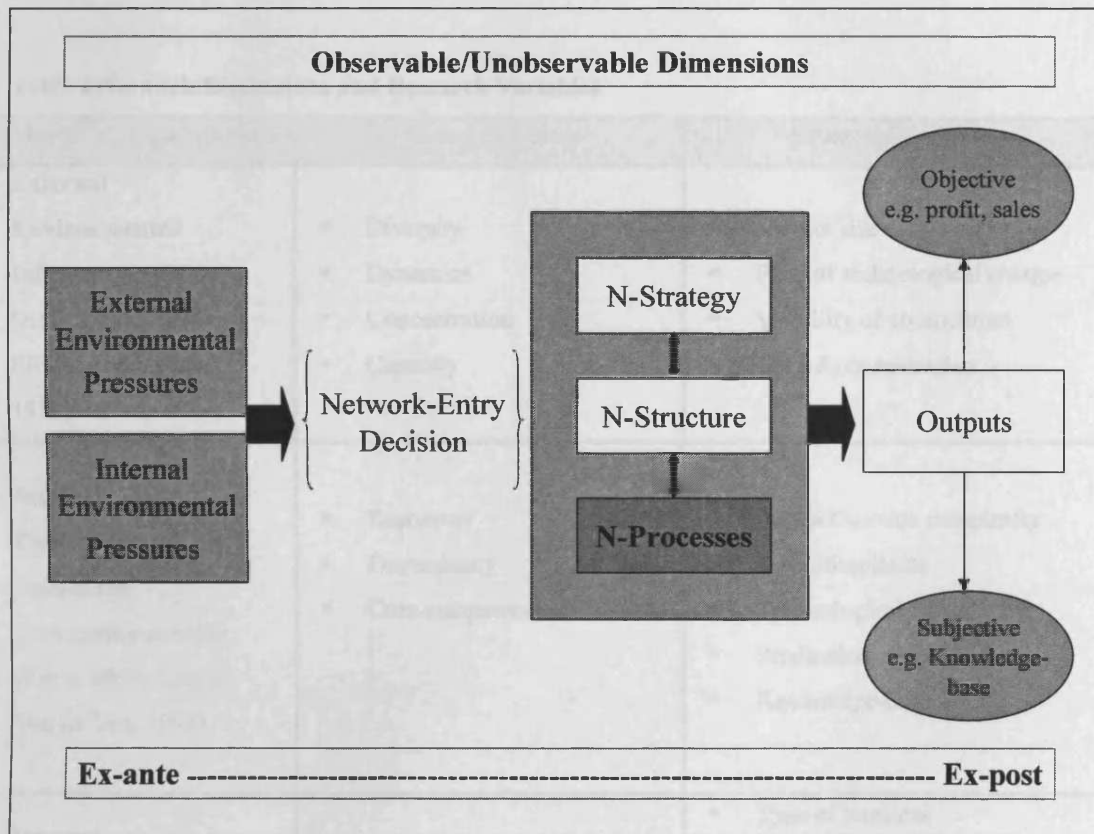
A review of the relevant literature suggests that there are different views of the network phenomenon, from Williamson's (1975) view of networks as an intermediary compromise between either market or firm, to Powell (1990) and Johannisson's (1987a) view of networks as a distinctive organisational arrangement qualitatively different from those of both markets and firms. As demonstrated above, the rationale for organisations entering into network relationships stems from a myriad of economic and strategic incentives including, the reduction of risk, access to markets, technology and know-how, the aligning of competencies as a combative strategy that attempts to secure the future of the organisations by improving efficiency through the effective displacement of dependency, risk, uncertainty and opportunism. In researching the network organisation, a number of recurring issues arise that require consideration, including the prominence of external environmental pressures and internal environmental pressures. Three principal levels or dimensions of analysis

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<sup>1</sup> *Note:* Network failure and the problems associated with networking are examined in more detail in chapter 2.

emerge as important areas of network research. These dimensions are labelled here as the *strategic/dimension*, the *structural/dimension*, and the *process/dimension*. As outlined earlier, an important and emerging area for further research is in linking inputs, processes, and outputs. Figure 3 presents an illustration of the major research issues and analytical dimensions.

**Figure 3 Overview of a Network Analytical Framework Model**



Source: Developed by the researcher, K. Geraghty - following review of the network literature

Figure 3 illustrates how networks emerge as a result of the internal and external forces that continue to constrain and effect the network organisation post-formation. Analytically, the network might be viewed as entity of activity that is influenced by external (commonly from the market) and internal pressures (commonly coordination and strategic limitations), whereby there is some linkage between the inputs, processes and outputs. Importantly, the above framework raises the notion of managing the network. For instance, making informed entry decisions, developing high-performance structures and process, setting appropriate and realisable strategies,

and evaluating performance; and perhaps of greater importance, intervening where processes are failing. However, before such proactive intervention can take place, processes must be identified and understood in terms of their influence on network performance. Table 4 below shows how studies have researched the network form from a number of different secondary dimensions (*strategic, structural and process* being primary), and lists the major research focus and features used to analyse the network organisation.

**Table 4 Network Dimensions and Research Variables**

Network Dimensions	Research Focus	Research Variables
<b>External Environmental Influences</b> (Achrol et al., 1983; Pfeffer & Salancik, 1978)	<ul style="list-style-type: none"> <li>▪ Diversity</li> <li>▪ Dynamics</li> <li>▪ Concentration</li> <li>▪ Capacity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Market size</li> <li>▪ Pace of technological change</li> <li>▪ Volatility of competition</li> <li>▪ Global concentration</li> </ul>
<b>Internal Environmental Influences</b> <i>Transaction-specific</i> (Reve, 1990; Ring & Van de Ven, 1992)	<ul style="list-style-type: none"> <li>▪ Resources</li> <li>▪ Dependency</li> <li>▪ Core competencies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Product/service complexity</li> <li>▪ Task complexity</li> <li>▪ Technological complexity</li> <li>▪ Production capacity</li> <li>▪ Knowledge-base</li> </ul>
<b>Internal Environmental Influences</b> <i>Actor-specific</i> (Human & Provan, 1997)	<ul style="list-style-type: none"> <li>▪ Domain similarity</li> <li>▪ Goal congruence</li> <li>▪ Value-adding ability</li> </ul>	<ul style="list-style-type: none"> <li>▪ Type of business</li> <li>▪ Size of organisation</li> <li>▪ Structure of organisation</li> <li>▪ Goals/objectives</li> <li>▪ Experience of networking</li> </ul>
<b>Strategic Dimensions</b> (Wilson & Jantrania, 1995; Jarillo, 1988)	<ul style="list-style-type: none"> <li>▪ Complementarity</li> <li>▪ Goal congruence</li> <li>▪ Capabilities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Relationship value</li> <li>▪ Strategic objectives</li> <li>▪ Strategic leadership</li> <li>▪ Competitive forces</li> <li>▪ Competitive advantages</li> </ul>



<b>Structural Dimensions</b> (Powell, et al., 1996; Van de Ven & Walker, 1984; Ring & Van de Ven, 1992; Reve, 1990)	<ul style="list-style-type: none"> <li>▪ Organisational Boundaries</li> <li>▪ Embeddedness</li> <li>▪ Centrality</li> </ul>	<ul style="list-style-type: none"> <li>▪ Density of relationships</li> <li>▪ Breath of relationships</li> <li>▪ Diversity of network portfolio</li> <li>▪ Partner asymmetry</li> </ul>
<b>Process Dimensions</b> (Ford, 1990; Miles & Snow, 1992; Van de Ven and Walker, 1984; Achrol, 1991)	<ul style="list-style-type: none"> <li>▪ Power and dependence</li> <li>▪ Mutual adaption</li> </ul>	<ul style="list-style-type: none"> <li>▪ Roles and responsibilities</li> <li>▪ Type and degree of communication and interaction</li> <li>▪ Performance measurement and reward systems</li> <li>▪ Trust, commitment, and relational and behavioural norms</li> </ul>
<b>Network Outcomes</b> (Jarillo, 1988; Human & Provan, 1997)	<ul style="list-style-type: none"> <li>▪ Objective</li> <li>▪ Subjective</li> </ul>	<ul style="list-style-type: none"> <li>▪ Economic and financial performance indicators</li> <li>▪ Strategic flexibility</li> <li>▪ Risk reduction</li> <li>▪ Processes</li> <li>▪ Knowledge and learning</li> </ul>

The ultimate goal of any network is to provide members with positive gains. These may take the form of improvements in profit or sales, access to new markets or technology, exposure to knowledge or know-how, or improvements in production or service delivery. In this sense, networks aim to improve efficiency, increase quality, and consequently seek to improve performance, however as simply illustrated in figure, network-level outcomes may be difficult to measure, particularly those that are more subjective, such as improvements in quality or knowledge base. This chapter has shown that despite strong interest in the networking phenomenon, relatively little attention has been devoted by researchers to assessing the effectiveness of multi-organisation networks (Provan, 1998). Most network research, in both the profit and not-for-profit contexts, has not explicitly addressed the issue of overall network effectiveness, focusing instead on primary and secondary research dimensions across dyad linkages, such as strategic alliance, joint ventures, cooperative partnerships, or vertical and horizontal coupling (Larson, 1992). While more recent work calls into

question the presumed benefits of organisational networking, there remains a lack of robust empirical work on why some networks are more effective than others, thus limiting the development of network theory (Salancik, 1995). This 'missing data' is surprising, but is to some extent understandable, given the complex nature of multi-organisational networks and the problems associated with performance measurement. The measurement and detailed understanding of multi-level networking, in terms of inputs, processes and outputs, is an important area for future research (Provan, 1995; Gillet, 2000).

### **1.13 Summary**

This chapter has focused on reviewing general issues concerning organisational networking. The chapter began by presenting two views of networks, the institutional economic view of the network as an intermediary hybrid or short-term phenomena, and the organisational view of the network as a complex social arrangement that is different from traditional markets or hierarchies. This chapter also presented a summary or index of the main approaches and perspectives in the study of networks. The principal approaches outlined included: economic; organisational; negotiation analysis; resource dependency; neo-institutionalism; organisational sociology; radical Marxist; social psychology; business policy; industrial marketing; and population ecology. These different approaches have in an iterative way, added to our understanding of organisational networking. It is worth noting that some perspectives have been more influential than others. Economic and strategy-based studies are notable as major contributors to network theory. Coase (1937) and Williamson (1975, 1985) have been instrumental in the development of a robust theory of exchange between firms. To emerge from economics and transaction cost theory are the important concepts of opportunism, certainty, risk, asset specificity, and the problems of contingency contracting. Such concepts are extensively investigated and cited across many disciplines. Williamson's (1975, 1985) transaction cost theory is particularly dominant. The concepts of opportunism, asset specificity, uncertainty, moral hazard, have been cited extensively, both within and outside traditional economic fields. Among managerial perspectives, industrial marketing studies of long-term buyer-seller relationships (Hakansson, 1982; Ford, 1980; Ford, Hakansson

and Johanson, 1986; Forsgren and Johanson, 1992) principally analysed the social-exchange aspects of inter-firm networks and have been particularly influential in adding the social dimension to inter-firm exchange, as has social network theory (Burt 1979; 1990). The importance of scarce resources has resulted in Pfeffer and Salancik's (1978) resource dependency perspective, another significant contributory approach. Upon reflecting on these antecedent contributions to contemporary network theory, it is important to remember, that while the roots of network theory are varied, with each different subject discipline adding knowledge in an iterative process of knowledge building, there are clear over-laps between approaches. Much of organisational and strategic studies, are grounded in economic principles of micro-economic firm behaviour. Despite the inter-twining of perspectives, it is acceptable to state that the focus of studies differ, and thus there is a clear distinction to be made when examining the methods employed by different theoretical approaches.

In addition to a review of the different approaches taken to network studies, this chapter also presented a rationale for inter-organisational networking. This chapter outlined the major motivating factors influencing organisations to network, classified under two main headings, namely '*economic*' and '*strategic*'. Firms commonly seek partnerships or network relations to achieve economic synergy (Luke et al., 1989). Networking facilitates resource sharing, including production capabilities or less tangible assets such as knowledge or know-how. The network thus presents a unique form of potential operational flexibility. The concept of the '*strategic network*' has been used to define the inter-organisational network as a purposeful and conscious arrangement among related profit-seeking firms, to gain or sustain competitive advantage *vis-à-vis*, their competitors outside the network (Miles and Snow, 1986; Jarillo, 1988). Strategic explanations for the existence of networks, while obviously based on economic principles, describe the managerial decision-making processes of organisations in the market place (similar to a population ecology theory). Teece (1992) illustrates how networks are used as a connecting and transferring mechanism for complementary and inter-dependent competencies between firms. Powell (1987) adds that organisational and technological competencies are not always easily transferable, but that the network facilitates the transfer of codified knowledge and technology, which are commonly difficult to trade in a market, or communicate

through the hierarchy. Reve (1990) highlights the importance of inter-firm relationships to sustainable competitive advantage.

Following on from discussions of the rationale influencing networking, this chapter presented arguments concerning theories of the firm, and consequently theories of the network. The argument that firms emerge from the imperfections of markets has been shown to hold some relevance to the assertion that networks emerge from the imperfections of hierarchies. This market-firm-network continuum raised the issue of organisational evolution from market to bureaucracy and then to market, but also highlighted the complexities of defining and demarcating organisational boundaries and modes of governance. Table 1 above provided a classification of different network types, while table 2 contrasted the network form with the archetypal features of market and hierarchy. Significantly, there are many factors influencing the type and form a network takes, from the number of partners, to the level of interaction, to objectives, expectations, and so on. This chapter revealed that while the range of approaches and studies of inter-organisational networking are broad and multi-disciplined (*breadth of understanding*), there appears to be a lack of understanding concerning the processes of networking (*depth of understanding*). Network theory is somewhat limited in explaining the factors that influence the success or failure of network arrangements (Grandori and Soda, 1995; Park, 1996; Ring and Van de Ven, 1992: 90; Jenson and Meckling, 1970; Mintzberg et al., 1996:60). In addition, the literature provides little in the way of guidance on how to manage network relationships post-formation. In a related vein, the benchmark against which to assess network outcomes, network effectiveness and network performance, remains ambiguous. Even in the general organisational-based network literature, which places a heavy emphasis on network-level properties (Aldrich and Whetten, 1981; Marsden, 1990; Scott, 1991), issues of network outcomes and effectiveness are mostly ignored. The network literature is weak in explicitly linking process factors (or inputs and contextual factors) to network-outcomes. These conceptual and theoretical limitations are compounded if the network is viewed in the non-profit public sector, where the formalisation of the network organisation is less clear and where the inputs and outcomes are arguably more salient.

In response to the growing significance and prominence of networks, organisational theorists argue for an increased emphasis on network research (Rogers and Whetten, 1982; Thorelli, 1986; Nohria, 1992; Ring and Van de Ven, 1994). It is interesting to note that the increased importance of the network perspective has refocused organisational theory away from traditional issues of strategy and structure, to broader societal, economic and political issues, such as the social relationships of social network theory, notions of transaction costs, ideas of dependency and legitimacy, formal and informal relationships, like Granovetter's 'loose ties'. Network theory conceptualises market processes in relational and sociological terms, where concepts of trust, reciprocity and partnership, take on greater importance. As such, network theory presents a powerful perspective and discourse as a meta-analytical approach to the study of organisations, or more appropriately, to the study of the behaviour of organisations. The weaknesses inherent in any abstract theory of an organisational reality may be minimised by further rigorous empirical evidence-based research.

This chapter reviewed the literature on network organisations and made some interpretation of the explanations for network formation, network behaviour, and network failure. The chapter presented an analytical framework for conceptualising the important inputs and outputs of the network organisation (figure 3). This analytical tool not only draws a link between network inputs and network performance but also shows the three important research dimensions of the network form, that of *strategy*, *structure*, and *process*. This chapter has shown how, while the majority of research has focused on network formation and network structure, there has been comparatively little focus on understanding network processes.

## 2.1 Introduction

This chapter moves discussions of networking away from more established debates concerning markets and inter-firm relationships, to the comparatively under-researched setting of the UK public sector, by reporting on recent moves away from internal-markets and bureaucracy to new collaborative governance and network relationships in the UK health sector. The public sector in the UK is the largest single employer, encompassing a wide range of organisations including defence, education, social services, and much more. It is therefore surprising, that much of organisational and management research continues to focus most attention on issues relevant to the private sector (Newman, 2001: 1). To date there has been little exploration of networks and networking processes within this non-profit public context. This chapter brings together important findings from a variety of literature sources to examine recent structural and procedural developments in the UK National Health Service, and addresses current speculation that the NHS, like other public sector services, is becoming a more networked institution.

Since the election of a Labour Government in 1997, there has arguably been a shift away from quasi-market and bureaucratic modes of public sector governance, towards more flexible and cooperative approaches to public sector organisation and management. Recent developments in the structuring of the Health Service reveal a myriad of new connections between health care agencies, for example in primary health where new primary care organisations have been established to network health professionals at the community level. A range of policy statements since 1997, exemplify this emphasis on collaboration and partnerships between public sector organisations. There is some suggestion by organisational theorists that institutions within the UK public sector, such as the National Health Service, are now moving towards a more network archetype and adopting a collaborative governance approach, a clear departure from hierarchy or internal-market (Kirkpatrick, 1999). This chapter attempts to make some appraisal of the significant implications of new network approaches to public service management. As such, the chapter identifies the principal forces influencing change in the UK public sector and applies a transaction cost logic

to explain a contemporary critique of internal-markets, and reports on recent moves away from quasi-competition and obligational-contracting to more relational-contracting and collaborative working between public sector contractors. The chapter also raises argument concerning the National Health Service as network organisation and discuss the important question of network management in a public health care context. In this regard, a number of recurrent relational factors are identified including, trust, opportunism, stability and certainty, goal congruence and innovative ability. The chapter ends with a discussion of the potential implications of networks for the NHS, particularly issues of managing tasks, the potential for network failure, the longevity of network forms, and the significant issues of network performance and accountability.

## **2.2 From Quasi-Competition to Relational-Contracting**

A significant feature of public policy over the last two decades has been the introduction of market mechanisms by the Conservative Governments of 1979-1996. The free-market approach to public management and administration originates from the principles of neoclassical economics and has often been cited as a basis for public sector reform. This liberal non-regulatory ideology has guided successive Conservative administrations and led to the introduction of a so-called 'internal-market' in the National Health Service during the late 1980s to the mid 1990s. Rummery (1998: 429-430) comments that:

*“The central trust of this policy was to increase efficiency and limit increases in expenditure by introducing market mechanisms into a bureaucratically controlled system”.*

Much of the recent academic literature on quasi-markets in the UK public sector has been critical of the internal-market, describing it as divisive and restrictive (Flynn et al., 1995; Davis and Walker, 1997). Critics of quasi-competition between services in the public sector have expressed the need for a new approach to the structuring and coordination of public services, one that moves away from obligational-contracting to more relational-based modes of coordination and delivery (Kirkpatrick, 1999: 8), based on constructive trust-based relationships between service providers and purchasers (Sako, 1992). The next section explores, in more detail, some of the

principal problems associated with the internal-market, and reviews recent claims that a more cooperative system of working (internal and external) is a solution to the problems facing public services in the UK.

### **2.3 The Failure of the Internal-Market: A Transaction Costs Appraisal**

Williamson's theory of transaction costs (1975, 1985) has been utilised as a means of appraisal or as a framework to highlight the negative consequences of competitive contracting and internal-markets in the public sector. There is some argument that the complexity of services offered by the public sector, from defence to health and education, increase transaction costs in terms of contracting such services, as a greater degree of time and resources might be required to specify and enforce detailed contingent claims contracts (Flynn et al., 1995, 1996). For example, compulsory competitive tendering (CCT) in local authorities in England and Wales is reported to have adversely affected the level of trust between local authorities (principal) and contractors (agents), where there has been a subsequent increase in perceptions of opportunistic behaviour (Davis and Walker, 1997: 49). Other studies indicate a significant increase in 'contract bureaucracy' (Keen, 1997), whereby service providers and purchasers have been forced to bargain and compete for resources, or to outsource peripheral services to the private sector, conversely, increased 'hierarchical bureaucracy'. As Boyne (1998b: 699) suggests, '*in such a situation, the costs may exceed efficiency gains*'. The suggestion is that the internal-market raised monitoring costs, increased opportunistic behaviour, adversely effected service coordination, and increased levels of uncertainty and instability across those public services where internal-market mechanisms were introduced (1980-1998).

A major criticism of quasi-markets and internal competition in public services is that the costs associated with the specification and monitoring of contracts are often high. Research by Flynn et al. (1995, 1996) in community health services reports how purchasers and providers encountered "*major conceptual and methodological problems in detailing the causal relationship between action and effect and linking this with needs and objectives*" (1995: 539). Similarly, problems are identified by Wistow et al. (1996: 156) in a study of contracting in social care where, "*links*



*between resources, needs, service characteristics and outcomes are unknown, unclear or hidden from view*". The need to monitor contractual arrangements adds an additional cost element to contracting, not often recognised at the outset. In addition, where service quality levels fall below a specified level, control systems are often absent to identify failures and challenge contracts (Flynn, 1996).

Opportunism is viewed as a central element in transaction cost theory of contracting and market-based exchange, defined as 'self-interest seeking with guile' (Williamson, 1985). A criticism of market-based contracting in the UK public sector has been that contractual arrangements have often been open-ended and often offered few safeguards against opportunistic behaviour (Kirkpatrick, 1999:8). In social care markets for example, many local authorities have been slow to develop a purchasing function and have relied on poorly specified 'spot contracts' with providers (Wistow and Hardy, 1999). In the NHS, Renade (1995: 253-4) found that the internal-market had resulted in the existence of 'information deficiencies' and a reliance on 'block contracts', which have allowed some providers to claim "*increased costs and hence prices which the purchasers found difficult to verify...*".

In addition to the problems related to the monitoring and writing of contracts, writers on quasi-markets in the UK public sector point to the difficulties of coordinating services as a major fault or problem area. The division between purchaser and provider roles, many suggest, has led to the erosion of existing and long-standing relationships between services. Maddock and Morgan (1998: 237) comment:

*"...quasi-mixed markets and purchasing systems within the public sector appear to be encouraging competition, secretive relationships and an entrenchment of traditional cultures rather than a break down of barriers and the generation of more specialised and egalitarian relationships at work, reinforcing not collaboration but competition"*.

Studies of contracting in health and social services (Walsh, 1995; Lewis et al., 1996; Charlesworth et al., 1996; Baggot, 1997) also voiced concerns about falling morale among public sector professionals. Maddock and Morgan (1998) suggest that achieving effective collaboration in a climate of relative 'low-trust' seems problematic and that the introduction of competitive forces has led to combative and hostile internal and external relationships in public services.

The issue of contract renewal appears to be a focal point for an examination of problems generated by quasi-markets. In economics and psychology, uncertainty is seen as a mechanism for inspiring agents to strive to win contracts, however, the public sector literature suggests that high levels of perceived uncertainty induced by the continual restructuring of public services and the introduction of internal market mechanisms, as experienced by employees in the public sector, undermines moral and commitment. For example, in social care, where the existence of contracts '*lead to a short-term outlook which can undermine long-term planning and strategic thinking*' (Maddock and Morgan, 1998: 241). In local authority services subject to CCT, it has been noted how the existence of a "*definite time horizon...within contracts...could undermine confidence and trust while contributing to contractor insecurity*" (Vincent Jones, 1997: 150).

A common conclusion to be drawn from recent studies on quasi-markets concerns the need for change in the management of contracts. There is a growing belief that arms-length contractual relationships are less appropriate than trust-based methods. Flynn et al. (1996) suggest that '*the complexity and inter-dependent nature of services requires more open-ended contracts based on mutual trust*'. In health services, it is argued that the most effective outcomes came when purchasers stepped outside contractual relationships, into closer network-based collaborative exchanges (Flynn et al., 1996: 61). Wistow et al. (1996: 171) add that:

*"The most appropriate form of governance structure in future will be some intermediate form of quasi-market, embedded in social networks, where relationships are more integrated and collaborative"*.

In local government for instance, some managers expressed the view that competitive contracting has caused restrictive and inflexible practices, whereby a more relational-style of contracting would be preferred (Walker and Davis, 1999: 12). Critics of market-based approaches advocate a move away from adversarial arms-length relationships (now deemed unsuitable for public services), towards more partnership-based practices (networking), where services are integrated, rather than fragmented. Some commentators suggest that the public sector should reflect recent changes in the private sector, where competitive firms are forming networks of alliances (Child, 1998).

This preference for new hybrid organisational forms is often based around the arguments generated by transaction cost economics and principal-agent theory (discussed in Chapter 1 and above), in which the cost of writing and maintaining contracts may be reduced by the development of trust-based relationships between principal and agent. Milne (1997: 18) for example, asserts that the success of voluntary contracting in the private sector might be replicated in the UK public sector, given appropriate policy and conditions. This growing belief in private sector mechanisms as the solution to the problems of the public sector, once again focuses attention on the dissemination of ideas between what is deemed private and public, now widely characterised under 'new public management' (Hood, 1995; Ferlie and Pettigrew, 1999). As with other managerial fashions there is a strong argument that, "*the belief in the potential for better management is connected to a favourable analysis of the achievements of the corporate sector...*" (Pollitt, 1993: 7). Recent publications in the public management and public policy fields have expressed the view that collaborative relationships between purchasers and providers are both conceivable and desirable (Milne, 1997). This view arises from studies that reveal an array of lingering organisational and administrative failings including, falling morale among service professional, regional variations in service quality, rationing, and a lack of coordination between agencies (Locock, 2000; Flynn et al., 1995, 1996). In health care, internal-markets and quasi-competition, introduced following the NHS and Community Care Act 1990, are implicated in fragmenting public service organisations and creating an environment of combative and arms-length relationships between the purchasers and providers of care. There is a growing consensus that quasi-competition failed to deliver efficiency improvements and undermined the unique collaborative nature of public services (Milne, 1997). Many commentators have advocated a move away from markets and bureaucracy to new collaborative network forms of governance and practice, built on trust, commitment, focused on the coordination of services, and targeted to patient needs.

## **2.4 The UK Public Sector: From Bureaucracy and Market to Network**

Hierarchies, markets and networks have been described as the three basic or alternative modes of organising (Thomposn et al., 1991). As chapter 1 outlined, there

is some consensus among organisational theorists that networks signify an advanced and unique form of governance (Powell, 1991: 265-276). There is also some suggestion of an evolutionary path from market to hierarchy, and from hierarchy to network (chapter 1, section 1.5). Significantly, there is a growing discussion in academic quarters as to whether the UK public sector is moving from hierarchy to network organisation. Ferlie and Pettigrew (1996: 81) ask:

*“The question arises as to whether there is now a deep-seated shift underway from organisation forms based on markets and hierarchies and towards more network-based forms of organisation?”*

The question raised by Ferlie and Pettigrew (1996), and the uncertainty that surrounds potential answers to it, has given rise to the research undertaken as part of this doctoral study, and is one of the central research questions addressed throughout the study and this thesis. This broad research question acts as a focus for the study and gives rise to the broad socio-political, economic, and management-organisational approach adopted by the study. In this sense, the study simply attempts to offer evidence in favour or against this principal research proposition.

#### **Primary Research Question 1**

**What evidence is there of a move away from market and hierarchy to network in the UK National Health Service?**

There is some suggestion that the UK public sector has experienced three distinctive periods of transformation, from the vertical hierarchy and bureaucracy of the 1970s, to the quasi-market of the 1980s and 1990s, and now to a more flexible and uncertain period of change post-1997. The UK public sector post-1950 until the late 1970s, of nationalised corporations and welfare state bureaucracies, is sometimes viewed as an explication of *Fordism*, a period dominated by large vertically integrated organisations, where the emphasis was on the mass production of standardised goods (Wood, 1989). The following period from 1979-1996, has been characterised as the internal-market era, during which time many utilities passed from the public to the private sector and where public services, such as health care, were reshaped against neo-classical principles of free-markets and competition. Today, there is some uncertainty about the status of the UK public sector in terms of dominant governing ideology. According to Ferlie and Pettigrew (1996), there are signs of a shift away

from hierarchy and competition towards more specialised and collaborative systems (1996: 82). The trend towards less hierarchical and bureaucratic structures is a general one. Industries across sectors have adopted more flexible modes of organising that are rooted in flexible technology and flexible work practices (Hirschhorn, 1984; Piore and Sabel, 1984). Whether or not this shift represents a new rhetoric of post-Fordist liberalisation, or an observable reality, remains questionable. However, it is possible to observe an increasing number of horizontal and vertical alliances between competitive organisations in the private sector; there are also signs of new management practices, such as Human Resource Management (HRM), essentially premised on collaboration between management and labour. Overall there is evidence of universal change across organisations in both the profit and not-for-profit sectors, such as the delayering or flattening of traditional hierarchical structures, the devolution of power down the organisational chain-of-command, the democratisation of the workplace through the introduction of new managerial practices (HRM for instance, Storey, 1999) and new managerial practices of involvement, participation and empowerment.

Within the private sector there are increasing examples of network-like arrangements, for example the Italian industrial textile districts (Lazerson, 1993). Private sector organisations are often seen to be positioning themselves within webs of relationships between buyers and sellers at different points along the supply-chain, and across different industries and business sectors. Similarly, across the spectrum of organisations that make up the public sector, issues of inter-agency cooperation and networking are assuming greater importance (Marsh and Rhodes, 1992). This is particularly manifest in public sector services such as health care, where critics have argued that health and social services have been too fragmented (Flynn, 1996). In addition, the trend towards more joined-up services, as seen in the private sector, has arguably taken hold in the wider public sector, with Government, practitioners, and commentators, calling for increased collaboration and joint-working (Powell, 1991; Flynn, 1996; Hudson, 1999; Newman, 2001). There is some inherent belief that collaboration will deliver higher standards of service quality and delivery. Some of the prominent forces influencing recent change in public services are examined below with insights taken from Ferlie and Pettigrew (1996) and Ferlie et al., (1996).

According to Johnston and Lawrence (1991), industrial markets are now shaped by a web of alliances between buyers and suppliers, where independent companies work together along the value-chain to produce better quality products at reduced cost. Supply-chain management is increasingly viewed in terms of the creation of horizontal value-adding partnerships (VAPs) between independent parties. Lazerson's (1993) Italian textile districts or the Chaebols of Korea are representative examples of this networking effect. In the UK public sector, the development of joint-production and joint-delivery systems, for example between health providers and social service providers, increasingly parallels the supply-chain alliances of industrial markets. In addition, the new emphasis placed on partnerships between public and private sector organisations (Public Private Partnerships – PPPs), illustrates how public organisations are seeking to increase networking opportunities and capabilities.

Across sectors, there is currently a strong emphasis of organisational flexibility. Strategic policy theory suggests that competitive success and organisational survival are in some way, related to the firm's ability to respond to changes in its environment. In most cases, this commonly means reacting to changes in demand and consumer styles. Traditional economics views the dilemma of change and flexibility in terms of the relocation of scarce resources, specifically manipulating the production function to react to market demands. In a managerial sense, change might be thought of as a managerial choice that results in some movement of resources, effort, investment, or time. In competitive markets firms attempt to organise in such a way that they can react to market conditions, maximise efficiency and profits. Contemporary thinking about organisation suggests that in order to respond to rapid fluctuations in demand and to ever increasing specialised markets, firms should reduce centralisation, diversify, delay, and promote practices of networking. As discussed in chapter 1 (section 1.4) the rationale is clear, cooperating with other players in the market provides a degree of flexibility, provides access to new markets, technology, and knowledge.

A critical element of collaborative strategy is the idea that flexible modes of production or service delivery might enhance an organisation's capabilities by improving its knowledge base (Thompson et al., 1996). Such discussions of flexibility

and organisational learning form part of the 'hierarchy-to-network' continuum argument introduced earlier in chapter 1. Within public services also, there is increasing emphasis on service variety and innovation. As consumer demands increase, or become more focused, suppliers of health care are increasingly forced to develop more specialised and targeted services (Ferlie and Pettigrew, 1996).

Twenty-first century advancements in technology, facilitates collaborative partnerships between organisations. High-technology centres, such as California's Silicon Valley, are places where hierarchy has been dismantled; where bureaucracy has been replaced by informal and non-authoritarian styles of management (post-Taylorist); where teamwork and partnership are dominant features of work processes. The quest for innovation and technological advancement has brought with it changes in the nature of organisation. Technology has helped create the idea of the 'virtual-organisation', a non-terrestrial cyber-space where products are developed and produced by the combined efforts of collaborative parties linked via computer. The need for fixed capital, such as offices or factories, has been negated by new technologies, internet and telecommunication technologies. Technology is not just the product, but also the medium through which exchange takes place, as well as the facilitator of interaction and the driving force behind many recent changes in industrial organisation. Examples of significant technologically driven developments in the UK NHS include the creation of 'NHS Direct', an internet/telephone-based direct-line service between the public (patients or users) and NHS nurses (practitioners). NHS Direct aims to improve communication between users and providers, and is designed to relieve pressure on front-line primary and secondary care providers, like GPs or Accident and Emergency Departments.

## **2.5 The National Health Service: From Bureaucracy and Market to Network**

The provision of primary and secondary health care in the UK is for the majority of the population, provided by the National Health Service. The NHS was established in 1948, following the National Health Service Act (1946), devised by the then Minister of Health, Aneurin Bevan, and has recently celebrated its 50th anniversary. It is the largest single employer in the UK, employing some 958, 380 (NHS Confederation,

2000). Klein (1992) refers to it as ‘a unique experiment in social engineering’, indeed no other European country, including Sweden with its reputation for high level social welfare, has an equivalent centrally financed health care system.

The NHS has been subjected to a number of reforms since its birth in 1948. Significant changes have taken place in 1974, during the mid-1980s and early 1990s. The Conservative governments of 1979-1997 were principally responsible for more recent interventions. The launch of *Working for Patients* (DHSS, 1989) brought with it the creation of an internal-market in health care, where district health authorities focused on purchasing, and hospitals and GP fundholders on providing services. During the 1980s and 1990s the NHS as an organisation, centralised its control mechanisms with the establishment of the NHS Policy Board and the NHS Management Executive (now the NHS Executive). These changes marked a move away from the consensus approach, towards professional management. Since 1997, public management policy has arguably moved away from the competition approach, with increasing emphasis now being placed on objectives of quality, control and accountability. The 1997 White Paper on health, ‘*The New NHS: modern, dependable*’ set out the Government’s plans for modernising the National Health Service. At the heart of these reforms has been an implicit belief in a ‘third-way’ approach to organising and managing the public sector. This alternative or compromise approach retains elements of hierarchical or centralised principles of financial management and performance monitoring, but also seeks to decentralise some functions in an effort to coordinate services and improve performance through a partnership and cooperation management philosophy (new collaborative governance). The third-way might be viewed as a combination of the command-and-control system of the 1970s and the competition approach of the 1980s and 1990s: a compromise approach.

In reviewing the modern development of the NHS in Britain, it is therefore possible to characterise three periods of relative distinctiveness, at least in terms of ideological dominance or central coordinating mechanism. These periods might be described as: *NHS as Hierarchy* (1948-1989), *NHS as Market* (1989-1997), and *NHS as Network* (from 1997). The first period from the inception of the NHS until the 1980s is often characterised as bureaucratic and hierarchical (Rhodes, 1997a). This characterisation



refers to a high degree of centralisation, with limited autonomy at the periphery. During this period, the UK public sector as a whole, equates to the archetypal hierarchical organisation (Harrison, 1993; Ferlie and Pettigrew, 1998), and has often been described in terms of a command-and-control economic or public system. The second period, 1979-1997, is characterised by the introduction of market mechanisms and the purchaser-provider split. The present period, of the new Labour Government, has been deemed the era of the 'third-way', a term reflecting multi-dimensional change, incorporating conservative management with liberal or socialist values. In the National Health Service for example, organisations are being aligned or integrated in a system that reflects the network organisation (as discussed above in 2.2 and in chapter 1). At an institutional level, health organisations are being integrated into a system of joined-up service delivery. Many public sector services, mental health, social services, general practices (primary care providers) and hospitals (secondary care providers) are increasingly characterised by chains of connections and linkages, and by new collaborative organisational arrangements (Flynn et al. 1996: 139). The latest collaborative ideology is clearly visible in recent moves away from structural hierarchy and bureaucracy to more network-based structures based on mutuality and reciprocity (Exworthy, et al. 1999: 15). For many commentators and policy makers, the network offers an alternative to the problems associated with either market or hierarchy (chapter 1 section 1.3. and 1.5.3) and thus, is providing an impetus and vehicle for change in the public sector. In many ways, there is some indication that the network is being promoted as a remedy to the failings of the public sector, particularly those experienced during the inter-market era.

In political terms, new Labour's policies for developing public services represent an ideological move away from traditional socialist-left ideals of complete State provision, towards a more neutral stance, combining the ideas of market incentives with those of public provision (Freedon, 1999, Powell, 1999a). Political commentators have labelled new Labour's strategy for public management as the third-way, something between the free-market approach and total command-and-control of State services. Sceptics or critics of this alternative ideology view the third-way as a managerial rhetoric, a new language that evokes notions of change; a political discourse that emphasises cooperation and partnership, replacing competition and

efficiency (Klein, 2000). While the Labour Government rarely uses the term network, there have been many references to the associated features of collaborative governance across policy publications, such as altruism, trust, cooperation, collaboration, partnership, alliances, multi-agency, inter-agency, and equity (Exworthy et al., 1999: 17). In much of the literature surrounding the topic, similar references have been made in relation to organisational and cultural change in the public sector (Rhodes, 1997; Thompson, 1991; Kickert et al., 1997; Clarence and Painter, 1998). There is a visible link between the rhetoric of the third-way and a network management paradigm, particularly in health care, social care, and mental health (Rhodes, 1997).

**Figure 1 The Evolution of Cooperation in Health Care**

Governance Mechanism	Characteristics	Literature
'NHS as Hierarchy' (1948-1979)	<ul style="list-style-type: none"> <li>▪ Hierarchical and bureaucratic</li> <li>▪ Top-down</li> </ul>	Harrison (1999); Saltman and Von Otter (1992)
'NHS as Market' (1979-1997)	<ul style="list-style-type: none"> <li>▪ Market mechanisms</li> <li>▪ Entrepreneurial</li> <li>▪ Competitive tendering</li> </ul>	Walsh (1995); Flynn (1997); Mohan (1995)
'NHS as Network' (1997-2003)	<ul style="list-style-type: none"> <li>▪ 'Third-way'</li> <li>▪ Cooperation / Collaboration</li> <li>▪ Partnerships / Integration</li> </ul>	Freeden (1999); Powell (1999a); Rhodes (1997a)

Source: Adapted from Exworthy et al. (1999)

Examples of recent change in the NHS include the removal of competitive contracting. Internal-market devices are being replaced by more long-term cooperative service agreements. The relationship between NHS health authorities and NHS Trusts is to move away from a principal-agent type relationship, towards more relational forms of contracting with NHS Trusts and partners participating in strategy and planning (Exworthy et al., 1999). At the primary care level, new primary care organisations, primary care groups in England (PCGs) and local health groups in Wales (LHG), will integrate and coordinate health care practitioners and

professionals at a local level, and will work closely with authorities and Trusts. In conjunction, new health promotion initiatives such as health action zones (HAZs) and joint health care commissioning and being underpinned by a reform strategy of collaborative networking. Such strategies are evident at all levels in the NHS, at the level of the individual employee, service professional, organisational unit, and on a larger scale at the level of the hospital, health authority, and NHS Trust. As Goddard and Mannion (1998: 106) state:

*“The policy aim of nurturing long-term relationships based on cooperation and trust can be viewed as an explicit attempt to solve the basic principal-agent problem in the purchaser/provider split”.*

There is some consensus in the practitioner and health services management literature that the NHS has indeed moved through different stages, from a hierarchy to a market, and more recently to a network. Academic commentary tends to be more qualified, regarding 1979-1996 as a period of ‘quasi-competition’. Exworthy et al. (1999) partially reject such a chronology, suggesting to the contrary that the NHS has and continues to exhibit signs of hierarchy, market and network. However, the transition argument, from hierarchy to market and more recently to network, is important from the point of view that it draws attention to the contextual properties the UK public sector, as compared with environmental conditions in the private sector. It is sometimes suggested in the media and in academic writing that the NHS represents a political football: parties continually view the Health Service in terms of a political agenda. There is some argument that political rhetoric and discourse masks the organisational realities of the NHS as a functioning institution. Thus, to characterise the present NHS as a network organisation and the previous NHS as a market (1979-1996) or hierarchy (1948-1979), is rather a skewed perception of reality. Professional networks have long been a feature of the NHS and most large organisations reflect a hierarchical structure (Wistow et al., 1996; Rhodes, 1997). In addition, there is some evidence that hierarchical bureaucracy might be increasing under new Labour (Paton, 1998; Klein, 1998; Le Grand, 1999). Exworthy et al. (1999:19-20) argue for the use of term ‘*quasi-network*’ as a more accurate descriptor. It is more likely that the NHS continues as a large complex organisation, to exhibit features of hierarchy, market and network (Thompson et al., 1991; Flynn et al., 1996; Walsh, 1995).

The above view is supported by organisational theorists that adopt a resource dependency perspective (Peffer and Salancik, 1978; Powell, 1991), arguing that public sector organisations compete for resources that are centrally allocated by government. Centralised control mechanisms will continue to produce combative and collaborative behaviours as personnel and organisations strive to meet performance targets. This view discounts the two-dimensional notion of the market-hierarchy-network continuum. Accordingly, networks are better viewed in orthogonal or three-dimensional terms (Hogget, 1996; Bradach and Eccles, 1994). As Flynn et al. (1996: 104) and Exworthy et al. (1999: 18-20) state, '*market, hierarchy, and network, are not completely separate or mutually exclusive*'. The triad is subject to change from a variety of sources. The political and policy framework is likely to affect organisational form and process factors. The introduction of the 'quasi-network' needs to be viewed against a strong background of hierarchical-centralised control, and in terms of existing inter-professional and inter-service networks. This raises the question of formalised network governance versus informal or evolutionary networks, something yet to be clarified in the literature. The development of quasi-networks will be subject to local contextual factors, Exworthy et al (1999: 20) state:

*"...given the uncertainty that exists concerning how these organisational types will interact over time and space the execution of local networks is by no means predetermined, where outcomes will be specific to particular areas and contingent upon prevailing policies"*.

While such insights take account of the complex and diverse nature of public sector institutions; the idea of some kind of progression from market to network, as outlined in chapter 1 and above in section 2.4/2.5, provides a useful framework for an examination of change in the governance and coordinating mechanisms of public sector services like the UK National Health Service, and provides impetus for this study. There is a clear need to examine recent moves towards network structures and processes in the wider public sector and in specific institutions such as the NHS<sup>1</sup>: at least as a means of comparison with earlier initiatives, but more importantly in terms of efficacy; particularly with respect to quality and performance improvements, and in relation to organisational, cultural and management issues.

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<sup>1</sup> Note: The political and socio-economic changes in the NHS are further explored in Chapter 5

## 2.6 Network not Panacea

Despite the growing enthusiasm for relational-contracting in the UK public sector and in health and social care services, some commentators suggest that collaborative forms of organisation create new and dynamic organisational and managerial challenges. According to Mintzberg, the network model does not represent a universal panacea of management (1996: 60). One weakness of the literature on inter-organisational networking is that it provides little in the way of a comprehensive review or explanation of the potential for network failure. As outlined in chapter 1, there is increasing evidence to suggest that organisations are entering into collaborative network relations with little prior consideration of the potential problems or costs. For instance, the Government's modernisation agenda, as outlined in the 1997 White Paper, *'The New NHS: Modern, Dependable'* (DoH, 1997), makes little or no reference to the investments of time, reciprocity, communication, finances, and the training, required to make collaboration deliver positive benefits, or improve organisational performance. Kirkpatrick (1999: 7) goes so far as to discount the power of networking and calls for a reappraisal of hierarchy.

Critics of public policy reforms argue that the management of public services continues to be based 'more on faith and doctrine than on demonstrable track record' (Pollitt, 1995: 150). According to some commentators, relational-contracting may not match the Government's objectives given the contradictory expectation of increased accountability and monitoring, "*calling for trust on the one hand and showing a lack of trust on the other*" (Davis and Walker, 1997: 53), in a public sector that has been fragmented by competition and continual changes in policy, whereby service professionals have become disenfranchised and immune to new solutions to old problems. Hudson (1999) asserts that public sector managers and professionals will face many new challenges in turning a policy of network-based collaboration into a workable and effective reality over the long term. From a managerial perspective, coordinating multiple agents to achieve common objectives may be far more of an elusive goal than ever expected. The managerial complexities of controlling the processes of collaboration, combined with the risk of partners pursuing their self-interest, raises many unanswered questions about the likely success of the network governance. The following sections of this chapter explore the potential for network

failure<sup>2</sup>, and look more closely at the significant factors influencing the potential success or failure of collaborative networking in health care.

## 2.7 Managing Public Health Care Networks

The management and organisation of the public sector remains a prominent area for debate and discussion across political and academic disciplines. If it is accepted *prima facie*, that the UK public sector has indeed moved through three distinctive eras, from hierarchical-bureaucracy to competitive-market, to collaborative-network, a research agenda emerges in terms of an evaluation of networking in a public sector context. As noted earlier, the public sector receives comparatively little research attention, with the bulk of research from organisational and management fields conducted in the private sector. The limited number of studies that adopt a network paradigm or investigate network relations between public service organisations is surprising given the size and importance of public services, such as the Health Service and Social Services. Of particular importance is research that addresses issues such as the management, control and performance of collaborative relations, as outlined in the chapter 1 (section 1.6).

Within the UK public sector, the National Health Service remains a diverse organisation, encompassing a range of professions and services, all of which exhibit different organisational, historical and cultural features. As such, many theoretical and practical questions arise about the implementation of network principles, structural, strategic, or procedural (see network dimensions, figure 3, chapter 1), in a public sector health care context. The existing network and public management literature provide little comprehensive answers to such questions, and while authors such as Hudson (1999) or Kirkpatrick (1999) raise similar concerns, they provide little in the way of empirical evidence. Even where there is some attempt to address these issues (Exworthy et al., 1999), offerings remain theoretically limited and fragmented. The gap between what is speculated about networks and the empirical realities of implementing cooperative arrangements, has yet to be bridged. In organisations where

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<sup>2</sup> 'Network failure': where networks do not deliver improvements in performance or where networks create additional organisational/managerial problems that might be deemed 'negative consequences'

the network model is reshaping organisational realities, as outlined above for the UK National Health Service, there exists an opportunity to account for network development, implementation and appraisal. This lack of empirical evidence and network research in public service organisations such as the National Health Service, supports the need for research into network processes, practices, and potential outcomes, and gives rise to two further research questions that this study aims to address.

#### **Primary Research Question 2**

What are the important process factors involved in the integration of agencies in health care, and how might these factors be linked to network outcomes and performance?

#### **Primary Research Question 3**

What are the potential implications of new network forms for the management and organisation of the National Health Service?

## **2.8 Identifying the Managerial Challenge**

While the potential benefits and rationale for network-based organisational collaboration in the public sector are comparatively clear, far less is understood about the potential problems or challenges of realising effective collaboration through the network form. The network literature is now beginning to explore the potential negative dimensions of organisational collaboration. Writers such as Miles and Snow (1992) and Child and Faulkner (1997), raise concerns about the pitfalls associated with coordinating activities between separate entities. Park (1998: 805) suggests that the literature has to a large extent ignored the difficulties associated with managing network organisations. Despite rather euphoric descriptions of inter-organisational networks in the private sector, academic-based studies have raised concerns about the potential problems of managing collective activities under network conditions. Some authors have suggested that the efficacy of the network requires evaluation as an organisational mechanism to govern inter-firm transactions (Kogut, 1989; Park and Russo, 1996). In much of the organisational literature, there is an assumption that networks are relatively stable, as a result of reciprocity; mutually specific and long-term investments to a relationship based on trust (Aldrich and Whetten, 1981).

Evidence however, indicates that networks are prone to failure, often do not achieve their intended goals, drain the resources of the involved parties, and that the obstacles facing them are formidable (Parkhe, 1993; Ring and Van de Ven, 1994).

While the frequency of new inter-organisational and intra-organisational arrangements has increased significantly over the last two decades, there is now a growing awareness of the difficulties of eliciting positive outcomes from network relationships (Buckley and Casson, 1988; Kogut, 1989). It is sometimes suggested that inter-organisational networks often fail because of the transaction hazards of opportunistic behaviour by parties seeking personal utility from the relationship (market-like characteristics), or as a result of bureaucratic costs associated with coordinating inter-firm exchanges (hierarchy-like characteristics) (Park, 1996: 802-803). The alignment and congruence of goals also presents a difficulty for managing collaborative processes, which again raises bureaucratic costs and induces opportunism. The inter-organisational network presents a range of additional managerial problems that result from the complex and unique nature of these hybrid governance structures. Significantly, issues such as trust, stability, innovation, goal congruence and control, have emerged as important process factors, and are the potential problem areas created by these new forms of working. The following sections of this chapter examine some of these relational factors in more detail with specific reference to the development of networks in a public sector setting.

### 2.7.1 Managing Public Sector Networks

In public sector services, health and social services in the US and UK, Provan (1998) acknowledges that there has been scant empirical evidence that integrated networks are effective (1998: 454). Provan (1998) argues that network success is likely to be a result of effective integration among small, overlapping subsets of organisations, often linked through a lead or administrative entity (Human and Provan, 1997), rather than as a result of integration across the network as a whole. Accordingly, writers and network researchers have put forward a range of major issues relevant to managing public sector networks including: how to control these new forms; stability and longevity over the short and long terms; the need to maintain a high trust and high commitment environment; aligning goals and congruence; evaluating performance;



remaining innovative; and eliciting the potential benefits of this new way of organising and working (Miles and Snow, 1992; Ring and Van de Ven, 1994; Park, 1996). Provan (1998: 454) states that:

*“In health and social services, many organisations, particularly at the community level, may well be considered part of a broadly defined delivery system and may well be connected to one another in a variety of ways, however the reality of integrated networks of service providers is that outcomes for a particular client group are more likely to be effected by the activities of small groups, or cliques, of tightly connected providers, rather than as a result of the activities of the complete network.”*

### 2.7.2 Control and Accountability

The potential for network failure in public services emphasises the important issue of control and accountability. Public health and human service systems are subject to control by external government entities that provide funding. The influence of external agents and funding bodies over individual organisations has been an important aspect of research on inter-organisational relationships. Results from Provan's (1995) study of community mental health systems in the US suggests that systems in which external fiscal control by the State is direct, and to a lesser extent not fragmented, are more effective than directly controlled systems in which the allocation and control of state funding is delegated to a local funding authority. As Provan states (1995:15), *‘this contradicts the prevailing wisdom that decentralised systems of fiscal control are best because they allow greater flexibility at the point of service delivery’*. The logic here originates from arguments by proponents of agency theory, in which indirect arms-length relationships between principal and agent allow for behaviours by the agent that the principal may find difficult to control. The risk averse strategy is for the State to directly control local funding of public services and to centrally monitor financial performance, rather than trying to set up a local intermediary that itself must be monitored and controlled (Provan, 1995:13). Such a conclusion contradicts current trends in health care management, where there has been a shift away from centralised control to more decentralisation of control.

#### **Literature Guide 1**

Network effectiveness is likely to be greatest where external mechanisms of control are direct and not fragmented, and where mechanisms of control, monitoring, and accountability are clearly defined.

### 2.7.3 Instability and Uncertainty

Another important consideration surrounding networks, in terms of longevity and organisational durability, is stability. There is some concern about the long-term stability of collaborative inter-organisational arrangements. For some, networks represent a purely temporal or intermediary governance arrangement (Williamson, 1985: 4), where short-term gains may be achieved by reducing transaction costs. Over the long-term, economies of scale and scope will be diminished and the costs of managing the relationship will begin to outweigh potential gains. Advocates of networks agree that the fragility of these dynamic forms of economic organisation stems from the instability and uncertainty of the social relationships on which they are formed (Powell, 1991). Ring and Van de Ven (1994) suggest that networks are vulnerable to disruption from a range of sources, both internal and external, including changes in influential personnel, changes in corporate alliances and fluctuations in business cycles. According to Contractor and Lorange (1988), networks are more vulnerable to environmental changes than more established forms of hierarchy. Accordingly, even a long-surviving network with improved norms of equity and trust will eventually slip into decline. As Van de Ven and Walker (1984) recognise, networks tend to be more cyclical and temporary, than structured and complete. Miles and Snow (1986) conform to Williamson's view of networks as unstable and intermediary arrangements. Miles and Snow (1986) assert that the norm of reciprocity and trust may not be sufficiently sustained over the long-term. As the number of alliances and collaborative arrangements increases between firms in the market place, more evidence is emerging of the fragility of the network organisation. As Miles and Snow (1986) suggest, the process of working within a collaborative framework between multiple organisations aligned via a network of relationships introduces a new set of problems, particularly how to keep the network productive and innovative over the long-term.

There is evidence to suggest that instability or change in an organisation's external environment might be linked to experiences of uncertainty (Burns and Stalker, 1961; Amburgery, Kelly, and Barnett, 1993). There is some concern that any effort to induce rapid change in a system, such as the redrawing of organisational boundaries, the restructuring of organisations, changes in organisational responsibilities, personnel

and funding, may reduce the effectiveness of the existing system by increasing feelings of uncertainty (Provan, 1995: 13). In public services where there is a growing emphasis on the integration and coordination of multiple agencies there is some concern that system-level changes, as described above, might negatively affect network-level outcomes. In addition, problems of network instability and uncertainty might be amplified if system users, the general public, patients, or clients, view change as unnecessary (Provan, 1995). In many instances in health and social services, stability and certainty are important factors in users' perceptions of service effectiveness.

The issue of stability in relations between organisations and the issue of maintaining feelings of certainty and security within network relationships presents a theoretical dilemma. A number of prominent writers on organisations, most notably Granovetter (1973) and Weick (1976), have professed the benefits of loose ties. The dilemma is that for networks, uncertainty brought about by environmental change is likely to reverberate among interdependent organisations. Tightly linked networks create an 'amplification effect' of environmental change (Simon, 1945, 1962), where networks transmit change in ways that have unexpected consequences (Pfeffer and Salancik, 1978). The solution to such a problem, as Granovetter (1973) argues, is to maintain loose ties, gaining the advantages of linkage without the potential negative effects brought about by system changes. The contradiction and problem for organisations in a public sector system, such as in health care, is that there is a strong requirement to develop and maintain fairly closely linked ties between provider agencies in order to serve client needs. The theory suggests that organisations that are undergoing significant change are less likely to be as effective as more established and stable systems. Environmental change and uncertainty will have a negative effect on network performance, but might be reduced where networks are flexible structures, where the system is free to react to change (Simon, 1945, 1962; Granovetter, 1973; Pfeffer and Salancik, 1978; Provan, 1995).

#### **Literature Guide 2**

Networks operate more effectively under conditions of general system stability and require flexibility to react to environmental changes.

It is arguable that the issue of network stability takes on more importance in a non-profit public sector setting, where clients, the general public, seek certainty and trust in the services provided by government or by the organisational agents of government contracted to deliver such services. Ferlie and Pettigrew (1998: 218) highlight the volatile nature of networks in the NHS, where many have encountered difficulties in maintaining “*interest and commitment over a long period once initial enthusiasm has worn off*”. Given the political uncertainty that influences change in the public sector, it remains uncertain and questionable whether autonomous network systems are more appropriate than centralised and hierarchical modes of organising.

#### 2.7.4 Trust

Much of the network literature suggests that collaborative arrangements require high levels of trust between members. There is a significant volume of work on trust, particularly in social psychology and sociology. Definitions of trust tend to centre on feelings of security, commitment and control. Lorenz (1991: 185), notes that trust in inter-organisational transactions be viewed as:

*“An action that (1) increases vulnerability to another who’s behaviour is not under control, and (2) takes place in a situation where the penalty suffered if trust is abused would lead to one regretting an action.”*

This review does not explore the issue and theoretical and conceptual rudiments of trust in great detail however, in relation to network partnerships, trust is viewed as an important aspect of the collaborative process. While the network literature proclaims that a high level of trust is required for effective networking, some authors raise the problem of manipulating trust. Sako (1992) argues that trust, as a concept and phenomenon, is something that is more often found than created. Empirical work in this area supports this view, for example research by Lane and Bachmann (1996) on inter-firm networks in Italy and Germany, revealed how trust had emerged from pre-existing social ties or in particular institutional frameworks, such as the legal or banking systems.

The concept and consequences of trust between actors in public service organisations has been far less investigated compared with studies of trust between partners in inter-firm networks. In many instances, public sector trust is often an implicit assumption,

given that market place conditions of profit maximisation and opportunism are far less prevalent, if they exist at all. It is often argued, that an element of institutional trust deeply embedded in the values of service providers, already exists in the UK public sector, which might support any effort to institutionalise collaboration. Pratchett and Wingfield (1996: 654) for example, note how the public service ethos continues to provide “*a degree of coherence and consistency of values amongst staff delivering a diverse range of public services*”.

A recurring theme in the literature is the paradoxical way in which ‘high-trust’, while necessary for collaboration, also has the potential to become a liability. Ring and Van de Ven, (1994) note how trust or goodwill, when taken to its extreme, creates the conditions for an abuse of trust. In particular, the authors warn of fraud, malfeasance and rigging. Such practices are not inconceivable in the public sector; there have been a number of high profile instances of malpractice and misconduct in the NHS covered by the media since the election of the Labour government in 1997, including the Shipman case and the case of the Bristol Royal Infirmary. The increased emphasis on self-regulation might be abused by network participants, for instance, it is possible that members of a cooperative alliance in a public sector institution might manipulate budgetary demands in an effort to increase funding or to ensure that existing funding is maintained (Ring and Van de Ven, 1994).

Trust presupposes decision making in a situation of risk, where the risk is attributable to the strategic behaviour of others, particularly in relation to opportunistic behaviour. Opportunistic behaviour may be blatant, cheating, stealing or malpractice, or it may be more subtle, withholding information, delaying, or game-playing (Lorenz, 1991: 185). One possible action is to avoid this risk by non-participation however, organisations are often dependent on suppliers or each other, if they are to realise the potential benefits of trade. Therefore, non-participation is generally unavoidable. Once organisations are locked into an agreement trust becomes an essential element; for if opportunistic behaviour is suspected, partners might increase monitoring or rewrite contracts, thus increasing transaction costs. While economists argue that the need for trust can be circumvented by the efforts of parties to acquire full information, or to contract for most contingencies, research by Lorenz in French subcontracting

networks shows how environment, practice, and bounded rationality, make trust a necessary element of economic transactions (Lorenz, 1991: 183-192). Lorenz (adapted from 1991: 187) makes three important points about the implications of trust:

- Some investments may not be made where actors do not trust each other to refrain from abusing their bargaining power to renege on contract terms, or to use a shift in circumstances to shift the division of profits in their favour.
- A considerable amount of expense may go into fashioning safeguards designed to minimise the risks of being a victim of opportunistic behaviour. These expenses could be avoided if there were mutual trust.
- Those in bilateral monopolies may hesitate to demand legitimate adaptations to contracts as a result of changed conditions, fearing that the other partner might view such action as illegitimate and opportunistic.

The above discussion begins to tap into the vast literature on trust, but shows how while trust is a prerequisite of networking and cooperation, it is a difficult relational value to control or manipulate, rather trust often forms from pre-existing relations between partners over time.

### Literature Guide 3

Networks are more likely to form where there is a significant degree of trust between partners, particularly where trust is more freely evolved.

#### 2.7.5 Innovation

The literature on network relationships in the private sector has raised some additional concerns about the ability of networks to remain innovative and dynamic. As in all social relationships, the bond between parties often leads to dependency. In the case of networked organisations, there is a risk that the junior partner, assuming there is an imbalance of power as in buyer-supplier networks, will become reliant or dependent on the parent organisation, and over time, the parent may subconsciously maintain the relationship and the status quo, with a subsequent loss of competitive forces and innovation (Miles and Snow, 1992). The very phenomenon that brings organisations

together can actually work against them over the long-term, where network relationships turn in to coalitions that resist innovation and offer security and safety for under-performing firms (Miles and Snow, 1992). Uzzi (1997: 58-59) refers to this problem as “*overembeddedness*”, “*over time... the social aspects of exchange supersede the economic imperatives*”. For example, in supply chain networks, like those found in the frequently cited Asian automotive industry, the supplier firm becomes dependent on the car manufacturer. As the supplier has secured business or a set amount of supply, the supplier develops complacency and stagnates due to the absence of open competition. This does not bode well for the parent company, for if the supplier stagnates the quality and speed of innovative turnover on the part of the supplier slows down, this subsequently has a knock-on effect on the quality and efficiency of the goods or services supplied by the junior partner. In this case, competition is the necessary incentive driving innovation, and where competition is removed, innovation slows down. In extreme cases, organisations might “*find themselves managing the assets of its partners and accepting responsibility for their output...*” (Miles and Snow, 1992: 65). Under such conditions, the purchaser gains neither the cost advantages and flexibility of short-term contracts in a spot market, or the ability to direct and control services, as is the case in a vertically integrated hierarchy.

#### **Literature Guide 4**

**Long-term and stable networks reduce the innovative capabilities of network members by creating secure relationships that reduce flexibility and the influence of external innovative drivers.**

#### **2.7.6 Goals and Priorities**

For writers such as Mayo (1945) and Barnard (1968), cooperation poses a fundamental problem of how to coordinate the multiple and divergent goals of the parties involved. Blau and Scott’s (1962) definition of a formal organisation ‘*as a purposive aggregation of individuals who exert concentrated effort toward a common and explicitly recognised goal*’, while commonly referred to as an explanation for the existence of organisations, is somewhat limited by the organisational realities as captured by Simon (1945: 257-78), whom suggests that individuals within organisations rarely possess a common understanding of goals. The coordination of

goals has traditionally been a key feature of traditional micro-economic and organisational research, and management functions (e.g. principal agent theory in economics and new forms of management such as human resource management). In networks, the management and coordination of goals is a particularly difficult task, as the number of organisations increase from the singular to the multiple. Very often organisational members of the network possess very different goals and priorities. Park (1996: 795) writing on this topic raises the potential problem of coordinating multiple players to accomplish common objectives. Importantly, the institutional and managerial arrangements that are established to control and manage inter-organisational collaboration are critical to the success or failure of network relationships (Kogut, 1988; Parkhe, 1993).

In relation to the managerial aspects of networks in a public sector environment, Pollitt (1993: 122) states that public organisations may find it difficult to maintain collaborative relationships between services with multiple and conflicting goals and priorities. According to Provan (1995), in the public sector where a public interest motive is involved, network outcomes are especially salient and the rationale for organisations cooperating to accomplish system goals, rather than organisational ends, is often stronger than in the private sector. For key groups like policy makers, service professionals and users, emphasis is often on achieving outcomes that enhance the overall well-being of clients, without regard to whether the goals of the provider organisation are being met (1995:1). As Provan (1995) concludes, such outcomes may not have any direct impact on the effectiveness of the organisations that make up the network. Thus, a paradox or conflict exists, between professional goals and organisational goals. This summation concurs within Abbot's (1988) theories of professional jurisdictions, in which professional and non-professional goal congruence is viewed as important to the operations of public sector organisations, where contributors to the institutional network are often high-ranking professionals with professional autonomy and allegiance.

#### **Literature Guide 5**

In order for a network to achieve positive sum gains for its members, partners entering into and operating networks should share similar goals and objectives. Where goals are incongruent, network failure is likely.



The range of issues discussed above highlight the difficulties associated with operating and maintaining cooperative networks of multiple actors. The literature suggests that trust-based network relationships are subject to rapid change and potential disintegration (Sako, 1992). There is also evidence that this problem might be compounded in a public sector setting: where political incentives often supersede organisational objectives; where employees are often loyal to their profession rather than to the organisation (Abbott, 1988); where there is a likelihood of resistance to change: and where there is a clear division between service management and service provision (Kirkpatrick, 1999). Given the complex dynamics of organisational networking, the challenges of control and accountability, maintaining stable long-term relationships, developing trust and harmony between partners, and managing the interests and goals of members, some writers purport that networks and collaborative governance are unsuitable modes for public service organisations (Kirkpatrick, 1999: 7-13). In response, the following section considers the potential implications of networks for public sector service organisations.

## **2.8 Implications for Public Sector Management in the National Health Service**

The integration of service organisations within the UK public sector is a prominent theme of government policy post-1997 and is widely debated by academics and practitioners. The prevailing view among many service professionals, policy makers, and researchers, is that by integrating services through a network of provider agencies, this will reduce fragmentation and increase the coordinated abilities of service providers. Ultimately, new collaborative ways of working will improve the effectiveness of the overall system (Rogers and Whetten, 1982; Alter and Hage, 1993). Collaboration, between services, between the public and private sector, between professionals, and across services, is now viewed as the best way of improving the quality of services provided by the public sector. In health and social services, providers of care are joining networks to lower operating costs and improve competitive advantage (Provan, 1998: 453). There is a prevailing assumption among governments, strategists, academics, and some practitioners in health and social services, that the delivery of human services to clients with complex and multiple needs, within the constraints of the context within which these services are being

provided, can be enhanced when provider organisations integrate through a network system (Alter and Hage, 1993). While working collaboratively across organisational boundaries is now a popular component of organisational operations, public sector administrations are attempting to address social problems by networking public sector institutions (Huxham, 1996).

According to Provan (1998: 453-454), integration occurs when organisations that provide services for a particular client group, work together to coordinate the services they provide. Integration may be formal or informal, and may involve simple social exchange or full-scale sharing of resources and skills. In non-profit sectors, such as health care in the UK and US, agencies are increasingly adopting the principles of cooperation and are reorganising organisational structures through the adoption of the network model. However, although the rationale for network involvement may be strong, there is very little empirical evidence to support the presumed relationship between the integration of agencies around a network model and network effectiveness, or empirical evidence that indicates what network characteristics are associated with effective network outcomes (Provan, 1995:3, also discussed above in 'network not panacea').

Within the UK National Health Service, there has been some move to implement a model of organisation and management that moves the emphasis away from combative arms-length competition between providers (internal-market), towards more personal and relational practices associated with a network approach. The NHS is often viewed as a focal point for an array of stakeholders' interests. The NHS is now engaged in a number of inter-agency alliances, clinical and non-clinical, aimed at improving service quality, inputs, processes and outputs. Within this framework, managerial tasks have taken on a greater degree of importance (Ferlie et al., 1996). Public sector managers are now facing more complex and multi-faceted responsibilities in relatively new institutional settings. In this regard, the network phenomenon is polycentric and diffuse in nature in health and public services (Ferlie et al., 1996). The introduction of 'clinical networks' of care, typifies this new and unique experiment in cross-organisational communication. Given that such innovations are to some extent outside the control of traditional management, there is

some argument that the networking phenomena is changing traditional management, moving the management function away from control and monitoring towards ideas of mediation, bargaining and consolidation. It is also argued, that the network elicits a form of ‘consensus management’ or a pluralist approach to labour relations that is different from the competition associated with the internal market or the bureaucratic style of the 1970s. In the National Health Service, secondary sources suggest a significant degree of change. Ferlie and Pettigrew (1996) state that:

*“Empirical work undertaken in the NHS shows that network-based styles of management should now be seen as of substantial rising importance within NHS purchasing organisations when assessed against both hierarchical and market-based forms of management” (1996: 87).*

Ferlie and Pettigrew (1996: 88) view the role of the network in health care as follows:

- To transfer ownership of a health agenda to wider groupings outside the NHS (e.g. helping local communities to take ownership of health issues)
- To engage in the production of joint goods with other producers (e.g. improved housing may be associated with improved health)
- To clarify responsibilities and patient flows so as to produce ‘seamless care’ across a complex web of organisations (e.g. post discharge planning)

The influence of the networking phenomena on the NHS is increasingly significant in terms of new organisational, social, cultural and political processes. As has been suggested in the initial chapters of this thesis, networking moves the focus away from the idiosyncratic principles of hierarchy towards more relational or matrix types of organisation and management. Ferlie and Pettigrew (1996) acknowledge a move from organising along uni-functional or professional lines, to more team-based and multi-disciplinary approaches in the NHS. Such evidence supports the idea that the NHS, like other public sector services, is becoming a network organisation. However, what are the implications of moving from market or hierarchy to network for services such as the NHS?

The move away from hierarchy and clear lines of authority, towards more integrated

forms of working may arguably created new complexities of task for managers. Managers in the NHS are now experiencing an increase in the number and breath of tasks they must perform. Increasingly, managers are expected to coordinate a portfolio of functional tasks. There is increasing requirements for more informal modes of communication and decision-making however, this counteracts the need for control and transparency.

Networks are built on principles of trust, reciprocity, flexibility, understanding, involvement and participation. Such elements espouse a level of 'closeness' and 'friendliness' that goes far beyond traditional market-place cooperation between competitive firms. The network theoretically requires substantial relational norms that are difficult, if not impossible, to manipulate, artificially create, or manage. In addition, the network then becomes vulnerable to changes in influential personnel, gatekeepers, mediators, or advisors (Ring and Van de Ven, 1994). The inter-personal component of the network organisation brings with it a level of risk that might not be as important in more structured organisations. As Kirkpatrick (1999) suggests, *'the benefits of networking must be weighed against the risks'*.

An import question relates to the sustainability of networks, particularly for public services such as health care. There are a number of theoretical concerns regarding network stability over the long-term. The longevity and stability of new forms of organisation takes on greater importance in a public sector setting. Not only are there more stakeholders, even if not directly involved, change is arguably more constant and publicised. From a theoretical perspective, there is some concern that networks are less suitable forms of organisation and governance for delivering public services that require high levels of monitoring and accountability. Additionally, as discussed earlier, network relations operate best, where there is a high degree of commitment from network incumbents, where there is available time and resources to promote the development of relationships. There is some question as to whether or not public sector networks like the National Health Service will elicit the desired level of commitment, or the time and resources they need to develop productive collaborative relations. There is also concern that the level of commitment and participation required by partners might be difficult to maintain (Ferlie and Pettigrew, 1996: 95).

The institutionalisation of the network is thus an important consideration. Thorelli (1986: 37-51) suggests that a 'broker' or 'champion' is required to animate the network over the initial introduction period.

In addition, as discussed in detail in chapter 1, the general problems of performance appraisal and suggested that there is some difficulty in associating network-level inputs to network-level outputs (figure 3: 35). Provan (1995, 1996), highlights the difficult task of causally relating network organisation, as a system, to system-level value creation. Provan (1996) discusses the problems of relating increased integration in a mental health care setting in the US to increased levels of care for mental health patients in the community. In the UK, health care commentators are becoming increasingly sceptical about the potential for service improvement via the network model (Kirkpatrick, 1999; Hudson, 1999; Exworthy et al., 1999). There is some concern that network forms of management might drain resources and divert precious time and effort. There are also concerns about the duplication of work and responsibilities, as roles become more interlocked. Some authors suggest that networks distort lines of authority (Ferlie and Pettigrew, 1996). A delayering of middle management and the devolution of power to autonomous NHS bodies, such as primary care organisations, will arguably reduce the direct power and control of senior management, currently located at the health authority level. In addition, any duplication of professional tasks might obscure direct responsibility making accountability more difficult to enforce. Ferlie and Pettigrew (1996) report a lack of clarity in network forms in the NHS. While senior managers often welcomed moves towards N-based forms of management, middle and junior managers felt threatened (1996: 95). The major theoretical problem with network forms of organisation is how to appraise performance and intervene if performance falls below expectations. As shown in chapter 1, the incentives for entering into networks are vast, ranging from improved knowledge transfer and communication to increased flexibility and responsiveness. However, in a public sector service such as the UK National Health Service, there is a constant requirement to show how public funds are used, or add value. This need for performance monitoring and quantitative analysis of performance contradicts the ethos of cooperative networks, in which performance is not measured in monetary or quantitative terms, but in more subtle or tacit terms.

## 2.9 Summary

This chapter moved discussions of networking away from more established debates concerning markets and inter-firm relationships, to the comparatively under-researched setting of the UK public sector, by reporting on recent moves away from internal-markets and bureaucracy to new collaborative governance and network relationships in the UK health sector. The public sector in the UK is the largest single employer, encompassing a wide range of organisations including defence, education, social services, and much more. It is therefore surprising that much of organisational and management research continues to focus most attention on issues relevant to the private sector (Newman, 2001: 1). To date there has been little exploration of networks and networking processes within this non-profit public context.

This chapter introduced the considerable debate in public management fields concerning the network organisation as an alternative philosophy or mode of governance for the commissioning and delivery of public services, such as health care. This chapter moves the network paradigm away from more established debates concerning markets and inter-firm relationships, to the comparatively under-researched setting of the UK public sector. The chapter focused on current rhetoric surrounding recent moves away from internal-markets and bureaucracy to new collaborative governance and network forms in the UK National Health Service. The chapter brought together important findings from a variety of literature sources to examine emerging structural and procedural developments in health care and addressed current speculation that the NHS, like other public sector services, is becoming more characteristic of the network archetype.

The preliminary evidence reported within this chapter suggests that following the election of a Labour Government in 1997, there has arguably been a shift away from quasi-market and bureaucratic modes of public sector governance towards more flexible and cooperative approaches to public sector organisation and management. Recent developments in the structuring of public sector institutions such as the National Health Service, reveal a myriad of new connections being formed between health care agencies, for example in primary health where new primary care organisations have been established to network health professionals at the community

level. A range of Government and Department for Health policy statements since 1997, exemplify the new emphasis placed on collaboration and partnership working between health care commissioning and provider organisations. This chapter identified the principal forces influencing change in the UK public sector. The chapter applied a transaction cost logic to explain a contemporary critique of internal-markets and elaborated on recent move away from quasi-competition and obligational-contracting to more relational-contracting and collaborative working between public sector contractors. The chapter also raised argument concerning the National Health Service as *Network Organisation* and discussed the important question of network management in a public health care context. In this regard, a number of recurrent relational factors were identified including, trust, opportunism, stability and certainty, goal congruence and innovative ability. This chapter also highlighted the potential implications of networks for the NHS, particularly with regard to issues of managing tasks, the potential for network failure, the longevity of network forms, and the significant issues of network performance and accountability. There is some concern surrounding the UK Government's desire to achieve short-term efficiency gains at the expense of long-term service development. This issue raises a critical dilemma in service management. Many unanswered questions arise concerning service development over the long-term. Recent efforts to develop collaborative network-based organisational forms and relationships in the UK public sector, primarily in health care and the NHS, are likely to require time and investment for trust to develop, before any beneficial returns might be recorded. As such, the implementation of new collaborative governance policy requires substantive evaluation and the manifestation of new network forms of working in health care require identification and appraisal, not simply in terms of quantitative performance, but in terms of changes to work processes and relationships between the incumbent organisational actors involved in delivering health care.

### **3.1 Introduction**

This chapter presents and reflects upon the development and application of the research design and methods employed to pursue the research questions established in previous chapters. The chapter discusses the philosophical biases underlying the choice of research design, strategy, and methods, particularly, the implications of these assumptions with respect to an interpretation and evaluation of findings. The chapter begins by discussing the philosophical foundations of scientific inquiry. The first section sets out the three dominant philosophical schools, or research paradigms, the positivist school/paradigm, the realist school/paradigm and the naturalist school/paradigm. The following section depicts how these different philosophical traditions have influenced research within management and organisational fields. The following section sets out the epistemological and ontological position taken to undertake this study, detailing how the study is influenced by a realist approach to the study of social behaviour and guided by a broad multi-paradigm preference to scientific inquiry. The chapter moves on by presenting an overview of the research process followed and the research strategy adopted to pursue research objectives. The subsequent section professes a rationale and justification for the development of an exploratory-descriptive research design that encompasses a pluralist mix of methods. This design is divided by three levels of network analysis: a national level review and analysis of change in the UK health care sector; a review and analysis of developments at the regional level in the National Health Service in Wales; and an investigation of networking and collaborative practices at the local community level across four Local Health Groups within a large health authority area. The chapter also sets out the research protocols used to guide data collection and analysis, and details the application of the research strategy, accounting for how the methodological approach required adjustment, refinement, and reevaluation at different stages. The final section addresses issues arising from the conceptualisation of the network phenomenon and sets out an analytical framework to guide network analysis and theoretic-empirical interaction and reflects upon the strengths and weaknesses of methods employed to establish research credibility and quality.



### 3.2 The Philosophy of Scientific Inquiry in Social Science

In the social sciences, philosophical questioning conjures up discussions of rhetoric, argument, dialectics, heuristics, pragmatics, and hermeneutics, with respect to scientific reasoning and logic. This chapter attempts to establish a philosophical basis for this study undertaken and to establish the procedures and parameters for data collection, analysis and credibility. A common goal of scientific research is to search for universal laws or meanings derived from some mode of accepted inquiry. In social science, this commonly involves understanding social phenomena. Invariably, the meaning or understanding a scientist attaches to discovery is subjective in terms of how they view the world. Scientists possess a point of view, or a philosophical bias that arguably influences how they discover and validate knowledge (Guba and Lincoln, 1998: 195-220). There are three principal epistemological perspectives or philosophical traditions in the social sciences, namely: *positivism*, *realism*, and *naturalism* (Wass and Wells, 1994: 9). Importantly, these research paradigms represent different philosophical positions that are commonly associated with different traditions of scientific inquiry.

Positivism is a philosophical position most associated with that model developed in the natural sciences, chemical and biological sciences for example. Positivism holds the epistemological assumptions that: only what is objectively observable is valid knowledge, with an empiricism that; explanation comprises of causal laws inferred from empirical regularities; subjects subservient to definition of knowledge, with subjective consciousness meaningless (Guba and Lincoln, 1994: 105-106). The scientific objective is often nomothetic within the natural sciences, where the aim is to abstract from subjective ideosyncracies, to uncover general laws that are replicable and generalisable to a wider or universal population. The nature of scientific inquiry is held to be impersonal, value-free, rational and deterministic. The process of inquiry is deductive, from abstraction of theory, to hypothesis development and testing, to statistical tests of causal inference and validity. This view of knowledge and inquiry attempts to:

*“...verify (positivism) or falsify (post-positivism) a priori hypotheses, most usefully stated as mathematical propositions...that can be easily converted into precise mathematical formulas expressing functional relationships”* (Guba and

Lincoln, 1994: 106).

The type of data most frequently sought is quantitative or numerical. A corner stone of research in the positivist tradition is the logic and use of experimentation. The emphasis is on control and measurement of relationships between variables. Generalisation from a sample to a population is the key distinctive objective of positivist methods, most often achieved through random selection and by discounting sampling error. When applying experimentation logic to the social sciences, such as management and organisation studies, a number of recurrent problems arise. Firstly, social behaviour occurs in a social environment (society) where the behaviour of subjects (people) is not easily manipulated or controlled. Removing the subject from the natural environment arguably distorts behaviour and leads to the problem of ecological validity, while taking the experiment to the environment compromises internal validity, as the subject is then influenced by additional (artificial) stimuli (Wass and Well, 1994: 11). Such problems are well documented in the social sciences, however proponents of positivist science suggest that the problem of 'human control' is negated by research that replaces physical controls with statistical controls, as in the case of economics. However, despite the sophistication of such techniques, problems of bias and inter-dependence exist, for example non-response bias or the problem of multicollinearity, whereby positivistic social scientists seek out causal inferences, rather than deterministic causalities.

In stark contrast to positivism, naturalism presents a very different rationale for scientific research. Naturalism is an anti-positivist position predicated on a set of alternative idealist assumptions about the study of social reality, in particular the rejection of the notion of independence of the social world from subjective interpretation (Wass and Wells, 1994: 13). Naturalism is extreme in its view that the entire logic of the experimentation is completely inappropriate for social research. Instead, a hermeneutic view of valid knowledge is adopted in which data is defined in terms of subjects' comprehension of their social world, and where explanation of this world is defined in terms of interpretative understanding of action on the part of the subject. As Weber (1947) distinguishes, the aim is explanatory understanding of human action, rather than positivist observation. Consequently, naturalist methodologies most often seek to explore, describe, and explain, behaviour from the

subject's perspective, by '*seeing through the eyes of the people being studied*' (Bryman, 1988: 61). In doing so, the subject determines what constitutes knowledge, where the subject's sense of reality is deemed '*objective*'. The aim is to uncover a subject's conceptualisation or interpretation of social environment. The naturalist school is in direct opposition to positivism, prior conceptualisations and assumptions of society determine what is knowable about the subject. Such a dichotomy in approach brings with it a divergence in the modes of data collection and analysis. In contrast to positivism, naturalist research tends to be inductive, with theory crafted from empirical observation, with reflection and the construction of abstract concepts or descriptive explanation. Theory is often grounded in the empirical world and not in the prior constructions of the academic world (Glaser and Strauss, 1967). In addition, there is some concern not to disrupt the natural behaviour of the subject. This accounts for the use of unstructured techniques and non-obtrusive methods, such as participant observation; were the method can respond to the subject, in contrast to the positivist subject responding to method. The naturalist approach is characterised by this closeness to the social world (empirical reality) and for its attention to detailed descriptions. Its mainly 'ideographic' methodology is premised on an 'emic' explanation of human behaviour: to uncover the process of interpretation and action at the level of individual meaning. As a result, the criteria by which findings are evaluated is quite different from that of positivist experimentation. Greater priority is accorded to ecological validity, the closeness or match of the data to the actions of the subject, internal validity, and the identification of the appropriate cause and effect relationship (Wass and Wells, 1994:15). Thus, when examining the scientific credibility of either positivism or naturalism, it is noticeable that they are premised on very different assumptions of what constitutes scientific knowledge, or more appropriately of how to arrive at explanation. In addition to the apparent polarised philosophical positions of positivism and naturalism there is an alternative or discrete intermediary position known as realism. The realist approach appears to reconcile the realist and idealist understandings of human action, whereby:

*“The real world exists independently of the subjective consciousness, but experience of the world is found through subjective consciousness”* (Wass and Wells, 1994: 9).

The epistemological assumptions that premise such thinking suggest that: knowledge

includes the observable and the tangible; general laws are not deterministic, they only explain human action; equally subjective interpretations are partially explained by the external world; human action is open to various interpretations, with the possibility of indeterminates. The scientific rationale behind the realist tradition is to uncover general laws, more ritualistic than deterministic. The nature of scientific knowledge is personal, value-bound, multi-causal, plausible, indeterminate and specific, unlike pure positivism, which favours objective value-free determinism, or phenomenological naturalist research, which favours value-bound inductive theory, grounded in observation (Dubin, 1982: 372). While positivism and naturalism offer two conflicting, even extreme views of research, realism arguably offers a more balanced solution to the weaknesses inherent in any one research approach. In practice, most scientific studies draw on a mix of positivist and naturalist epistemologies and methods (Wass and Wells, 1994: 16). For example, quantitative studies often involve dialogue with subjects in a natural setting or incorporate some subjective interpretation of findings or data collected from secondary sources. Similarly, qualitative research, such as case study research, compare similar units (cases) sampled from a population, in an effort to assert representativeness to a wider population. Whipp (1998: 52) adds that the main approaches to research in the social sciences, that fall under the heading of quantitative or qualitative research, “...are not antithetical; indeed, they are often used together”. According to Giddens (1984) the relationship between methodology and epistemology must be reconciled at a philosophical level. The defining factor of realism might be its emphasis on reconciliation, recognising the role of both ‘etic’ and ‘emic’ explanations and interpretations of human action, subjective and objective (Giddens, 1984).

### **3.3 The Methodology of Social Science**

Since the beginning of modern science, many different methods of research have been applied to social subjects (Bonet and Sauguet, 2001: 7). In the nineteenth century, German philosophers opened questions about methods in inquiry, introducing concepts such as, experience, intention, meanings, and purposes, as valid components of reasoning and logic, marking a move away from the more traditional or rigorous proof-driven science. Today much of the debate between the natural sciences

(objective) and the sciences that study human action and behaviour (subjective) centre around questions of credibility, validity, reliability and generalisability. In social science, issues of scientific justification continue to divide schools of inquiry, as in the case of positivism and naturalism. The validity issue continues to occupy a large portion of the contest between quantitative and qualitative methods. The need to establish scientific credibility imposes the condition that researchers evaluate and justify the research they conduct, in terms of relevance, desirability, replication, and in terms of the validity and reliability of the methods employed. Social science disciplines or fields, such as economics, sociology, psychology, management and organisation studies, are founded on the study of human behaviours and actions (Weber, 1949). As such, Bonet and Sauquet (2001) suggest that the concept of action involves three main components. First, there is a purpose to an action to change one state of affairs into a future state. Second, the actor engages in cognitive processes about how to enact action. Third, the output of these two earlier processes effects action or change. The important conclusion is that mental plans are not directly observable by third parties, and that without knowing them, the act has no meaning. In everyday social life and in scientific research, actions are interpreted usually according to typifications (Bonet and Sauquet, 2001). Social scientists seek to build theories about human behaviour through scientific interpretations. Thus, in this way, social science involves double hermeneutics, a cycle of experience, observation and expectation, on the part of the scientist. For both naturalist and positivist research, there is some requirement to distinguish between theoretical conceptualisations of reality and empirical experiences of reality. The conclusion to be drawn from such philosophical discussion is that there are a number of visions of our empirical world and there are a number of alternative perspectives for identifying, uncovering or validating knowledge, that assert important guidelines of justification and explanation for when actual methods of research are applied.

The conventional academic motivation for research within management and organisational fields is commonly a desire to seek greater understanding of social aspects of work or industrial organisation, and frequently seeks to describe and explain behavioural phenomenon at the industry, organisation, group or individual level (Wass and Wells, 1994: 6). Sources of theoretical and empirical knowledge in

management and organisational research are often derived from sociology, psychology, economics, political science, mathematics and statistics, and are very often adapted or combined to address managerial problems (action research for instance). A unique feature of management and organisational research is the diversity of approaches taken and the range of methodologies employed, from the ideographic (ethnography), to the nomothetic (sample survey). This methodological diversity arguably stems from the contrasting philosophical perspectives found across the management-organisational research spectrum. The theoretical and epistemological eclecticism that this implies has resulted in a trend towards methodological and technical pluralism (Burrell and Morgan, 1979; Hassard, 1991).

The vast literature pertaining to research methods suggests that methodology is very often a product of two fundamental elements of choice. Firstly, that the subject area or research topic constrains or places a limits on what is possible, for example, access limitations, time, or resource constraints. Secondly, a more tacit than explicit choice, is the researcher's philosophical bias or research paradigm (Hakim, 1989). Kuhn (1962) in the *Structure of Scientific Revolutions* reflects upon the notion of paradigm. For Kuhn, paradigms not only involve the formulated principles of a theory and its explicit methods, but also many other forms of knowledge consisting of, for instance, general laws, ontological ideas, lines of development, problems that are admitted and notions of relevance. Giddens (1984) asserts that there is an underlying relationship between methodology and epistemology. Guba and Lincoln (1988: 200) state:

*“A paradigm...represents a worldview that defines for its holder, the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts...”*

What emerges from such discussions is that methodology as the instrument of scientific research is, at least in part, metaphorically influenced by a pre-existing belief of what is real, what is possible, and what methods are required and accepted to uncover what is true (Kuhn, 1962). As outlined previously, the scientific researcher is influenced by an ontological and epistemological view of how to retrieve and record data to create, discover or present knowledge. Critically, paradigms as sets of basic beliefs are not open to proof in any conventional sense, paradigms arguably represent the most informed and sophisticated view that its proponents have been able to devise

(Guba and Lincoln, 1998: 200). Paradigms are human constructions and as such are subject to human error. A potential limitation or adverse effect of any single mode of thinking, for instance viewing the visible world from one primary methodological position, might be that this could theoretically limit the researcher: whereby paradigms lead to traditions, and whereby traditions negate the exploration of alternative methodologies. Thus, there is some concern that association to a philosophical paradigm restricts a researcher's natural freedom of thought and inquiry (Guba and Lincoln, 1998).

### 3.4 Study Ontology and Epistemology

This study mainly follows a realist tradition, that scientific knowledge is personal, value-bound, multi-causal, plausible, indeterminate and specific. All data that is observable or retrievable is deemed important (Wass and Wells, 1994: 9). Additionally, philosophical or methodological pluralism vindicates the use a multiple methods. The approach here is multi-paradigm, incorporating, for example, elements of functionalist causality and fundamental laws, realist impartiality and interpretivist subjectivity (Burrell and Morgan, 1979; Easterby-Smith et al., 1991; Hassard, 1993). In positivistic terms, this study partly adopts a research framework that is problem-orientated, seeking to understand the network phenomenon and effective network management. The study maintains elements of functionalist reasoning, chapters 1, 2 and 3 assert a number of questions and research propositions that might be formulated as testable hypotheses, such as to explain causal linkages between network input factors (NIFs) and network outputs, subjective and objective performance measurements (see figure 3, chapter 1). A significant proportion of the study is directed towards the recovery of facts, for instance retrieving data on Health Service organisation, health policy, and statistical data. This study also incorporates key elements of research that is subjective or naturalist, recognising that reality is also socially constructed that, *'the social world is regarded as a product of inter-subjective experience and exists only through the meaning that social actors apply to it'* (Hassard, 1993). As such, this study seeks to explore and understand the networking phenomenon by engaging with research subjects, health care professionals and network members, in a form that allows for more qualitative data gathering and

interpretation. The study focuses of participants' feelings, emotions, attitudes, meanings and experiences of being involved in multi-organisational networks, whereby theory might be induced from holistic data gathering, in depth and over time from mainly small population samples (Easterby-Smith et al., 1991).

**Table 1 Table: Scientific versus Naturalistic Paradigms Applied to the Research Study**

	<b>Positivistic Scientific</b>	<b>Naturalistic</b>	<b>Study</b>
<b>Ontological Assumptions</b>	Singular, convergent, fragmentable, universal laws	Multiple, divergent, inter-related, patterns	Patterns and Common Behaviours
<b>Researcher-subject relationship</b>	Independent of each other	Inter-related	Inter-related and reflexive
<b>Nature of truth statements</b>	Generalisations, nomothetic statements	Idiographic (understanding particular events)	Idiographic - understanding networking phenomena
<b>Methodological Techniques</b>	Quantitative Statistical	Qualitative	Qualitative
<b>Stance</b>	Reductionist	Expansionist	More Expansionsit (holistic-complex)
<b>Purpose</b>	Verification	Discovery	Mixed
<b>Timing and Specification of Rules</b>	Before Inquiry	Before, During and After	Before, During and After
<b>Design</b>	Preordinate	Emergent	Mixed
<b>Style</b>	Interventionist	Selectionist	Observant
<b>Setting</b>	Laboratory	Natural Setting	Health Service UK
<b>Analytical Units</b>	Variables	Patterns	Networks
<b>Contextual Elements</b>	Control	Interference	Negotiation
<b>Quality Criteria</b>	Rigorous Data	Grounded Theory	More Grounded

Source: Constructed from Methodology Literature - Multiple Sources

Wass and Wells (1994: 16) note that in practice, most research projects draw on a mix of positivist and naturalist epistemologies and methods. In addition, the use of multi-dimensional research techniques is well documented in the management research field. Significantly, Wass and Wells (1994) suggest that different research methods may reveal different aspects of a phenomenon (1994: 19). In a similar vein, Morgan and Smirich (1980) argue that certain strategies are more appropriate for some social



phenomenon than others. The advantage of a methodology that is guided by one main research paradigm but encompasses a broad methodological approach to a research problem can enhance the explanatory powers of any subsequent findings (Blacker and Brown 1989). The triangulation of methods is one example of a mixed methodological approach. Hassard (1993) presents a strong case for such research, as it allows the researcher to engage with the subject in a mode that reflects both the nature of the phenomenon and their values and interests. In practical terms, this study incorporates a range of methods and thinking. This study lies between pure positivistic or pure naturalistic style research, is influenced by a realist philosophical tradition, and incorporates a pluralist mix of methods. Table 1 below illustrates the this position. The study attempts to provide a pragmatic and objective, yet reflective and subjective, account of a social phenomenon, networks in health care and of the processes involved in this real world context; arguably adhering to a philosophical position in terms of ontology, epistemology and methodology, that lies between realism and more interpretivist traditions.

### **3.5 Research Design**

The central formulation feature of any research project is the ‘research design’ (Churchill, 1991). The research design of a study is the framework or plan for a study, which acts as a guide for the collection, analysis, and interpretation of data (Churchill, 1991: 127). Yin (1994) adds that, ‘*the research design is the logic which links the data to be collected to the initial questions of the study*’. Accordingly, there are three principal categorisations of research designs: exploratory, descriptive and causal (Yin, 1994). The major emphasis of an exploratory research design is on the discovery of ideas and insights. Exploratory research aims to formulate problems, develop propositions and analytical constructs, and is typically concerned with the establishment of research priorities, the refinement of ideas, and the clarification of concepts (Churchill, 1991). Exploratory designs commonly employ a range of qualitative methods including: literature searches, experience surveys, ethnographic observation, and case study investigations. The descriptive research design is typically concerned with determining the frequency with which a phenomenon occurs or the depth of a relationship between specific phenomenon. Descriptive studies are

commonly guided by initial hypotheses, sometimes developed during an exploratory phase. This type of study generally aims to describe the characteristics of groups within a population, or to make predictions about future behaviours for the sample under investigation (Churchill, 1991: 144-160). A causal research design is concerned with determining 'cause-and-effect' relationships, very often through experimental or quasi-experimental methods (Frankfort-Nachmias et al., 1996) and is generally positivistic in ontology. Causality refers to one or more objects/variables having a direct effect on the outcome of another (Churchill, 1991: 128). In social science, casual designs, for example non-spurious co-variation methods, are sometimes applied to social settings to investigate economic, social, or psychological phenomena. This commonly takes the form of mathematical models that analyse data quantitatively, using statistical techniques such as cross-tabulation, multiple regression and path analysis (Hair et al., 1998). In practice, most research in social science tends to be non-experimental, whereby social scientists attempt to demonstrate causality inconclusively, through causal inference, using quasi-experimental designs (Frankfort-Nachmias et al., 1996: 131-145).

The task of crafting a suitable research design, is often influenced by factors such as philosophical bias, time, and opportunity, but is more commonly predicted by the objectives of the research. As Churchill (1991: 129) states, "*the crucial tenet of research is that the design of the investigation should stem from the problem*". In response to the above, this study favours a mixed exploratory-descriptive research design. In exploratory terms, the emphasis of this study is on developing new and original insights into network organisational arrangements (as described in chapter 1) and into network governance and practice in a public sector health care setting, as a response to the limited research in this area (as discussed and detailed in chapter 2 and chapter 3). Additionally, this research project aims to better formulate the 'network phenomenon' and to produce high quality research outputs that help develop more rigorous propositions and analytical constructs, that lead to clearer research priorities or aid in policy formation or management practice. In descriptive terms, the research project is concerned with determining the type and forms of network relations in health care and to account for changes in governance and the recent move away from markets and hierarchy to new collaborative forms in health care. The study seeks to

describe how new collaborative governance is reshaping health care organisations and aims to account for the impact on relations between health care agencies and staff in the primary care sector of the UK National Health Service. A non-experimental design was favoured over more experimental designs types, as the research focuses on participants engaged in the processes of organisational networking in a ‘non-experimental’ social setting, beyond the direct control of the researcher, whereby the emphasis of the study is on greater ‘*understanding*’ and ‘*insight*’ into the organisational and relational features of network forms in the UK National Health Service.

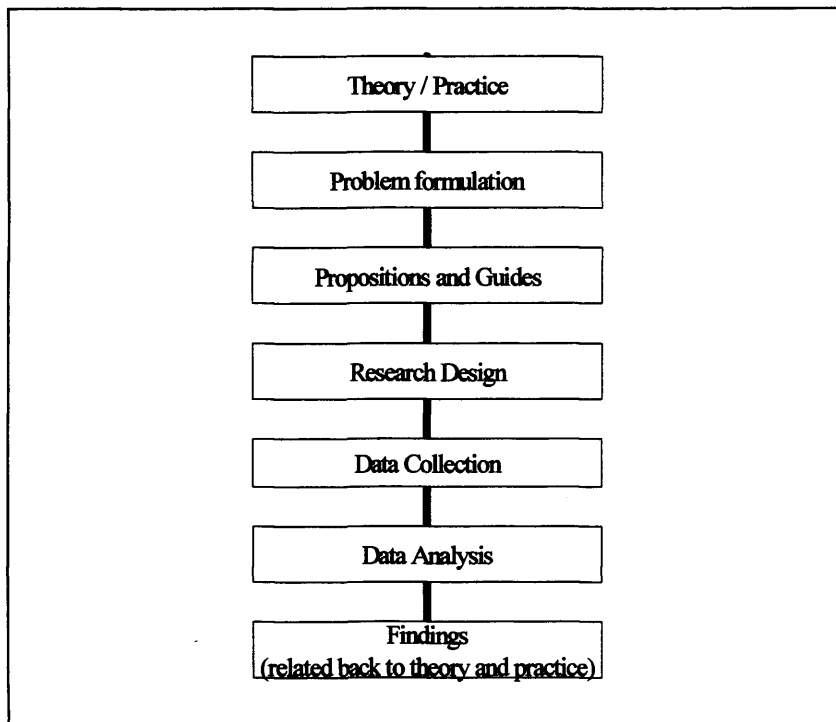
### 3.5.1 Research Process

Frankfort-Nachmias and Nachmias (1996: 19-20) state that ‘*the research process is the overall scheme of activities in which scientists engage in order to produce knowledge*’. This idea that there are different approaches to formulating a research problem and then investigating that problem, introduces the temporal and structural aspects of framing research. There are two distinguishable research processes, *deductive* and *inductive*. A deductive research process generally entails the development of a conceptual model and theoretical structure that is ascertained by drawing and testing propositions in an empirical setting, and is arguably linked with more positivistic philosophical traditions. In contrast, an inductive process commonly requires general inferences induced from particular situations, or the development of theory from an observation of an empirical reality, and is commonly applied by research from the naturalist tradition. The research process is thus a metaphor for research, an action with stages, a beginning and an end.

An important characteristic feature of the research process followed by this study is its cyclical nature. It begins with a problem or idea and ends with a tentative generalisation, as seen in the literary outputs in chapters 1 and 2. These propositions about networks are testing to some sense in the empirical setting of health care, but are flexible to the degree that: generalisation ending one cycle informs the next cycle. Frankfort-Nachmias and Nachmias (1996: 20) refer to this interrelated cycle of events as ‘self-correcting’. The process is iterative and flexible. If a proposition is rejected, new advances/modifications might be generated and tested. Importantly, the process

calls for a constant reevaluation of the methods and the propositions.

**Figure 1 A Logical and Cyclical Research Process**



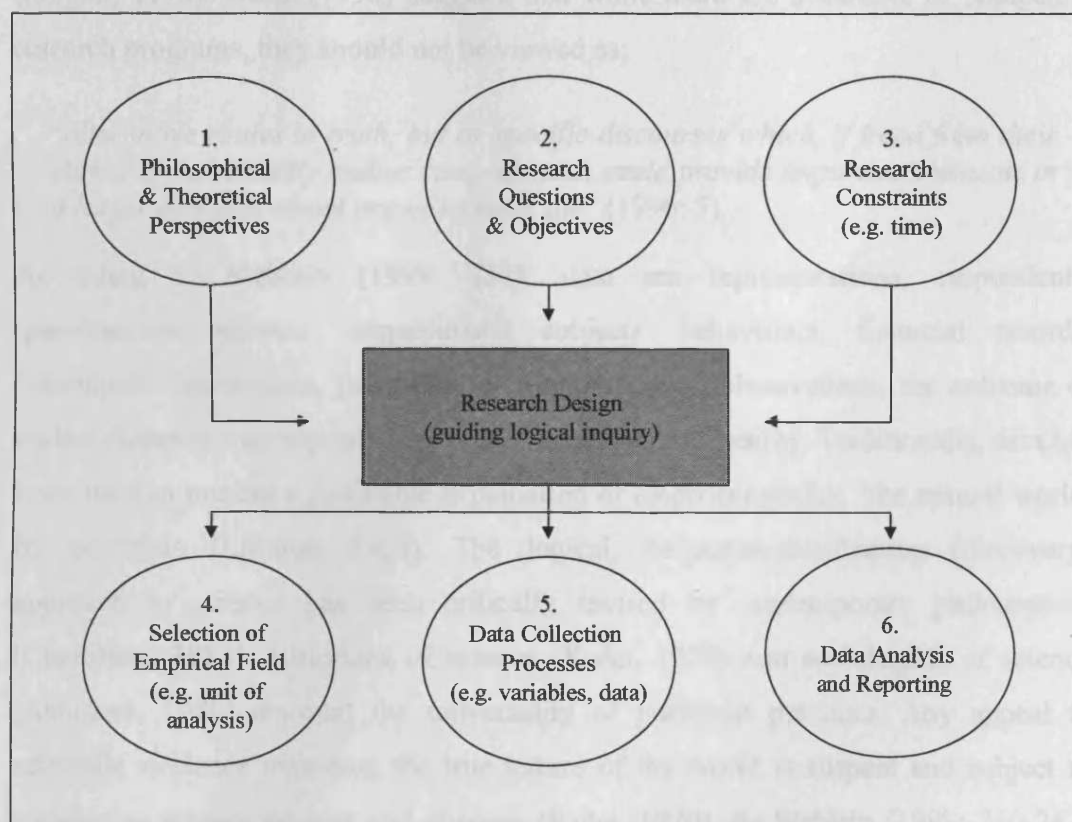
Source: Adapted from Churchill (1991: 69)

This study follows a research process similar to that illustrated in figure 1 above. The study generally follows a rationale of testing or applying existing theory in an empirical reality, but also allows for the potential of emerging theory. As stated previously, the aim of this study into networking governance and practice in the National Health Service, is to contribute qualitatively to theory building. Consequently, a mixed deductive-inductive approach is followed, while adhering to some of the recommendations espoused by methodological writers such as Eisenhardt (1989) or Glaser and Strauss (1967). Overall, the research process followed is logical and systematic. Figure 1 illustrates the features of this type of research process, whereby the outcome of one stage relates back to preceding stages, and where the outcome of a particular stage forms the basis for the succeeding processes. In this study, the process of research is iterative, beginning with a statement of a problem (chapter 1 and the issue of the lack of understanding surrounding the network form of organisation), followed by emergent research propositions/questions (chapter 1 and 2 concerning the management of network relations in the Health Service). Following

this, a research design is formulated (chapter 3), that guides data collection and analysis (chapters 4, 5, 6, 7), whereby findings are outlined and discussed in relation to original research questions raised and where conclusions are drawn and related back to the current body of literature on the research topic (chapters 8 and 9).

According to Yin (1987), the research design and process together play a pivotal role in any study, as it is '*the logic that links the data to be collected to the initial questions of the study.*' This is illustrated by Borum's model of research presented in figure 2.

**Figure 2 An adaptation of Borum's Model of Research**



Source: Yin (1993)

The research design is critical in that the design mediates between theoretical conceptualisation and empirical reality. To this end, Borum's model (figure 2) provided the framework for empirical investigations. Overall, this study lies between the prescriptive and predictive qualities of positivism and the inductive and

discovering nature of naturalism, is primarily exploratory-descriptive in style, and attempts to combine both deductive and inductive reasoning.

### 3.6 Data and Sources

Studies of organisations are generally concerned with understanding organisations as actors within a societal context. Organisational science is most often founded on empirical study of attitudes, symbols, documents, behaviours, experiences, artefacts, meanings, measures, fact and figures (Stablein, 1999: 261). There has been considerable debate as to what constitutes organisational science and what data is deemed appropriate to validate knowledge creation and extension (Burrell and Morgan, 1979). Deetz (1996) suggests that while there are a number of competing research programs, they should not be viewed as:

*“alternative routes to truth, but as specific discourses which, if freed from their claims of universality and/or completeness, could provide important moments in a larger dialogue about organisational life” (1996: 5).*

According to Stablein (1999: 257), data are representations, respondents' questionnaire answers, experimental subjects' behaviours, financial records, informants' expressions, participant or non-participant observations, the outcome of earlier research, may represent aspects of organisational reality. Traditionally, data has been used to present a justifiable explanation of empirical reality, 'the natural world' by scientists (Lakatos, 1965). The logical, deduction-falsification (discovery) approach to science has been critically revised by contemporary philosophers (Chambers, 1982). Historians of science (Kuhn, 1970) and sociologists of science (Ashmore, 1989) discount the universality of positivist practices. Any appeal to scientific evidence regarding the true nature of the world is suspect and subject to revision as science evolves and changes (Kuhn, 1970). As Stablein (1999: 260-262) asserts, the empirical world is more often invented rather than discovered, where data is used to represent a reality that is not deemed completely objective, instead scientists arguably make sense of reality through human conceptions of reality. Stablein (1999: 261) suggests that:

*“...different kinds of data result from the intersection of the nature of the empirical reality scholarly communities seek to understand, and the*

*representational process each uses to represent aspects of organisational life”.*

Data sources are broadly classified into two categories, ‘*primary*’ and ‘*secondary*’ (Diamantopoulos and Schlegelmich, 1997). Primary sources include the generation and collection of data specifically related to the research problem, commonly through primary collection methods, for example, via participant observation or from personal interview. Secondary data refers to data that has already been collected for some purpose other than the current research inquiry (Zikmund, 1997). Secondary sources commonly include both academic and non-academic published research findings, internal organisational reports, minutes of meetings, and an array of statistical and financial data recoverable from institutions such as the Office of National Statistics (ONS), the Organisation for Economic Cooperation and Development (OECD) or the World Health Organisation (WHO). Data used in management and organisational studies are often categorised by convention rather than as a result of clear typology. In most research in organisational science the principle data used are: survey data, experimental data, case data, or secondary data. This study seeks to draw on all available and relevant data to support research investigations and subsequent findings.

### **3.7 Design Aims and Research Strategy**

According to Weber (1949; 1947), all forms of social science must achieve both an understanding (*verstehen*) and explanation of the particular phenomena under investigation. This research in seeking to explore and better understand the network organisation, focuses attention on ‘*particularisation*’, or ‘*coming-to-know*’ the subject through ‘*thick description*’ (Greetz, 1973), and as such, incorporates significant elements of a more descriptive research design. Accordingly, the study is primarily qualitative in design. In seeking explanation, the intent is to collect data that has some explanatory power, or that might be generalisable to a wider population (Stake, 1995); to contribute to a generic theory of network organisation and the theory of network management in health care. The research design applied by this study has two principal components or motivations: ‘*understanding*’ and ‘*explanation*’. At a macro-institutional level, this study seeks to account for recent developments in the UK health sector, to account for moves away from market mechanisms and bureaucracy towards new network forms of governance and organisation. The study seeks to

record and analyse the health sector and to account for recent developments shaping change, specifically within the primary care sector. The focus is primarily on new network forms of organising within primary health care. At the micro-institutional level, this research seeks to explore the processes and relational issues involved during organisational networking in a health care setting. The study aims to generate original understanding of the organisational phenomenon of networking by exploring network participants' 'attitudes', 'experiences', 'perceptions' and 'feelings' towards cooperative networking in the context of the public sector and the National Health Service. The study also aims to add to network theory by providing greater understanding of the factors involved in network processes, particularly factors that might affect network outcomes, success or failure.

As well as the loose exploratory nature of this study, there is also a large emphasis placed on descriptive within the study, supported by data and empirical observation. This research seeks to contribute to the development of a network research framework that is analytical, conceptual and theoretical, that provides some explanation of empiric workings of network organisational arrangements, particularly within the research setting of a public sector based health care organisation. The aim is to provide further and more detailed explanation of the important factors to be considered when entering into, operating, or dissolving, network relationships. The study seeks to draw tentative linkages (in a non-causal non-quantifiable manner) between network inputs, network processes, and network outputs. In addition, by adopting a novel network approach to the study of new collaborative forms in the NHS, this study puts forward and tests a methodological and analytical framework for the study of network organisation that follow-on researchers might find useful and helpful, as either a guide to investigation, or as a point of reference for future studies.

### **3.8 Design Application and Levels of Analysis**

Translating the research design into a workable programme of data collection and analysis involved a series of methodological steps, linked back to the overall objectives and aims of the study and the analytical framework guiding the research process. This section presents a historical and detailed review of the design



implementation phases of the research and outlines the different methods used to collect and analyse data, as part of what is commonly known as the 'operationalisation' of the research design. The main phases of data collection and analysis are detailed in the table 2.

**Table 2 Phases of Data Collection, Analysis and Presentation**

<b>Stages</b>	<b>Design Elements</b>	<b>Principal Data Sources</b>	<b>Principal Methodological Instruments and Analysis</b>
<b>Phase I</b>	The National Health Sector Review and Analysis	Secondary	<ul style="list-style-type: none"> <li>▪ Public Management Literature</li> <li>▪ Documentary Analysis</li> <li>▪ Review of Policy Publications</li> <li>▪ Review of Secondary Research</li> <li>▪ Specialist and Advisory Interviews</li> </ul>
<b>Phase II</b>	The Primary Care Sector Review and Analysis	Secondary	<ul style="list-style-type: none"> <li>▪ Public Management Literature</li> <li>▪ Review of Policy Publications</li> <li>▪ Review of Secondary Research</li> <li>▪ Specialist and Advisory Interviews</li> </ul>
<b>Phase III</b>	The Regional NHS Wales Sector Review and Analysis	Primary & Secondary	<ul style="list-style-type: none"> <li>▪ Secondary Data Analysis</li> <li>▪ National Assembly for Wales Policy Publications and Statements</li> <li>▪ NHS Wales Policy and Directives</li> <li>▪ Interviews with District Audit</li> <li>▪ Interviews with Policy Makers</li> <li>▪ Interviews with Health Professionals</li> </ul>
<b>Phase IV</b>	The Local Health Group Level Review and Analysis	Primary	<ul style="list-style-type: none"> <li>▪ Internal Documentary Inquiry</li> <li>▪ Face-to-face Interviews</li> <li>▪ Telephone Interviews</li> <li>▪ Attendance at LHG Board Meetings</li> </ul>

The first principal component of the research design and data collection process involved a review and evaluation of the UK health care sector. This sector review accounts for change in the management and administration of the National Health Service, examining the drivers of change in the sector, including political, economic, social and cultural aspects of change. To analyse this research field a review of a wide range of data and literary sources, including government policy statements and publications, Department of Health and NHS circulars, secondary research outputs, and specialist public and health management publications. The sector review outlines a range of key issues current in this field, and examines recent organisational restructuring and policy developments, with particular focus on new collaborative multi-agency partnerships in health care. This broad sector review and analysis of the health care sector is presented in chapters 4. The following major element of the research design involved a review and analysis of change in the primary care sector of the NHS. This review focuses on the antecedents of networking forms in primary care and the rise of collaborative governance and practices within primary health care. Primary health care has undergone considerable change and restructuring following the implementation of the 1997 White Paper on health Paper '*The New NHS modern and dependable*' (DoH, 1997). The redevelopment and reorganisation of the primary health care field has been a central feature of the reform agenda over the period, whereby the NHS has become more primary care focused. The review draws out the rationale for the recent move away from fundholding and markets to new primary care groups and local health groups in England and Wales, outlining the role of primary care organisations in delivering a primary-led NHS. The review process also explores the potential implications of network-type organisational and managerial changes, in particular implications for service provision, professional cooperation, collaborative management, and more generally, for service improvement, and highlights potential opportunities created by recent changes and reflects on the likely barriers to implementing collaborative-networking in primary care. This review is supported by a range of data sources, including policy publications and an examination of specialist academic and health literatures. Findings from this review are presented in chapter 5. Following on from a review and analysis of the wider health sector and primary care sectors, the next stage in the research design involved an investigation of the regional variations in policy and policy implementation in the

National Health Service of Wales. This regional sector review explored recent developments in the organisation, structuring and management of primary health care in Wales. This regional review investigates the networking phenomenon at the organisational level by looking at the political and policy agenda for increased inter-service collaboration in NHS Wales and by exploring the development of new multi-agency local health groups within primary care in Wales. This task is supported and legitimated by a number of convergent research methods including: a review of health policy publications in Wales; a review of secondary data and research to emerge on collaborative practices in NHS Wales; and a range of specialist interviews with health professionals, health commentators, and health researchers, involved in primary care development in Wales. In addition, observations made during practitioner-based conferences and during initial meetings with practitioners and health-related professionals provided some basic level of ethnographic-type data.

The last major stage of the research design involved an exploration of networking via an investigation of activities across four newly formed Local Health Groups within one Health Authority area in NHS Wales. This case component of the research design represents a major part of the research strategy. In accordance with the main objectives of this study, this local level review and analysis reports on the activities of four Local Health Groups. The Local Health Group represents the focal point, or central coordinating mechanism, for an examination of collaborative behaviours and relational processes. The focus is on LHGs as networking devices, that aim to bring together local health professionals and agencies in a more cooperative and collaborative mode of working, distinctly different from previous organisational forms of operating. A major element of this local level review is to record the views and meanings professionals and service personnel attach to the networking process within these new organisational arrangements. Network investigations conducted as part of this review are primarily inductive, in that the aim is to become ethnographically immersed in the cases, as in a grounded theory approach (Glaser and Strauss, 1967) or more traditional case study styled research. The aim is to observe and record participants' roles and perspectives as network incumbents. However, this study differs from much case study research, where the categories of a phenomena are often unspecified at the outset of the research process and are free to emerge; the

phenomena under investigation here have already been discussed and specified before empirical data collection begins, (chapters 1, 2, and 3). Consequently, the purpose of this phase of the research design is to interact with network informants, using deductive and inductive methodology that allow for *emic priori* to be contested, modified, certified, or for new insights to be identified as emergent theory. In addition, unlike much case study research, the emphasis in this study is on links between LHGs, health care agencies and health professionals, rather than examination of unitary organisations.

### **3.9 Research Instruments and Data Analysis**

Three principal research instruments were utilised to collect and analyse data during the different stages of the research design, principally: *documentary inquiry*, *observation*, and *interview*. Given the complexity of the research setting, in terms of scale, operations, staffing, and in relation to the rapid pace of change in the sector, the use of a range of different data collection techniques, documentary inquiry, observation and interview, facilitated the rich context description needed to describe, explore, and assess networking, both as a governance philosophy or doctrine embedded within specific public policy, and as an organisational form, organisational process and management strategy.

During the early stages of design development and network conceptualisation, the use of a survey instrument was considered as a potential data collection device. The survey would be aimed at all local health group (LHG) members across NHS Wales. A basic survey model was developed during 2000-2001, but was abandoned as a viable research instrument for a number of reasons. Firstly, there was some difficulty crafting a survey that might capture all the major elements of network relations, such as instances of conflict or mistrust between partners. Secondly, there were major concerns about the nature of survey methodologies. Commonly, the use of surveys as a tool for studying networks or other collaborative forms, stem from more quantitative studies that attempt to quantify and analyse 'specific relational variables', often with statistical techniques such as multi-variate models or factor analysis. A review of a range of such studies and techniques (Provan, 1984, Provan and Milward, 1995;

Skarmeas, 2000) revealed major problems in identifying, scaling, and measuring the vast array of constructs impacting on network relations. Thirdly, early interviews with specialist practitioners in the field and interviews with specialist advisors and researchers working in the same research area, revealed a recurrent 'low response rate' to surveys of health care practitioners, particularly general practitioners. An early interview with a prominent health care researcher in Wales indicated that:

*“Health care professionals are constantly asked to fill in questionnaires and take part in interviews...most of them just throw the letters in the bin and carry on doing their jobs”* (Senior Health Care Researcher, Int. 01).

Fourthly, during 2000-2001 further interviews with health care researchers in Wales led to the discovery that a research team at the Centre for Social Policy Research and Development (CSPRD), Institute of Medical and Social Care Research Centre, University of Bangor Wales, were undertaking a substantive study into the inter-agency working capabilities of Local Health Groups in Wales, commissioned by the National Assembly for Wales Office of Research and Development. The study was due to run until March 2002 and would involve a large scale survey of all LHG members in Wales, followed by three case-study type investigations across three Local Health Groups, located in north Wales. In response to the above feedback from specialists in the field, extensive literature searches, and interviews with health care representatives, the survey instrument was abandoned in favour of a broader set of investigative research methods, namely; documentary inquiry, observation, and interview. In keeping with the objectives of the study, to achieve greater understanding and explanation of networking in health care, these instruments would be used to collect and analyse a wide range of exploratory and descriptive data across the main phases of the research design (table 2 above). Given the potential lack of data following the dismissal of a survey instrument, the task of reviewing policy publications, reviewing secondary data and generating insights via observational and interview methods, took on greater significance as the study proceeded. As a result, more time was allocated to developing a comprehensive health sector review (chapter 4), primary health sector review (chapter 5), and NHS Wales sector review (chapter 6), than originally anticipated at the outset of the study. In particular, a comprehensive review of all research findings on local health groups and collaborative working in NHS Wales, was conducted between 2000-2003. This review and analysis of



secondary data became an important part of NHS Wales sector review and not only provided valuable insights into the working of LHGs, but provided direction and reference points for field observations and interviews during local level LHG investigations (chapter 7).

### 3.9.1 Documentary Inquiry

According to Yin (1994), documentary inquiry corroborates and augments evidence from other sources. Documentary inquiry represented a significant part of the first and second phases of data collection and analysis. Documentary inquiry is extensively employed to analyse change and policy events in the UK health care sector, the primary care sector, and the NHS Wales sector. This task involved an extensive review of Government publications, policy and statements, either in the form of Bills of Parliament, White Papers or Department of Health publications. The outcome of such documentary inquiry identified a number of important trends in policy, in terms of discourse and direction. This method helped identify a number of factors impacting upon the sector, such as service rationing, increased quality and performance measurement, managerialism and new budgeting and funding regimes. Documentary sources, including internal reports, Government policy publications, and NHS reports and guidance documents, provided valuable insights into the overarching plan of reform in the public sector as well as more specified reform strategies in primary health care, specifically moves away from internal-market systems towards more integrated organisational arrangement and working practices and the development and implementation of new primary care groups. In Wales, a review of National Assembly for Wales policy publications and health circulars helped build a picture of regional development initiatives and helped tap into the cultural aspects of NHS Wales.

### 3.9.2 Observation

Observing a phenomenon or some aspect of an empirical event is often an integral part of the research process. Observation is an important primary research instrument that involves the researcher making visual contact with empirical phenomena and is commonly one part a broader research design (Yin, 1994). Historically, observational methods have been extensively used in disciplines such as sociology, anthropology,

and psychology, whereby the behaviours of people are observed. In contrast, observational techniques have been less widely used in management and organisational fields, whereby observation has commonly been more systematic than ethnographic (Bryman, 1989). The main strategies of observational methods are commonly delineated across two dimensions, firstly; whether the researcher has prescribed a list of themes or factors they wish to measure prior to making observations or simple unstructured observation and, secondly; the role of the observer, as 'covert observer', as 'external non-covert observer', or as 'internal participant' (Bryman, 1989). The researcher in this study conducted observations as 'external observer' (Bryman, 1989; Patton, 1990). Observation played a key role in helping the researcher acclimatise or make sense of the research setting. During the early part of the data collection process (2000-2001), attendance at a number of Health Service practitioner conferences provided initial observations of the general research setting and norms of professional working. Of particular importance was attendance at the 2001 Royal College of General Practitioners Wales Annual Conference and the 2001 'Wales Care Research and Clinical Effectiveness Symposium'. These events provided a platform for observational notes to be taken and for a number of ad-hoc interviews to be conducted with health care professionals working in primary care in Wales. Data retrieved provided rich contextual data concerning how health professionals working in NHS Wales viewed recent policy changes and innovations, and their feelings concerning the creation and implementation of new local health groups.

Observation also played a significant role as part of investigations within the four Local Health Groups studied as part of phase IV of the research design (table 2). Observations provided a view and record of interactive and collaborative behaviours in the real-life setting of the LHG and in real-time. This mainly took the form of researcher attendance at executive board meetings across the four LHGs investigated over a two-year period from 2000 until early 2003. Since the creation of local health groups in NHS Wales in 1999, all LHGs were obliged to hold regular executive board meetings. Attendance at executive board meetings across the four LHGs studied within a health authority area of NHS Wales, provided a large data set to draw inferences concerning networking within and across the four LHGs. The task of

recording such field observations invariably involved a selective process on the part of the researcher, whereby common, patterned, or unusual behaviours, were recorded. The main method of recording involved (1) noting down on paper the general procedures involved during LHG board meetings, (2) the members that attended, (3) the events that took place during these board meetings, and finally (4) the researcher's feelings and interpretation of events. One of the main objectives of attending these LHG meetings was to observe interactive and collaborative behaviours from the perspective of inter-professional and inter-agency working (an important aspect of the study highlighted by literature introduced in chapter 2). Additionally, observations also looked closely at power relations and areas of conflict within the LHG groupings. Importantly, observations revealed that general practitioners dominated the formal proceedings of LHG executive meetings across all four LHGs and were the main group in all instances of conflict or disagreement (discussed later in chapter 7).

Following the emphasis placed on exploration and description throughout this study, much of this observational data is highly descriptive. The process followed to analyse collected observational data involved making-sense of such descriptions and using a high level of interpretation to evolve generalised explanations for the situations, events, and interactions observed. The important reference point for interpretation of all findings is the existing literature on the subject, and as such formed the backdrop for this analytical process, whereby findings were considered against pre-existing theory and understanding. In this way, findings are inductively drawn from the data but deductively appraised within established network theory. Abstracts from the data are presented in chapter 7, in the form of examples of specific cases, descriptions of events, or quotations from field notes. The validity of observational accounts relies on the truthful and systematic representation of the research (Mays and Pope, 1995a: 183).

### 3.9.3 Interview

Given the exploratory nature of the research design, the use of interviews provided a valuable methodological tool to gather data on network incumbents' views and attitudes to collaborative working as part of local health groups. Interviews were utilised from the outset of the study, as part of Phase I investigations of the wider



health sector, Phase II and investigations of primary care, and Phase III investigations of the regional NHS Wales sector. Insights from interviews not only provided insights into the workings of cross-agency and multi-professional networking in NHS Wales, but also aided in the refinement of research questions, propositions and constructs. In the early stages of the study, interviews were often undertaken at random, on an opportunity basis, for example at the Wales Primary Research Symposium, December 2001. The rationale for this ad-hoc approach stemmed from the need to use all interactions with health care professionals and policy makers as potential times for interview, relationship building, and data collection.

A semi-structured interview schedule was later developed for more formal interviewing, using theoretical inputs from the literature and feedback from early interviews and dialogue with health care researchers and professionals (appendix 2 and 3). This interview schedule was first pilot tested, to assess the viability of the questions and the format followed. This involved sending the interview schedule to three different and independent health care professionals, two general practitioners and one nurse practitioner, working within local health groups other than those selected for field investigations. The three respondents subsequently read, completed, and returned the interview list with attached commentaries concerning the appropriateness of individual questions, or the overall structure of the schedule. Overall, the pilot test proved very positive and led to only minor adjustments in the interview schedule, such as the rewording of some questions. Following the successful piloting of the interview schedule, a membership list was drawn-up for each of the four Local Health Groups selected by the study. Subsequently, individual members were offered the opportunity to take part in a short interview (appendix 4). In most cases, letters of invitation to interviewees were distributed by the researcher during attendance at LHG board meetings. The rationale for this method was to increase the potential response rate and to be on hand to provide interviewees with an introduction to the research project.

The response rate to interview invitation letters was initially extremely poor. Following first attempts to contact members of the four Local Health Groups, less than five individual members agreed to be interviewed. As a result, follow-up

telephone calls were necessary to trace members and discuss possible reasons for non-participation. In most cases, respondents reported 'a lack of time and considerable work overload' (example of comments following telephone follow-up), as the primary reason for non-participation. In some instances, members agreed to short telephone interviews, and as such, a number of mini-telephone interviews were conducted. In an effort to increase the base of interview data, the researcher engaged in a process of relationship building with key gatekeepers within the four LHGs, which led to a number of interviewee referrals. The task of building an interviewee portfolio and undertaking interviews started in 2000 and carried on until the later stages of the study into 2003. Overall, the use of telephone interviews and face-to-face interviews resulted in approximately fifteen interviews with members drawn from across the four LHG studied, as well as approximately thirty interviews with health care researchers, specialist advisors, NHS managers, members of other LHG in Wales, professional representatives, and representatives of bodies allied to local health groups. In addition, more data and insights came from numerous informal meetings and conversations with health care professionals throughout the course of the study. Over sixty formal and informal interviews were conducted during the course of the study.

Interviews were concerned primarily with accessing and understanding the views and experiences of professionals working as members of local health groups, or allied agencies or interest groups. As a result, the interview questionnaire (appendix 3) was designed around a range of important 'research themes' identified during the conceptualisation of network processes in the early part of the study, detailed in chapter 1 and chapter 2. A semi-structured style of questioning was adopted in order to explore these research themes in a systematic and comparative way, however interviews also retained a level of flexibility to allow for further qualitative 'probing' and 'verification' to allow for unexpected insights or accounts to emerge (Yin, 1994). To widen the scope of empirical data collection, telephone interviews were also utilised as a mode of accessing LHG officials, however telephone interviews required some refinement of the more open-ended face-to-face interview questions. Overall, interviews provided original insights into the empirical realities of inter-organisational and inter-agency networking within and across the four Local Health Groups studied. Interviews revealed network members' perceptions of network processes, and helped

clarify theoretical and literature-based precedents. Interviews were particularly useful in determining the network actors' level of responsibilities and level of support and commitment to collaborative working arrangements. The use of in person interviews proved particularly useful for exploring contentious issues, such as professional trust and conflict. The use of semi-structured questions allowed for considerable probing into respondents' attitudes and feelings towards collaborative working.

While some critics might argue that the number of interviews conducted during this study is relatively low for an intensive qualitative study, the uniqueness and insightfulness of the study lies in its depth and breath. Not only is the study wide in terms of the different levels of analysis, including, national level, primary care sector, regional level, and local level, the study is also deep in terms of the use of multiple methods, policy analysis, literature review, documentary inquiry, observation, and interview. It is the combined outputs from such methodologies that gives this study credibility and originality<sup>7</sup>. This study is not a case analysis of networking in local health groups, but rather a multi-level review and analysis of networking governance and practices in the primary care sector of the United Kingdom National Health Service, during 1999-2003. As such, this study presents a narrative on changes that have occurred in health administration and organisation during this time, principally the move away from market mechanisms to more cooperative modes. The study delves into the empirical setting to present a unique insight into the cooperative behaviours of actors, namely health care agencies and health care professionals, during this period.

Despite the systematic manner in which the data reported by this study has been gathered, analysed and recorded, there is no doubt that findings drawn from documentary inquiry, observations and interviews, are highly subjective and value-bound, and as such are open to critique. However, these findings are verifiable in that other researchers may also observe the workings of local health groups, or perhaps local health boards (LHBs), and draw similar or contesting views. However, follow-on researchers would need to account of the time context in which this study took place, whereby LHGs were in an early stage of development and operations. Below, the relative benefits and limitations of the main methodological techniques employed

during this study including: documentary inquiry, observation, and interview, are presented in respect of strengths and weaknesses.

**Table 3 Strengths and Weaknesses of Methodological Instruments**

Instrument	Strengths	Weaknesses
Documentary Inquiry	<ul style="list-style-type: none"> <li>▪ May be reviewed repeatedly</li> <li>▪ Low use of resources</li> <li>▪ Inexpensive and time efficient</li> <li>▪ Unobtrusive</li> <li>▪ Broad coverage</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reporting bias – unverifiable sources</li> <li>▪ Retrievability may be low</li> <li>▪ Highly selective</li> <li>▪ Access – may require approval</li> <li>▪ Socially constructed from secondary accounts</li> </ul>
Observation	<ul style="list-style-type: none"> <li>▪ Context driven</li> <li>▪ ‘Real time’ coverage of events</li> <li>▪ Requires little technical support</li> <li>▪ Retention of ‘naturalness’ of setting</li> <li>▪ Unique access point</li> <li>▪ Holistic data collection</li> </ul>	<ul style="list-style-type: none"> <li>▪ Access often problematic</li> <li>▪ Time consuming</li> <li>▪ Highly selective</li> <li>▪ Reflexivity</li> <li>▪ Potential hazards – physical, legal social and psychological outcomes/effects</li> <li>▪ Low level reliability</li> </ul>
Interview	<ul style="list-style-type: none"> <li>▪ Access to informant ‘insights’</li> <li>▪ Little equipment required</li> <li>▪ Flexible – researcher can probe, verify, clarify questions and responses</li> <li>▪ High response rate</li> <li>▪ Highly targeted</li> </ul>	<ul style="list-style-type: none"> <li>▪ Time consuming</li> <li>▪ Labour and resource expensive</li> <li>▪ Interviewer bias</li> <li>▪ Response bias</li> <li>▪ Reflexivity</li> <li>▪ Ethical issues – privacy and confidentiality</li> </ul>
Secondary Data Review	<ul style="list-style-type: none"> <li>▪ Wide coverage</li> <li>▪ Relatively inexpensive</li> <li>▪ Systematic</li> <li>▪ Verifiable</li> <li>▪ Objectivity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Contingent on data quality</li> <li>▪ Non bias control</li> <li>▪ Relevance</li> <li>▪ Reliability</li> </ul>

Sources: Formulated from Bryman (1989) and Yin (1994)

### 3.10 A Multi-Level Network Analytical Framework

One of the most critical aspects of network theory is that of 'relationships among interacting units' (Granovetter, 1983). Importantly, actors are inter-dependent rather than independent, where relational ties between actors act as channels for transferring resources, and where structure is comprised of relations among actors (Wasserman and Faust, 1995). The network perspective offers a useful way of understanding collaboration, "*an activity that is fundamentally about connections among interdependent actors who must transfer information and other resources to achieve outcomes*" (Gillet, 2000: 6). There are already indications from organisational science that an understanding of relationship phenomenon, such as collaboration within and between organisations, can be greatly enhanced by a multi-level analysis. Particularly of interest, are the comments of Wasserman and Faust (1995) that, for social network analysis it is the relationships among entities, rather than the entities themselves, that serve as the unit of analysis. Furthermore, it is becoming widely accepted among organisational and management researchers that networking is an inherently multi-level process (Gillet, 2000: 6). Network forms of exchange involve indefinite, sequential transactions within the context of a general pattern of interaction. Here sanctions are typically normative rather than legal. An assumption in the literature on inter-organisational networks is that they act as distinct 'governance structures', or modes for coordinating the production of goods and services, compared with pure markets or hierarchies (Powell, 1996; Grandori and Soda, 1995). The network is also viewed as a dynamic flexible organisation, encompassing the benefits of both market and hierarchy. One important difference between networks and traditional hierarchies is the increased emphasis placed on building and maintaining social relationships based on reciprocity and mutual support. Macneil (1985) suggests that network relationships are 'entangling strips of reputation, friendship, interdependence and altruism'. Thus, networks are particularly useful for the exchange of commodities whose value is not easily measured, such as qualitative items, like know-how, technological capabilities, methods of production, entrepreneurial skill, innovative intangible or tacit knowledge, and so on. Indeed, such important assets are not easily traded in markets or communicate well across hierarchies. Thus, networks present themselves as effective mediums of learning and knowledge transfer.

The theoretical underpinnings of network approaches to social phenomenon, in comparison to the individualistic perspectives of economics or psychology, are different in that they offer a systematic picture of global social structures and their components (Knoke and Kuklinski, 1991). The organisation of social relationships thus becomes a central concept in analysing the structural properties of networks, within which individual actors are embedded. Network analysis aids in the detection of emergent social phenomenon that do not exist at the level of the individual. Knoke and Kuklinshi (1991: 173) suggest that network analysis incorporates two significant assumptions about social behaviour (1) that any actor typically participates in a social system involving many other actors who are significant reference points to one another's decisions. Therefore, the nature of the relationships between actors affects system members' perceptions, beliefs and actions, and (2) that the importance of elucidating the various levels of structure in a social system, where structure consists of regulated patterns of relations among concrete entities (White et al., 1976).

According to Knoke and Kuklinski's (1991: 176), there are four main elements that should be considering when researching the network form. These are: the unit of analysis from which data can be collected and analysed (*sampling unit*), the characteristics of the relationship, including its strength and depth (*form of relations*), the form the relationship takes, such as arms-length relationships, embedded relationships, trading relationships, formal or informal ties (*relational content*), and the level from which data is to be extracted (*level of analysis*). Applying this logic to the empirical context of this study reveals the following:

### 3.10.1 Sampling Unit

The researcher decides the most relevant type of social organisation and the units within that social form that comprise the network nodes. These are potential units from which samples may be drawn according to scale, size and complexity and include: individuals, groups, complex organisations, classes and strata, and nation states. This study takes the local health group (LHG) as the sampling unit and focal point of network analysis. The LHG is situated within higher level system of the UK public sector and the National Health Service. The rationale of chapter 4 is to elucidate this broad sector environment. This study also focuses on a lower level

system, the primary care sector within the NHS. Chapters 5 and 6 explore changes in primary care at the national level and within the specified context of primary care in NHS Wales. Importantly, the LHG is a '*central organising node*' that links service groups and service professions in a collaborative process of health care commissioning and provision. The local health group is an organisational unit '*embedded within a web of relationships*' within the National Health Service in Wales.

**Note: A Description of Local Health Groups**

April 1, 1999: Local health groups established, as the formalisation of the Welsh Assembly's plans to improve primary health care by promoting primary care-led commissioning and provision as set out in the White Paper – *Putting Patients First* (Welsh Office, 1998a). In their first year, LHGs acted as advisory sub-committees of health authorities. Over the following four years (1999-2003) the remit of LHGs has increased to include the commissioning of local Health Services. LHGs are a multi-professional organisation, encompassing one general manager, six general practitioners, two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member and one lay member.

The local health group is a new multi-layered, multi-professional, health care organisation, indicative of a move away from hierarchy to new network forms in health care. The selection of the LHG as an appropriate unit for analysis is based on the rationale and premise of being 'purposive' (Miles and Huberman, 1994), in respect to an exploration of network process and relational constructs. This study specifies the LHG as the unit of analysis, over primary care groups (English equivalent) for two main reasons. Firstly, the political and operational context of PCGs and LHGs differs significantly. A study of PCGs and LHGs would require attention of a more comparative nature. In addition, the resource constraints inherent in this project limit the scale and scope of exploration, element no. 3 of Borum's model of research (figure 2 above). Secondly, researchers from across the UK have begun to empirically examine the networking phenomenon *vis a vie* the PCG (Hudson, 1999; Kirkpatrick et al., 2000; Ferlie and Pettigrew, 1999), whereas far less attention has been focused on researching the NHS within Wales. This study is one of the few empirical network studies based on local health groups. Significantly, the LHG may be classified as a network of professional and agency interests, involving medicine, nursing, community nursing, dentistry, pharmacy and public interests; institutionalised within

these new primary care organisations, and as the central coordination mechanisms for health care agencies and interest groups across primary health care.

### 3.10.2 Forms of relations

According to Knoke and Kuklinski (1994: 176), relations or relationships between actors have both '*content*' and '*form*'. Content refers to the substantive type of relation and its connections. Examples of different types of relations include, cooperative relationships, advisory roles, monitoring, and managerial forms of relations. Form refers to the properties of the connections between pairs of actors that exist independently of specific contents. There are two basic aspects of relations: the intensity or strength of the link between actors, and the level of joint involvement in the same activities. This study seeks to address collaborative relations between NHS provider and commissioning agencies, services and professions, involved in LHGs and primary health care. The content factor being examined is cooperative working and joint-decision making in a multi-agency, multi-professional, LHG. In relation to relational form, rather than seeking to quantify the intensity of connections between pairs of actors (as in Provan, 1995), this study seeks to scrutinise the level of cooperation taking place and partners' feelings towards the collaborative process.

### 3.10.3 Relational content

This represents the specific network linkages to be investigated. Table 4 outlines a number of commonly researched contents and references to associated research. This study is principally focused on boundary penetration relations in terms of viewing the local health group as a networked organisation linking different network actors that cross over traditional boundaries in health care commissioning and delivery.

**Table 4 Outline of Relational Content and Research Factors**

Relational Content	Description	Reference
Transaction relations	Actors exchange control over physical or symbolic media	(Burt et al., 1980; Lauman et al., 1978)



Communication relations	Linkages between actors are channels by which messages may be transmitted from one actor to another in a system	(Marshall, 1971; Lin, 1975; Rogers and Kincaid, 1981)
Boundary penetration relations	Actors cross over set boundaries for a possible common purpose (e.g. inter-agency collaboration)	(Levine, 1972; Allen, 1974 Mariolis, 1975; Sonquist and Koenig, 1975; Burt, 1982)
Instrumental relations	Actors generate relations in an effort to elicit goods, services, information, or other elements	(Granovetter, 1974; Boissevain, 1974)
Sentiment relations	This is perhaps one of the most investigated relational features of networks, in which individuals express their feelings of affection, admiration, deference, loathing or hostility toward other actors	(Hunter, 1979; Hallinan, 1974; Sampson, 1969)
Authority / power relations	These networks indicate the formal rights and obligations of actors to issue and obey commands	(White, 1961; Cook and Emerson, 1978; Williamson, 1970; Lincoln and Miller, 1979)

Source: Adapted from Knoke and Kuklinski (1994: 176-177)

Following on from authors such as Levine and White (1961) and Burt (1979, 1982), this study looks at the objectives of the higher level system, the Government, the Secretary of State for Health, the NHS Executive and health authorities, and compares these with the objectives and perceptions of actors working at the lower level system level. The focus of empirical investigation is on new collaborative and networking capabilities in primary health care within and between LHGs and health care

agencies. This study is also principally interested in sentiment relations, whereby the processes of inter-agency collaboration is investigated by examining how individuals express their feelings of affection, admiration, deference, loathing or hostility toward other actors (Hallinan, 1974). As such, the research design aims to collect personal accounts of feelings, perceptions, emotions, and experiences, via a range of qualitative methods.

**Table 5 Different Levels of Network Analysis**

<p><b>Level 1 The Egocentric Network</b></p>	<p>Consists of each individual node, all actors relate with other nodes. If the sample size is N, there are N units of analysis, each actor can be described by the number, the magnitude, and other characteristics of its linkages with other actors.</p>
<p><b>Level 2 The Dyad</b></p>	<p>Consists of a pair of nodes. If the sample size is N, there are <math>(N^2 - N)/2</math> distinct units of analysis. Dyadic analyses seek to explain variation in dyadic relations as a function of other characteristics of the pair for example, the degree of similarity of their attribute profiles.</p>
<p><b>Level 3 The Triad</b></p>	<p>Where N is the sample size there are <math>(N/3)</math> formed by selecting each possible subset of the three nodes and their linkages. Triad research has commonly examined sentiment structures to determine transitivity relations (between A to B to C and so on).</p>
<p><b>Level 4 The Complete System</b></p>	<p>Studies of the complete network examine the patterning of ties between all actors to ascertain the existence of distinct positions or roles within the network system (e.g. gatekeeper) and to describe the nature of relations among these positions. N nodes and <math>(N^2 - N)</math> possible dyadic ties complete the single system.</p>

Knoke and Kuklinski (1994: 178) also identify several levels at which to analyse collected data: the egocentric, the dyad, the triad, and the complete system. Four conceptually different levels of analysis are proposed (table 5). This study is primarily interested in networks as modes for coordinating organisational activities through the processes of cooperation between separate organisations. In particular, the focus is on

organisations or organisational sub-units during cooperation and on networks as the nexuses of integration. More generally, networking or collaborative integrative cross-organisational processes include all the range of organisational coordination devices from lateral communication, to inter-dependent information and planning systems, to complex integrated structures, building and maintenance, trust, reciprocity, opportunism and commitment (Ring and Van de Ven, 1996).

### **3.11 Methodological Reliability and Credibility**

The design and methodological instruments applied during this research have purposive benefits, but also inherent limitations, which are open to criticism. This final section of the methodology chapter reflects on a number of key concerns to emerge from the study following the application of the research design. This section comments on how these different concerns have been logically and systematically addressed to establish the validity, and reliability and quality of the study.

Fulop et al. (2001) and Ferlie (2003), writing on the topic of methodology in public management research, suggest that research within the field needs to become more rigorous and quality orientated. Ferlie (2003: 10-17) proposes five important '*research domains*' to assess the quality of research and five '*indicators of quality*' that aid the operationalisation of research domains (table 6). These five research domains and indicators of quality are applied to this research project to justify the overall credibility of the study and its methodology.

The issue of relevance is often a contested domain. The power of qualitative research lies in its 'closeness' to the subject being studied (Yin, 1994). Whereas researchers in the positivist paradigm seek to remain detached from the research subject, interpretivist researchers in the social sciences often seek to become immersed in the empirical context (Eisenhardt, 1989). This study has followed this path and has attempted to embed the researcher within the contemporary setting of health care. The study originates from, and is guided by, the researchers observations of the social phenomenon under investigation. As discussed in chapter 2, networking in health care has recently emerged as a key policy area and a major reform strategy in the NHS.

This study tracks the development and implementation of this contemporary policy and elaborates on the relationship between policy and practice and thus follows the work of Lewin (1951), Hammersley (1990), Argysis (1999), Huxham (2001) and Huff and Huff (2002), in seeking to engage in research that holds relevance to issues of broad public policy or concern.

**Table 6 Research Domains and Indicators of Research Quality**

Research Domains	Indicators of Quality
<p>Relevance: the research should engage with issues of public concern, give voice to excluded groups, and contribute to desired social and organisational change.</p>	<p>Indicator 1: The research accesses and develops theory. (relates to external and construct validity)</p>
<p>Reliability: there should be a clear 'audit trail' so that work can be repeated.</p>	<p>Indicator 2: The research design, methods used, data-base, and rules for analysis, are clearly presented. (relates to reliability and internal validity)</p>
<p>Internal Validity: there should be sufficient data and insight to produce a rich and truthful picture.</p>	<p>Indicator 3: The empirical data are rich and deep (relates to internal validity)</p>
<p>External Validity: there should be a capacity to generalise beyond a single site, empirically, conceptually, or through literature.</p>	<p>Indicator 4: The empirical data are broad (relates to external validity)</p>
<p>Construct Validity: the data should be connected to an underlying theory through intermediate, operationalised, and well specified constructs.</p>	<p>Indicator 5: The analysis can be communicated to multiple audiences and displays a relevance to practice and theory. (relates to relevance)</p>

Reliability is a key domain within most discussions of research methods (Lee, 1999). However, reliability is problematic within qualitative work. It has been simply defined in terms of 'consistency in scores' (Lee, 1999), but this is more suited to a positivistic paradigm where the robustness of a scaling instrument is important. Research in the qualitative tradition tends to be subjective and value-bond, in addition to being highly reflexive and normative. However, Yin (1994) suggests that qualitative research can be equally reliable if a number of rules or norms of research are established and

followed. Yin (1994: 36-37) suggests that reliability can be achieved if a study has followed a specified set or procedures that are well documented and that could be replicated by other researchers, in this way '*an auditor could repeat the procedures and arrive at the same results.*' In this study, a clear protocol of work has been established and documented that sets out the study rationale, philosophical basis, design, process, strategy, and methods that might be followed others. Additionally, the implementation of the study and the findings to emerge have been documented in detailed in chapters, 4, 5, 6, and 7, and outputs from the different stages of the study are clearly summarised and discussed in chapters 8 and 9.

Internal validity is the measure by which research accurately accounts for and portrays the social and organisational settings studied, while external validity is the measure by which findings are of wider significance beyond the immediate setting: both are important in the assessment of qualitative public management research. This study has dealt with a number of different sub-contexts, including the public sector as a whole, the health sector, the institutional sector of the National Health Service, the primary health care sector, and the micro-institutional setting of the local health group. Across all these settings, this study has sought to accurately portray a true and consistent picture of contemporary activities within these contexts. This has been achieved by the use of (1) a broad range of methods that triangulate the research subject, and (2) a multi-levelled analytical approach that has sought to capture the idiosyncrasies and attributes of the different sub-contexts. This raises the study's internal validity claims, while its emphasis on exploring the 'process dimensions of networking' means it holds relevance for other organisations undergoing similar networking initiatives, not just within health, but in other areas of the public sector and for organisations in the private sector.

Yin (1994) stresses the importance of construct validity. The domain of construct validity suggests the importance of careful theory operationalisation: from theory to the field, and reconnection, from data to theory; so that the themes or processes studied are clearly related to an operationalised theory. In this study, chapter 1 outlined the general theoretical field of network research, drawing on concepts and theory from economics, sociology, social-psychology and organisational-management

theory. Chapter 2 moved forward to relate network theory to the research setting of the UK public sector and health care and presented a range of research, conceptual work, and theoretical frameworks, for examining networks in the public domain. The outputs of the empirical phases of this study are related back to the theoretical field.

In seeking to craft a rigorous and high quality piece of research this study has met much of Fulop et al.(2001) and Ferlie's (2003) guidelines for establishing top quality public management research. The external validity of the study has been established from theoretical inference and analytical generalisation drawn out from the empirical data. The study began by highlighting weaknesses in network theory that showed a lack of theoretical and empirical research on networking in the public domain. The study subsequently went on to address some of these deficiencies by elaborating on the adoption and implementation of network practices in the NHS. The study has attempted to relate its findings back to the theoretical field, to advance both network theory and public management theory and practice. As Ferlie states (2003: 14) “...*a strong relationship to a body of theory is an important indicator of external validity and construct validity*”. The reliability and internal validity of the study have been established via an explicit description of the research design, methods and data analysis used, a so called ‘audit-trail’, set out in the methodology chapter. Internal validity has also been enhanced by the use of a broad range of methods, including secondary data analysis, observations, and interview, that result in data that is rich and deep in content and explanatory power.

This study opted to utilise a range of methods and instruments including: documentary analysis, observations and interviews. These different methodologies delivered a comprehensive range of data for analysis. One potential problem of this study’s multi-level research design was that of data overload. As Yin (1994) and others have commented, qualitative research generally produces large volumes of ‘rich data’ that requires ‘logical treatment’ (Eisenhardt, 1989; Glaser and Strauss; Miles and Huberman, 1994). For researchers involved in qualitative studies there is often a risk of becoming lost in the range and depth of data retrieved. The solution to the problem lies in the logic and procedures for data collection and analysis (Yin, 1994). Accordingly, this study collected and analysed data according to a logical

research process (figure 1) with a well-specified analytical framework (section 4: 8).

Qualitative exploratory research is most often criticised by authors from the positivist tradition. Silverman (2000: 102-108) highlights this, noting that findings from qualitative studies are not easily generalised or representative of a wider population. Frankfort-Nachmias et al. (1996: 113) questions the validity of inductive qualitative research findings. In response, advocates of research from a more phenomenological research perspective argue that qualitative research should not be judged against positivistic principles of validity and reliability; as the rôle of such qualitative work is to take a subjectivist or interpretivist exploration of social phenomenon using a different scale or focus of inquiry, whereby the search is for consistent patterns of behaviours or events and on meanings and understanding of a phenomenon, not just verification or falsification (Glaser and Strauss, 1976; Eisenhardt, 1989; Miles and Huberman, 1994; Yin 1994). The methodology of this study has sought to lay bare the myth that qualitative research is neither reliable or representative to a wider population base, by presenting research that combines the use of multiple methods to support the credibility of the study's findings. As discussed earlier (section 3.2 and 3.3), the use of multiple methods acts as compensation for the individual weaknesses of specific methods. The power of this study is further enhanced by the multi-levelled approach followed to investigate networking at the national level, the regional level, and the local level. The national level analysis of government health policy might be termed a hermeneutic exploration of policy and change, while the more detailed analysis and study of networking within primary health care organisations might be viewed as a heuristic empirical study of networking in a real-life setting of a local community. The validity and viability of this study has been enhanced by the use of multiple methods that triangulate the research problem (Morgan and Smirich, 1980; Blacker and Brown, 1989; Hassard (1993). As Hakim (1987: 61) states, '*this allows for a more rounded, holistic study*'. Overall, the explanatory power of this study has been heightened by selective appropriate and purposive sampling; in comparison with the need for random selection associated with more quantitative methods (Glaser and Strauss, 1976; Eisenhardt, 1989; Miles and Huberman, 1994). Issues of poor reliability have been further addressed by linking key concepts and theory to an appropriate empirical setting, particularly where a broad range of data sources are

used (Miles and Huberman, 1984), and the overall validity of the study is boosted by linking different exploratory and descriptive methodologies (Silverman, 2000).

### **3.12 Summary**

This chapter has outlined the methodology and research design that has underpinned this research project. The overall objective of the research design has been to explore the networking phenomenon in the UK health care sector. The chapter discusses the philosophical biases underlying the choice of research design, strategy and methods. This study mainly follows a realist tradition, that scientific knowledge is personal, value-bound, multi-causal, plausible, indeterminate and specific. All data that is observable or retrievable is important (Wass and Wells, 1994: 9). This study partly adopts a research framework that is problem-orientated, seeking to understand the network phenomenon and effective network management. A significant proportion of the study is directed towards the recovery of facts, for instance retrieving data on Health Service organisation, health policy, and statistical data. This study also seeks to explore and understand the networking phenomenon by engaging with research subjects, health care professionals and network members, in a form that allows for more qualitative data gathering and interpretation. The study focuses on participants' feelings, emotions, attitudes, meanings and experiences, of being involved in multi-organisational networks; whereby theory might be induced from holistic data gathering, in depth and over time from mainly small population samples (Easterby-Smith et al., 1991). In practical terms, this study incorporates a range of methods and thinking. This study lies between pure positivistic or pure naturalistic style research, is influenced by a realist philosophical tradition, and incorporates a pluralist mix of research methods.

This study favours a mixed exploratory-descriptive research design. In exploratory terms, the emphasis of this study is on developing new and original insights into network organisational arrangements and into network governance and practice in the National Health Service, in response to the limited research on networks in the public sector. Additionally, the study aims to better formulate the 'network phenomenon' and to produce high quality research outputs that help develop more rigorous propositions



and analytical constructs, that lead to clearer research priorities, or aid in policy formation, or management practice. In descriptive terms, the research project is concerned with determining the type and forms of network relations in health care and to account for changes in governance and the recent move away from markets and hierarchy to new collaborative forms in health care. The study seeks to describe how new collaborative governance is reshaping health care organisations and aims to account for the impact on relations between health care agencies and staff in the primary care sector. The emphasis of the study is on greater understanding and insight into the organisational and relational features of cooperative networks.

This study follows a research process similar to that illustrated in figure 1 above. The study generally follows a rationale of testing or applying existing theory in an empirical reality, that also allows for the potential of emerging theory. Consequently, a mixed deductive-inductive approach is followed; while adhering to some of the recommendations espoused by methodological writers such as Eisenhardt (1989) and Glaser and Strauss (1967). Overall, the research process followed is logical and systematic. The study follows the tenets of other network researchers such as Knoke and Kuklinski (1991) and Gittel (2000), by adopting a multi-level analytical approach involving network analysis at the national sector level, the regional sector level of NHS Wales, and a local level investigation of networking across four Local Health Groups within a large health authority area. Within this research design, a range of research instruments are utilised to collect a broad set of data, including, documentary inquiry, observations and interviews. This chapter sets out the research protocols used to guide data collection and data analysis, and details the application of the research strategy, accounting for how the methodological approach required adjustment, refinement, and reevaluation at different stages. The chapter addresses issues arising from the conceptualisation of the network phenomenon and sets out an analytical framework to guide network analysis and theoretic-empirical interaction. The chapter ends by reflecting upon the strengths and weaknesses of the methods employed, and addresses issues of research credibility and quality. The reliability and credibility of the study have been established via an explicit description of the research design, methods and data analysis used, an 'audit-trail' (Yin, 1994), that might be followed or contested by other researchers.

#### **4.1 Introduction**

This chapter analyses the broad environment of health care in the UK. The goal of the chapter is to review change at the wider sector level and to account for recent developments in the organisation and management of the National Health Service. The chapter identifies the major impetus for change in health policy, including social, economic, and political pressures, leading to an archetypal shift away from traditional hierarchy and market mechanisms, towards more diffuse and collaborative approaches in health care administration. The chapter reviews the new Labour Government's modernisation agenda and provides detailed insight into changing governance philosophy in the Health Service. This chapter moves the study into the research data collection and analysis phase of the research design. Findings are supported by a wide array of data sources including, an extensive and detailed review of public policy publications. The chapter substantiates analysis with evidence and argument from the public management literature and a range of secondary research. Overall, this chapter reports on the status of the organisational or institutional setting in which the research takes place using a meta-analysis of change at the sector level. In seeking to present a contemporary and detailed account of recent developments impacting on the present-day National Health Service (1999-2003), this sector review and analysis does not attempt to record every major event, political, economic, or social event, that has taken place since the birth of the NHS in 1948; rather it is highly selective, seeking to represent or make some appraisal of the significant issues that are shaping the sector.

#### **4.2 Analysing the UK Health Sector**

The task of identifying and interpreting a sector within which a research project takes place is often neglected by organisational and management researchers (Rasanen and Whipp, 1992). Despite the important conclusions that might be drawn from such inquiry, many researchers forget to identify and characterise the research setting or environment. In addition, conceptualisations of the network organisation challenge longstanding ideas concerning the coordination of activities and the production of

goods and services as part of a finite entity. Importantly, the network organisation has generated a considerable amount of discussion about how organisations are defined and understood (detailed in chapter 1). Powell (1991) and others have suggested that the archetypal hierarchical entity, with clear boundaries and lines of authority, is something of a narrow one-dimensional view of contemporary organisation. In contrast, the network organisation is something of a dynamic entity, an institutional form characterised by a complex web of inter-linkages and influences. As with any other organisational form, our understanding of 'network organisation' is partly fixed to our ontology or epistemological assumptions of what constitutes organisation and what methods are appropriate for researching the specified unit of analysis (discussed in chapter 3). Organisational theorists suggest that network researchers should apply new and innovative methodologies to the study of these hybrid forms, particularly in unique research settings like the National Health Service. Gittel (2000) for example, calls for a more multi-level approach, one that accounts for the influences of government, politics, the law, and socio-economic factors. The multi-level perspective presupposes widening the lens of inquiry in such a way that it points more broadly to the wider sector level. Rasanen and Whipp (1992: 4) suggest that all research should take account of the wider sectoral context in which research is conducted; whereby additional or more tacit concepts (influences) such as, politics, culture, religion, society, and nation, emerge as informative points of examination. Importantly, sector analysis often requires the researcher to review historical developments within a sector (reference to population ecology, Carrol et al., 1988), in such a way that the past may inform inferences concerning future or predicted events Rasanen and Whipp (1992). As Porter (1987: 57) asserts:

*“An organisation’s strategy is partly grounded in the past...historical events not only lay the foundations for contemporary strategies, they inform us of how events might unfold in the present and in the future”.*

Following the recommendations of Rasanen and Whipp (1992), to widen the research field in order to elicit more informative points of examination, and Gillet’s (2000) view, that network research is better informed by more multi-dimensional approaches, this study has set out from the beginning as a broad multi-level inquiry into network governance and practice in primary health care. Additionally, Porter’s (1987) notion of studying the past to understand the present and future is also adopted here, whereby

this chapter, as well as subsequent chapters, report on recent developments in the management and organisation of the UK National Health Service, with particular attention being paid to developments within the primary care sector. As Ferlie et al. (1996: 43) suggest:

*“To understand the processes of restructuring in the British Health Service of the 1990s, it is necessary both to understand the wider process ongoing in the public sector and the fate of earlier reforms within the NHS”.*

Rasanen and Whipp (1992: 4-5) suggest that a number of components of sector analysis be used individually or in combination, to define or interpret a sector, including: comparable history, products, services, suppliers, regulators, geography, and economics. This chapter focuses on the central political, economic, and socio-cultural phenomena, impacting upon organisational design, organisational strategy, and overall governance philosophy, within the UK National Health Service, post-1997.

### **4.3 The Socio-Political Context of the NHS**

The Labour Government of Prime Minister Clement Attlee created the UK National Health Service on the 5th of July 1948. Aneurin Bevan, Minister for Health and Housing, established the NHS based on a system of coalminer cooperatives in Wales. The 1945 Labour Party election manifesto proposed a new organised system of publicly funded and publicly provided health care:

*“...the best Health Services should be available free for all. Money must no longer be the passport to the best treatment. In the new National Health Service there should be health centres where the people may get the best that modern science can offer, more and better hospitals, and proper conditions for our doctors and nurses. More research is required into the causes of disease and the ways to prevent and cure it”* (‘Let Us Face the Future: A Declaration of Labour Policy for the Consideration of the Nation’, 1945).

Since the creation of the NHS in 1948, the interim half-century has witnessed transformations in the social, economic, and political context, of the Health Service. For many commentators, the original commitment to collectivism and belief in central planning that epitomised the first years of the Health Service, has most recently given way to a new philosophy of public management, characterised in modern times by

pragmatism and individualism. The modern era of the NHS is one dominated by discussions of performance, value-for-money, innovation and service quality. However, in contrast to the prevailing organisational practices shaping private organisations, the UK National Health Service continues to exist as a unique form of public provision. While many national industries have moved from public to private ownership, particularly during the 1980s, the overall architecture of the NHS has remained relatively intact. The NHS continues to be centrally funded and administered by government. Klein (2001: vii) accounts for the NHS phenomenon by suggesting that:

*“The NHS is popular...it is an anomaly, an exercise in institutionalised nostalgia...the NHS symbolises a simpler and warmer world of camaraderie, solidarity and national success”.*

Placed in an international context, Britain’s NHS might be viewed, particularly when compared with other post-industrialised nations such as the US, as an outdated system of health care delivery. No other advanced economic nation possesses such a centralised health care system. Whereas, other comparable social democratic nations maintain pluralist health care systems delivered by local government, as in Sweden; or are funded through a variety of insurance schemes, as in Germany, the Netherlands, Australia and New Zealand; Britain’s health care system relies on a national monopoly. Another unique feature of the British National Health Service is its level of political affiliation. The NHS is very often subject to reforms that result from changes in government. In addition, as a public good, the Health Service is frequently used as a political tool, either by the government in office to demonstrate commitment to public services, or by opposition parties to highlight governmental incompetence or neglect. As such, the NHS is subject to considerable political attention and is often the focal point for conflicting political, economic or ideological arguments. It is this degree of influence that makes the NHS a unique organisation and research setting. Klein (2001: ix) suggests that:

*“The NHS illustrates with special sharpness, for example, one of the main policy dilemmas faced by all modern societies: how best to integrate experts into the policy machinery – how to reconcile policy-making seen as the product of political processes and policy-making seen as a search for abstract rationality based on expertise. Again, the NHS’s experience underlines the tensions between policies designed to achieve national standards in the pursuit of equity and other policy aims, such as the encouragement of local*

*participation: it can be seen as a case study of conflicting values in the design of social policies. Lastly, the NHS provides an opportunity to study the classic question of political analysis: who gets what? In short, a health care system can be seen as a political world in its own right, where the balance of power will determine the distribution of resources” (originally in Klein, 1983).*

#### **4.4 The Labour Government and the Politics of the ‘Third-Way’**

In 1997, the Labour Government returned to power after a period of over eighteen years in opposition. The swing of votes from the Conservative Party to Labour, at 10%, represented the largest two-party shift since 1945 (Butler and Kavanagh, 1997). With a total of 419 Members of Parliament (MPs) and a majority of 179 MPs, the Labour Administration arrived in power with one of largest government majorities of the twentieth century. By contrast, the Thatcher Government of 1979 held a much smaller majority of 44. The 1997 election also marked the beginning of a new political era according to political analysts, one in which a strong Labour Government of socialist values, replaced a Conservative Government of economically liberal conservative policies. In policy terms, ‘*new Labour*’ purported itself as something different from previous Labour or Conservative governments. Since 1980, a succession of leaders, Neil Kinnoch, John Smith, and Tony Blair, had fought to distance the party from its ideological roots, the ‘old-left’. Symbolically, the Government’s commitment to the public control of the means of production embodied in Clause IV of the Party’s constitution was abandoned (Klein, 2001: 189). The belief in nationalisation, central planning and technocratic paternalism, that had provided the context and the rationale for the creation of the National Health Service in 1948, had been discarded by 1997, despite assurances that new Labour remained committed to public services. Unlike previous Labour Governments, 1997 marked a move away from more traditional socialist values to a new set of goals and ideas on how to best provide public services. The new philosophy, ideologically positioned somewhere between the ‘old left’ and the ‘new right,’ came to be known as the ‘*third way*’. The language of the third way, embodied in new Labour policy statements and publications, emphasised the importance of community, partnership, collaboration, cooperation, responsibilities and opportunities. Another feature of the third-way, something that may well distinguish ‘new Labour’ from ‘old labour’, has been the relationship between the public and private sectors. For new Labour, the marketplace

is something to be embraced and encouraged (1997 Labour Party Manifesto). Accordingly:

*“Prosperity depends on creating a dynamic knowledge-based economy founded on individual empowerment and opportunity, where government enables, not command, and the power of the market is harnessed to serve public interest”*  
(Tony Blair, quoted in Klein, 2001: 191).

This new Labour pro-business or pro-market sentiment has had some influence on wider policies, for example new initiatives in education designed to equip young people with the skills required to compete in an international technologically driven market place, or public-private alliances in transport, introduced to develop the UK transport sector, and a range of public-private-partnerships across the public sector, including health care. The new Labour Government also proposed a number of grand policy visions after coming to power in 1997. The third way implicitly promised to reconcile past dogmas: patriotism versus internationalism, for example Britain’s involvement and relationship with the European Union; rights versus responsibilities, including new freedoms of information, the reform of the, economy, the fair distribution of wealth, and the alleviation of poverty. However, the first years of Labour in power (1997-2001), revealed a focus on economic, rather than social policies, characterised by low public expenditure. The Labour Government curtailed public spending. The Chancellor of the Exchequer, Gordon Brown, attempted to control spending on public services in an effort to address public debt. In addition, the Labour Administration sought to honour manifesto pledges to stabilise or reduce taxation, particularly income tax. This emphasis on fiscal and monetary discipline characterised new Labour’s approach to public investment. In addition, the Government introduced a new slogan of ‘investment in public services conditional on achieving results via reform’. The promoted style of government set goals, rather than regulations, and monitored performance, rather than prescribing practices. For services like the NHS, the emphasis moved away from control and central planning to partnership, collaboration, and innovation, with investment linked to targets and outcomes (Klein, 2001: 192). Accordingly, the hallmark of this approach to the public sector reform is pragmatism:

*“The vision is one of national renewal, a country with drive, purpose and energy. In each area of policy a new and distinctive approach has been mapped out, one that differs from the old left and the Conservative right. This is why new*

*Labour is new. New Labour is a party of ideas and ideals but not of outdated ideology. What counts is what works*” (Prime Minister Tony Blair, Labour Party Election Manifesto, 1997: Forward).

A number of initial conclusions may be drawn from the above review of Labour’s first three to four years in office (1997- 2001). Firstly, the Government’s seemingly prudent economic measures generated growth in the economy while reducing inflation. The devolution of interest rate powers from central government to the Bank of England is symbolic of a new approach to economic management. This period has been one of controlled public spending. Paradoxically, the Labour Government did not invest comparatively large amounts of public funds into public services over this period. Table 1 below shows levels of spending on health care as a percentage of Gross Domestic Product (GDP) and how the UK has invested far less in health compared with other leading OECD nations.

**Table 1 Total Expenditure of Health Care as a Percentage of Trend GDP 1997-2000**

	Percentage of Trend GDP				
	1980	1990	1992	1997	2000
Australia	7.5	7.7	7.9	8.7	9.2
France	-	8.7	9.1	9.1	9.4
Germany	8.8	8.8	10.1	10.5	10.7
Norway	8.7	8.7	9.3	9.7	10.3
United States	8.5	11.8	12.6	13.0	13.2
United Kingdom	5.5	6.2	6.6	6.8	7.3
OECD Average	7.1	7.4	7.8	7.9	8.2

Source: OECD (2003) 'Health-Care Systems: Lessons from the Reform Experience' (extracts from table 9: 63)

Following a spending review in 1998, the Government pledged to increase funding for the NHS and announced an annual increase of 4.7% over three years (*Modern Public Services for Britain: Investing in Reform*, 1998). By January 2000, this figure had risen to a rate increase of nearly 4% per annum in real terms, according to Government figures (Secretary of State for Health, 1999). In response to increasing criticisms relating to under funding in public services, the Government introduced a new spending plan for the Nation Health Service in 2000. Following the March 2000



Budget, the NHS received a major boost in funding, a rise in real terms by 7.45% for 2000-01 and by 5.6% in each of the following three financial years (table 2). The extra resources under the NHS Spending Review 2000-01 allocated funds to finance NHS wages, additional staff recruitment and the rehabilitation of the capital stock, and some reorganisation costs (OECD, 2000: 18). One of main priorities behind the extra spending involved the lowering of NHS waiting lists, which became a major political issue around 2000. A major part of the extra funding post-2000 has been directed towards modernising services. The NHS Plan published in 2000, set out a number of key areas for reform and improvement, including tackling health inequalities, reducing bureaucracy and contracting costs, and tackling local health needs, as well as a number of priority areas, such as heart disease, cancer and mental health.

**Table 2 United Kingdom National Health Service Funding Post-1997**

	Total for the United Kingdom £ billion, in cash terms						Average
	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	
Previous plans	45.1	49.3	52.2	55.5			
New allocations	45.1	49.3	54.2	58.6	63.5	68.7	
Annual real growth (%)			7.4	5.6	5.6	5.6	6.1

Source: Budget 2000 Quoted in OECD (2000) 'Public Expenditure Reform: The Health Care Sector in the United Kingdom' (table 1: 19)

In addition to stricter economic and fiscal control, the new Government has set about the restructuring of many government departments. The social welfare system has seen the introduction of the 'working families' tax credit'. Much emphasis has been placed on coordinating different streams of government to address specific problems, for example, the establishment of a Social Exclusion Unit that brings together various departments to tackle poverty, and the 'new deal' initiative, which seeks to address unemployment, health and education issues, at community level.

One of the most frequently raised issues during the first years of the Labour Government has been the issue of rationing. Decisions on the allocation of treatments and services, such as for specific drugs or specialist services like in vitro fertilisation

(IVF), has remained the responsibility of health authorities and NHS Trusts. In some instances, the Labour Government has relaxed the centralist approach concerning health care allocation, or 'rationing' (Klein, 2001). However, the problems and difficulties of health care rationing have become a prominent issue in the national press and media, highlighting regional and geographical variances in policy and practice. 'Post-code rationing' emerged as the term that encapsulated the problems of allocation. A publication by the Government in 1999, '*Quality and Performance in the NHS: High Level Performance Indicators*', documented the extent of variations in access to services and set out plans to standardise health care delivery. In addition, there has been a rise in negative publicity surrounding health provision reported in the media, particularly following the Shipman case, the Bristol Royal Infirmary case, and the Alder Hay Hospital case. Since coming to power in 1997, the Labour Government has been under pressure to address issues of rationing, fraud, staffing, funding, and poor performance in the Health Service. The Government's response has been a broad programme of administrative reforms, under the heading of a '*modernisation agenda*'.

#### **4.5 The Modernisation Agenda and the NHS**

In 1997, the Labour Government set out a new vision for the UK National Health Service based on cooperation between services, rather than competition:

*"In health policy, we will safeguard the basic principles of the NHS, which we founded, but will not return to the top-down management of the 1970s. So we will keep the planning and provision of healthcare separate, but put planning on a longer-term, decentralised and more cooperative basis"* (Prime Minister, Labour Party Election Manifesto, 1997: Forward).

The Labour Government set about replacing the internal-market and modernising the NHS. Specifically, the main policy aims included: the reduction of waiting lists; the raising of quality standards; addressing regional variances in public delivery; increasing staffing numbers; reducing bureaucracy; and the freeing of managers and professionals (DoH, 1997). Over the following four to five years, a new modern NHS would be developed as set out in the Government's White Paper, '*The new NHS: Modern, Dependable*' (1997). Reform of the NHS since 1997 has included the abolition of fundholding and the introduction and development of new primary care organisations. In addition, the Government has raised investment by providing extra

funding for the NHS. In January of 2000, the Government pledged to raise the rate of spending on the NHS from 3% to 5% each year in real terms, in an effort to bring the service in line with a European average by the year 2006.

The 1997 White Paper on Health has been the guiding document for recent change in the NHS. A number of evident themes emerged from the 1997 White Paper. Firstly, more emphasis began to be placed on improving health across the population, encapsulated in new health improvement programmes (HIPs), introduced during the period. Secondly, there has been an attempt to innovate in the delivery mechanisms used to provide health care, both around hospitals (secondary care centres) and GPs (primary care centres). Thirdly, greater emphasis has been placed on raising standards, particularly the speed and coverage of treatments and the quality of the care provided. New and challenging targets were set for reducing deaths from cancer, coronary heart disease, accidents and suicides (Secretary of State for Health, 1999). As Klein (2001: 207) comments, *'the NHS had a critical role to play within wider reforms designed as part of some grand scheme of social engineering'*. As such, the NHS is now required to engage with all other agencies to address wider social problems. A statutory duty has been imposed on health authorities to work with local government in promoting the economic, social, and environmental, well-being of communities. A philosophy of *'cooperative governance'* is clearly visible in the Government's approach to the modernisation of the Health Service. The Government has sought to better integrate the vast array of health care organisations within the NHS, to further embed these organisations within a wider programme of health and social care. This is sometimes referred to as *'joined-up government'*. A recent example is that of health action zones (HAZs), a scheme introduced to bring together many organisations previously outside the traditional boundaries of the Health Service. Lastly, the Government has sought to improve efficiency through improved performance measurement, backed up by the threat of centralised intervention where such targets have not been met. This policy model has been particularly evident in education. More recent performance indicators (PIs) measure different dimensions of activity: fair access, regional variation, coverage, budgetary control, speed of delivery, and patients' perceptions of the services received. The NHS Executive and more local health authorities may intervene where performance standards fall short of targets (NHS Executive, 1998).

In 1997, the Labour Government announced the termination of the quasi-market, specifically the abolition of fundholding (discussed in chapter 2 and further in chapter 5). The 1997 White Paper, *'The new NHS: Modern, Dependable'* (1997), outlined the architecture of the new NHS. The 1999 Health Act detailed the Government's vision of the new NHS, as a more responsive and efficient Health Service. The thrust of the reform programme has been targeted towards primary health care. While, the independent contractor status of GPs remains, GPs and other health care professional were asked to form and operate new primary care organisations (PCGs). The introduction of the PCG marks a departure from competition and a moved to new more cooperative forms of working. PCGs are expected to evolve over time, from advisory to their local HA purchaser, to autonomous primary care trusts (PCTs), holding primary and hospital care budgets. The plan is for PCGs, or PCTs, to commission secondary care services via rolling multi-year contracts, with service agreements between health authorities, PCGs and NHS Trusts, to reflect national standards and targets and local health improvement programmes. Annual accountability agreements are to be drawn-up between PCGs and HAs. PCGs are allowed to retain budget surpluses, which can be spent on services or facilities of benefit to patients. These new plans aim to transfer health authority responsibilities over to new PCGs and PCTs.

The task of raising quality standards in the NHS has been given increasing emphasis under the heading of 'clinical governance', introduced in 1998. Clinical governance represents the formalisation of a more micro-institutional strategy to improve performance and illicit further accountability. NHS Trusts are now required to establish and monitor quality standards, and are responsible for implementing new clinical standards originating from new monitoring agencies, such as the Commission for Health Improvement (CHI) and the National Institute for Clinical Excellence (NICE). This framework of control and influence marks out both the nature and structure of management-professional relationships within the new NHS. The Commission for Health Improvement currently monitors the implementation of clinical governance and monitors the delivery and quality of care provided by NHS Trusts (Secretary for Health, 1998).

The issue of performance and control play a significant part in characterising the context of the NHS post-1997. In an effort to increase control and enforce accountability there has been some tension between the needs of the centre to raise efficiency and the needs of the periphery. A prominent feature of the Government's strategy to improve performance has been the writing and dissemination of national service frameworks (NSFs). National service frameworks have been developed to ensure that the NHS delivers top quality services at the national level, ensuring greater consistency in the availability and quality of services for a range of major care areas and disease groups. The aim is to reduce unacceptable variations in care and standards of treatment, using best evidence of clinical and cost-effectiveness. NSFs are developed by the Department of Health in England and the Welsh Assembly Government in Wales. The Commission of Health Improvement (CHI), in partnership with the Audit Commission, has a statutory responsibility to review the progress and implementation of NSF's in England and Wales. The rolling programme of NSFs, launched in April 1998, took forward an established framework on cancer (The Calman Hine framework). This framework and the Cameron report in Wales were the subject of a major national study by CHI and the Audit Commission, published in December 2001. CHI carries out national studies in partnership with the Audit Commission. Major NSF studies include: cancer care, coronary care, diabetes and renal services. Accordingly, NSFs have taken on priority status and act as a 'model of best practice', and are used as a template for the organisation and management of services (Secretary of State for Health, 1998).

An important step in the plans for modernisation has been the creation of a National Institute for Clinical Excellence (NICE), responsible for promoting 'best practice' across NHS services, and the introduction of a Commission for Health Improvement (CHI), responsible for monitoring and facilitating quality initiatives. The roles of the Institute and the Commission form part of the overall strategy for raising and enforcing standards in the NHS. Below is a description of the new agencies introduced to monitor and improve the NHS:

The *National Institute for Clinical Excellence* (NICE) was established as a special health authority for England and Wales on 1 April 1999. It is part of the NHS, and its

role is to provide patients, health professionals and the public, with authoritative, robust, and reliable guidance, on current best practice. NICE guidance covers both individual health technologies, including, medicines, medical devices, diagnostic techniques, and procedures, and the clinical management of specific conditions. Guidance advice is given to healthcare professionals, patients, and their carers, to help them make decisions about treatment and healthcare. NICE guidelines are developed using the expertise of the NHS and wider healthcare community including NHS staff, healthcare professionals, patients and carers, industry and the academic community.

The *Commission for Health Improvement* (CHI) was set up in April 2000 to improve the quality of patient care across the NHS. Its principal role is to review standards of care provided by the NHS in England and Wales. Scotland has its own regulatory body, the Clinical Standards Board. CHI aims to address variations in care provision. Standards of care offered by the NHS often vary across hospitals, between departments in the same hospital, and between general practices. CHI acts as an independent inspectorate of the NHS. Its role is to ensure that standards set by the Government, through its health policies, NSFs, and clinical guidance provided by NICE, are met. Local health care organisations in the NHS are reviewed every three to four years. CHI has powers to carry out or assist in investigations and enquiries into serious service failures. CHI is also responsible for helping NHS organisations draw up action plans to tackle problems or areas of weakness, providing expert support and advice drawn from the best service providers. On 31st March 2004, the Commission for Health Improvement (CHI) ceased operating. All CHI's functions have been transferred to a new body, the Healthcare Commission.

Established in April 2001, the *NHS Modernisation Agency* supports the NHS and its partner organisations in the task of modernising services and improving experiences and outcomes for patients. The Modernisation Agency supports NHS clinicians and managers in their efforts to improve their services. The best performing organisations are rewarded with more power to make decisions at a local level. The Agency also supports NHS organisations where services are poor or failing; identifying problems and helping to get these organisations back on track. The Modernisation Agency aims to: provide leadership for service improvement; to promote a patient-led service; to

develop current and future NHS leaders and managers at all levels in the NHS; and all health professions; to modernise services, ensuring they meet the needs and convenience of patients as outlined in the NHS Plan. The Modernisation Agency is to act as a 'centre of excellence', identifying and celebrating good practice in the NHS and demonstrating how know-how can be spread across the whole service. The Agency will link into international health and public and private sector networks to ensure it is at the forefront of thinking and experimentation (DoH, 2002).

#### **4.6 The 2000 National Health Service Plan: Key Features**

In July of 2000, the Government published its major policy document for reforming the National Health Service, '*The NHS Plan, a Plan for Investment, a Plan for Reform*' (DoH, 2000). The plan sets out the Government's programme for the development of the National Health Service over the ten-year period, 2000 to 2010:

*"This is a Plan for investment in the NHS with sustained increases in funding. This is a Plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is to give the people of Britain a Health Service fit for the 21st century: a Health Service designed around the patient"*  
(Forward by the Prime Minister: NHS Plan July 2000: 8-9).

The challenge, according to the 2000 NHS Plan, is to use the resources available to achieve real benefits for patients and to ensure that the NHS is modernised to meet modern public expectations. In announcing the increase in funding for the NHS, the Prime Minister set five challenges that need to be addressed, specifically: partnership; performance; professions and the wider NHS workforce; patient care; and prevention. In seeking to meet these objectives, the 2000 NHS Plan sets out ten core principles that are to underpin the new NHS. These principles are to guide the modernising and rebuilding of the Health Service. The NHS Plan (DoH, 2000) shows the Government's commitment to the principle of a publicly funded Health Service, free at the point and based on need, not ability to pay. However, the NHS Plan (2000) states that the existing model of the NHS is inadequate in dealing with the current demands placed on the Health Service. Accordingly, the NHS Plan sets out to replace the existing health system:

*"We are on a journey – begun with the NHS Plan – which represents nothing*

*less than the replacement of an outdated system. We believe it is time to move beyond the 1940s monolithic top-down centralised NHS towards a devolved Health Service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values”* (Secretary of State for Health, Alan Milburn, NHS Plan, 2000: 14-16).

The NHS Plan focuses attention on the supply-side dynamics of the provision of health services and care. The central theme of the document is about increasing funding and resources for the NHS to create greater capacity. Increases in budgets and direct funding, staff numbers, principally nurses and doctors, hospitals, and hospital beds; are aimed at reducing waiting times for surgery, access to specialist care and hospital appointments, and improving the quality of care provided. A brief outline of the key themes in the NHS Plan and recent reforms are presented below:

**Table 3 Core Principles for Reform in the NHS 2000-2010**

1. The NHS will provide a universal service for all based on clinical need, not ability to pay
2. The NHS will provide a comprehensive range of services
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers
4. The NHS will respond to different needs of different populations
5. The NHS will work continuously to improve quality services and to minimise errors
6. The NHS will support and value its staff
7. Public funds for healthcare will be devoted solely to NHS patients
8. The NHS will work together with others to ensure a seamless service for patients
9. The NHS will help keep people healthy and work to reduce health inequalities
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance

Source: NHS Plan: Preface (2000: 3-5)

The NHS Plan (2000) confirmed plans set out in the 2000 Budget that spending on health will increase to a level equivalent to 9.4% of GDP by 2008. This increase in spending is aimed at bringing UK spending on health in line with European levels of health spending, particularly in line with Germany, France, the Netherlands and Sweden. The Government has decided that 7.5% is the optimal level of real NHS growth in England over the next five years (detailed above in section 4.5). The new architecture of the NHS is to be established over the period 2000-2005. The National Institute for Clinical Excellence (NICE) has been given a central role in ensuring that



NHS spending is targeted at the most cost-effective treatments, reinforcing the Government's 'spend and monitor' strategy of health reform. National service frameworks (NSFs) covering cardiac, cancer, and mental health services, will be used to set national targets that are to be monitored and appraised. In addition, the NHS is to be audited and monitored by a new independent inspectorate, to assure the quality of hospitals and primary care on behalf of patients. The NHS Plan also refers to the need to establish new incentives to improve care in the NHS. Primary care groups, and follow-on PCTs, will be free to purchase care from the most appropriate provider, public, private, or voluntary. In addition, hospital payment systems are to switch to 'payment by results', using a regional tariff system to reward performance. Hospital clinicians, principally consultants and surgeons, will be offered incentives to work out-side traditional working times, on weekends for example, while hospital or DTC/surgical units that do more will attract higher rates of investment and funding.

The concept of 'choice' is another important factor in the Labour Government's plans to reform the NHS. Importantly, the UK NHS will move toward a more Scandinavian system of health provision in which patients are given information on alternative providers, and are able to switch to hospitals that have shorter waiting times (NHS Plan, chapter 10: 88-89). Additionally, by 2005 all patients and their GPs will be able to book appointments at both a time and a place that is convenient to the patient. This might include NHS hospitals locally or elsewhere, diagnostic and treatment centres, private hospitals or hospitals overseas.

One of the most remarkable additions to NHS policy since the election of the Labour Government in 1997 has been the move toward public-private provision of public services in the UK. In an effort to increase the capacity of the NHS the Government is seeking to craft new partnerships with private sector investors. This strategy is most visible in the building of new hospitals using public-private-finance initiatives, designed to access the resources and expertise of the private sector. In the case of new hospitals, private investors will build and finance the development of new hospitals in the short-term, whereby the hospital will move into public ownership once financial investors receive a return on principal investments. The new concordat between public and private is clearly articulated in core health policy statements:

*“The time has now come for the NHS to engage more constructively with the private sector...for decades there has been a stand-off between the NHS and the private sector providers of healthcare. This has to end. Ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients” (NHS Plan, 2000: 96).*

The NHS Plan secures the new role of the private sector in helping to develop the mainstream NHS and in elevating pressure on secondary care providers by increasing available capacity. The private sector is to supplement the capacity of the NHS while NHS capacity grows organically. Public-private-partnerships (PPPs), while controversial, reflect a form of external networking that extends beyond the traditional public sector boundaries of the National Health Service.

Another important theme in the Government’s plans for reforming the NHS is the devolution of power down the hierarchy to local and regional levels. As part of this approach, the Department of Health is to be reduced in size, whereby negotiations over national employment contracts will be undertaken by NHS employers, collectively, rather than by the Department of Health. Another feature of this plan concerns the allocation of resources. Instead of public capital being allocated by the Department of Health from Whitehall, the Government is considering establishing an ‘arms-length Bank’ controlled by the NHS, that would invest capital from the budget settlement for long term and innovative capacity growth and redesign (NHS Plan, 2000: 95-99). This strategy of devolution of power in from the Department of Health parallels the devolution of control over interest rates to the Bank of England, and the political devolution of power from Westminster to the Regional Governments of Wales, Scotland, and Northern Ireland. The NHS Plan also makes the case for a radical redesign of the relationship between health and social services. The Government is proposing to legislate to make local authorities responsible for the costs of hospital bed-blocking. Rather than imposing structural reorganisation or nationally ring-fenced budgets, this scheme means that social service departments will be incentivised to use some of their large 6% real annual increases to stabilise the care home market and fund home care services for older people. There will be matching incentive schemes for NHS hospitals to make them responsible for the costs of emergency readmissions, to ensure patients are not discharged prematurely (NHS Plan, 2000: 70-73).

Reform of staff contracts and methods of working is a major part of Government's reform agenda. A significant feature of reform will be the drafting of new contracts for GPs, consultants, nurses and other staff. The new NHS pay system will be designed to allow for regional differences in the cost of living, particularly for public sector workers in London, and are to be used to break down traditional occupational demarcations. In seeking to expand the size of the healthcare workforce, the Government is offering higher pay rates for higher levels of labour productivity and flexibility.

The NHS Plan sets out a number of ambitious targets to be reached during the ten-year period between 2000-2010. Waiting times for outpatient appointments should fall to a minimum of three months and a maximum wait of six months by the end of 2005. Waiting times for operations should be reduced from a maximum of fifteen months to six months by the end of 2005, and to as little as three months by 2008. Net increases of 15,000 more GPs and consultants, 30,000 more therapists and scientists, and 35,000 more nurses, midwives and health visitors, by 2008, and hospital capacity to grow by at least 10,000 more general and acute beds. A major part of the overall Plan is that primary care trusts should control over 75% of the growing NHS budget. This emphasis on primary care is aimed at reducing substantially the mortality rates from major killers by 2010; from heart disease by at least 40% in people under 75; from cancer by at least 20% in people under 75; and from suicide and undetermined injury by at least 20% (all figures taken from NHS Plan 2000: multiple chapters). The NHS Plan places primary care at the centre of the change agenda. Overall, the role of primary care is to be enhanced. Primary care will provide a greater range of services and will control over £25 billion of the total NHS budget. The aim is to improve professionals' working lives, increasing job satisfaction and supporting GPs and other primary care staff in improving patient care. While the general practice will remain the basic unit of primary care, new methods of multi-disciplinary working are being pioneered to diversify the delivery of services within a more flexible system that offers a wider range of more accessible services. Key features of the NHS Plan include: 3,000 GP premises to be substantially refurbished or replaced by 2004; 500 one stop primary care centres by 2004; all GPs have access to NHS net by 2002; 50% of PCTs to have electronic personal medical records by 2004; electronic prescribing

of medicines by 2004; at least 2,000 more GPs and 450 more than now in training by 2004; all primary care groups (PCGs) to become PCTs by 2004; new PCTs to commission primary, community and social care; 1000 extra primary care mental health workers; 500 extra community mental health workers; a major expansion of PMS; new arrangements for single-handed practices; 48 hour appointment target by 2004; practice staff to book hospital appointments within guaranteed time-scales; NHS Direct to triage all out of hours calls by 2004; 1,000 GP specialists; and nurses undertaking more roles and responsibilities in the community (NHS Plan, 2000).

#### **4.7 Central Themes in Health Policy**

The myriad of policies and initiatives introduced by the Labour Government post 1997 arguably have a strong connection with the past in terms of initiatives designed to modernise the National Health Service. Accordingly, Klein (2001: 193-194) writes that, *'despite the constant invocation of the word 'new', there is in fact a large element of continuity with the 'old' or past market policies of the Conservatives'*. The Labour Government came to power in 1997 with a manifesto pledge to retain the NHS within the public realm and to dismantle all elements of the internal-market created under the previous Conservative Government. Frank Dobson, the first Secretary of State for Health, requested that health authorities restrict contractual relations with the private sector. GP fundholding was targeted in the initial wave of demarketisation and was quickly dismantled. However, despite the anti-market rhetoric and discourse, the Labour Government has retained some essential elements of the internal-market, such as the purchaser-provider split and the concept of GP commissioning, although within the new infrastructure of primary care groups or trusts. There has been little evidence of radical change in health policy over this period. Instead, many of the concepts and strategies evoked under the previous Conservative Government have reemerged under new Labour. While the 1997 White Paper on health and the NHS Plan 2000 set out some clear guidelines for developing primary care, secondary care has remained relatively untouched, apart from the host of new external monitoring agencies established, such as the National Institute for Clinical Excellence, the Commission for Health Improvement and the NHS Modernisation Agency. Table 4 below illustrates the raft of policy developments in

health care post-1997, and the increasing emphasis placed on cooperation and joint-working in health care.

**Table 4 A Chronology of Policy Events in the NHS Post-1997**

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1997	Labour Party Manifesto: 'New Labour because Britain deserves better' sets out the Labour Party's vision for health care reform
1997-2000	Abolition of GP fundholding and its replacement initially with primary care groups (PCGS) in England and Local Health Groups in Wales
1998	NHS Executive: The new NHS: Modern, Dependable: A National Framework for Assessing Performance, details of new National Service Frameworks (NSFs) and Health Action Zones, the beginning of GP Commissioning Pilots, and new performance indicators established
1998	Secretary of State for Health: A First Class Service: Quality in the new NHS, outlines the role and objectives of Clinical Governance, the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI)
1999	Secretary of State for Health Saving Lives: Our Healthier Nation, Primary Care Groups begin operations, new statutory duties on partnership, work of CHI and NICE begins, new unified local health budgets for hospitals and community services
2000	Secretary of State for Health: The NHS Plan - A plan for investment, a plan for reform, including plans for modernising the NHS, the creation of new Primary Health Groups, an outline for Health Improvement Programmes (HIMP), and proposals for Health Action Zones (HAZs)
2000	April: 17 Primary Care Trusts (PCTs) created
2000	Abolition of the NHS Executive and the incorporation of its functions into the Department of Health and 26 Local Health Action Zones (HAZs) established in England to test new approaches to improving health through multi-agency partnership
2002	Abolition of the NHS Executive regional offices, devolution of some functions to new strategic health authorities, and the creation of four new regional directorates of health and social care in the Department of Health
2002	Reorganization of health authorities, going from around 100 to 28 strategic health authorities in England, and the devolution of many responsibilities of health authorities to PCTs
2002	Creation of PCTs in all areas, replacing PCGS, including some mergers and restructuring, and transfer of responsibilities from health authorities
2003	Creation of first wave of foundation NHS trusts, based on existing NHS acute hospital trusts with proven good performance records
2004	Secretary of State for Health: NHS Improvement Plan: 'Putting people at the heart of public services', sets out the priorities for the NHS from 2004 until 2008 and gives further detail to the 10-year process of reform first set out in the NHS Plan 2000.

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Sources: Multiple Sources, principally Department of Health 1997-2004.

Following the publication of more recent policy directives during Labour's second term in office 2001-2004, specifically '*Delivering the NHS Plan: next steps on investment, next steps on reform*' (Department of Health, 2002a) and '*Growing Capacity: a new role for external healthcare providers in England*' (Department of Health, 2002b), there has been some move back to the ideas of a mixed-economy in health care. The retention of the purchaser-provider split has meant that the concept of market-buyer and market-seller has remained intact. The role of the PCT as buyer organisation is an attempt at keeping the notion of incentives and choice alive. In future, PCTs are to procure services from the best suppliers, thus forcing providers to raise standards to attract resources. This system is a variant on the old fundholding concept. However, in Labour's market, a regional price tariff will apply and competition will only apply to service quality and waiting times. The new view of the public user as a stakeholder and investor for instance, clearly has some link with the notion of the consumer publicised as part of the internal-market reforms introduced by previous Conservative Governments during the 1980s and 1990s. Accordingly, patients are now to be allowed to choose their service provider. For example, new Government guidelines suggest that a patient waiting six months or more for an operation can opt to go to another provider who can offer treatment more quickly:

*"Choice is central to the Government's vision for the NHS. Greater choice for all patients will help ensure all patients experience an NHS that is centred on their needs. Choice has always been available to some people. Some have had the resources to opt out of the NHS. Others have proved informed and articulate enough to access choices within the NHS that are not routinely available to others. The Government believes that all patients should have the advantages of choices over their healthcare. The NHS should develop as a personalised service, open to everyone. Patients value choices. We face more and more choices in our everyday lives. People expect to be involved in, and play a key role in the decisions that effect their lives. This is as true in healthcare as in other areas. Increases in capacity and diversity go hand in hand with patient choice. A wider range of services and providers will allow patients to choose services that best meet their needs"* ('Choice of Hospital', DoH 2003a: 3).

To support consumers in decision making, more information on quality and performance is to be made available to patients, that is to be audited for accuracy and completeness. The previous Conservative slogan of '*the money followed the patient*', has resurfaced under new Labour in the form of, '*resources will follow the choices patients make*'. In addition, new Labour pragmatism, demonstrated by the avocation

of public-private partnerships (PPPs), shows a recycling of previous market-based ideas on building closer relationships between the private and public sectors.

The issue of autonomy for professionals and health care agencies has emerged as an important theme of contention since 1997. In one respect, the introduction of primary care groups has transferred certain powers of decision-making from the health authority to community care professionals, while paradoxically the Government has also introduced a whole range of review and monitoring arrangements. The issue of performance and control play a significant part in characterising the context of the NHS post-1997. The Government and Department for Health have taken a national focus with centralised standards and targets. The introduction of clinical governance exemplifies this wholesale approach. All organisations and staff are now duty bound to adhere to the principles of clinical governance and demonstrate how they plan to raise quality standards. The Government has sought to introduce national standards and targets for care, and as such, has created a range of agencies to monitor and enforce these standards, including the Commission for Health Improvement (CHI) to monitor the implementation of clinical governance and the delivery and quality of care provided by NHS Trusts, and National Institute for Clinical Excellence (NICE) to produce and monitor guidelines of best-practice. This framework of external control and influence marks out both the nature and structure of management-professional relationships within the new NHS. In an effort to increase control and enforce accountability there has been some tension between the needs of the centre to raise efficiency and the needs of the periphery to gain autonomy and independence.

Another important feature of NHS reforms since 1997 is the increasing move to new forms of provision. One of the Government's key targets has been the reduction in patient waiting times. In an effort to reduce waiting lists the Government is now considering alternative ways to provide extra capacity in the NHS. The NHS Plan (DoH, 2000) suggested that capacity might be increased via recruitment of more staff. However, since 2002 the Government has outlined new plans to involve the private sector to commission private hospitals, and more radically, to offer patients treatments in European Union hospitals (DoH, 2002b). The Government has also suggested a range of radical ideas for increasing capacity, including:

- Developing and extending private finance initiatives to other parts of the Health Service, such as primary care
- Primary care trusts and NHS Trusts are to form joint ventures with private companies and the voluntary sector is to provide specified care products
- Introducing new public-private partnerships for certain services, such as diagnostics and imaging, that will be provided in specialist centres commissioned by the NHS
- Using private sector hospital capacity for NHS patients
- Allowing patients to receive treatments in other European countries<sup>1</sup>

These innovations in health care delivery reflect a new plurality in provision and a new type of Health Service, one that maintains a State-funded universal system, free at the point of delivery, but where provision will take either public or private forms. These policy themes suggest a very new conceptualisation of the NHS. However, while there is a level of continuity between current health policies and those introduced under previous Conservative Governments, new Labour health policy goes further in terms of the restructuring and refocusing of the NHS. The new NHS appears to be a mix of new flexible and autonomous organisations like PCGs or foundation hospitals, that are strictly controlled and monitored by centralised and bureaucratic targets, that are enforced by external monitoring agencies, with an inter-twining of new forms of public-private provision arrangements, where the patient has choice and is viewed more as a consumer than a user. Underlying the ideology of the new NHS and the many innovations in health care delivery is an implicit and explicit belief in the power of ‘*collaboration*’ over ‘*competition*’. The rhetoric and language of collaborative governance is clearly visible in Government statements, policy publications and Department of Health circulars. Many policy outputs expressly use the terms ‘cooperation’, ‘teamwork’ and ‘network’, to describe the new NHS. One DoH statement in 2002 commenting on recent changes in the NHS and the role of the NHS Plan stated:

*“In July 2000 the Government published the NHS Plan. This sets out an ambitious vision for a service designed around the patient and responsive to patients’ needs: a fast, high-quality, modern and convenient NHS. It was*

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<sup>1</sup> Source: Department of Health (2002a; 2002b; 2003b)



*recognised that we had to change the way the NHS worked to achieve this vision. With these structural changes we have taken the first steps in achieving our aims" (DoH, 2002)<sup>2</sup>.*

The statement went out to outline the new structures of the NHS, detailing the role of primary care trusts in delivering the main objectives set down by Government. Accordingly, one of the central strategies for reaching the goals set by the NHS Plan 2000 are to form new partnerships and relationships within and outside the NHS:

*"New structures means new relationships: new ways of working and new partnerships both between NHS organisations and with other stakeholders. ... Relationships with other partners such as local authorities and voluntary organisations are also vital, particularly for PCTs as they work towards improving health and integrating health and social care. A number of important, semi-formal arrangements, such as cancer networks, have already been developed and need to be preserved. ... Networks are also an important part of the public health agenda in the new NHS. They will ensure that expertise and specialist skills are pooled and then shared with PCTs" (DoH, 2002).*

The thrust of the cooperative reform agenda has been directed towards primary care (detailed further in chapter 5). The language of governance is of partnership and cooperation, rather than competition, and for integration, rather than fragmentation. Collaboration is ubiquitous as a policy discourse. The manifestation of this discourse is in the new structures being implemented, such as the abolition of fundholding arrangements and the imposition of new primary care groups, however this collaborative governance permeates throughout many areas of the National Health Service and the wider public sector.

#### **4.8 Summary**

This chapter has shown how the 'third way' approach to the management of the NHS reflects the Labour Government's aspirations and ambitions for the modernisation of the NHS. While there has been some move towards synthesis and reconciliation, most notably a move away from principles and practices of competition and internal-market, exemplified by the removal of fundholding, new plans and new targets have created new expectations, which have arguably not been met. The pragmatism of new Labour has seemingly attempted to reassert some of the principles that helped create

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<sup>2</sup> [www.doh.gov.uk/about/newshs.htm](http://www.doh.gov.uk/about/newshs.htm) (retrieved 27/11/2002)

the NHS, including solidarity, commitment, social justice, equity, and fairness, however, more recent developments have sought to reinvent the NHS and the health system in general. Overall, change in the NHS, in ideological, social, and cultural terms, is linked to the Government's plans to create and integrate new health care organisations that deliver better services to patients. In both primary and secondary care funding has increased however, additional financial resources only started to come on stream post-2001 following criticisms of under-funding up to this point. As such, financial prudence characterised the Labour approach to public service investment between 1997 and 2001. In 2000, the Government launched the guiding document for the future development of the National Health Service, the '*NHS Plan*' (DoH, 2000). This document set out the Government's ten-year plan for investment and reform of the Health Service. A major part of the Plan targets reform in primary health care. The Plan pushes the goals of the 1997 White Paper further, by enhancing the role of primary care organisations, PCGs and PCTs, in delivering a primary-care led NHS. The Plan also introduces a range of more ambitious and contentious issues, such as the use of private sector hospitals and the private sector to alleviate waiting lists and times in the NHS. Such policy developments mark a turning point in the history of the NHS. These innovations in health care delivery reflect a new plurality in provision and a new type of Health Service, one that maintains a State-funded universal system, free at the point of delivery, but where provision may take either public or private forms. These policy themes suggest a very new conceptualisation of the NHS. While there is a level of continuity between current health policies and those introduced under previous Conservative Governments, new Labour health policy goes further in terms of the restructuring and refocusing of the NHS. The new NHS is to be a mix of new flexible and autonomous organisations, like PCGs or foundation hospitals, that are strictly controlled and monitored by centralised and bureaucratic targets that are enforced by external monitoring agencies, with an inter-twining of new forms of public-private provision arrangements, where the patient has choice and is viewed more as a consumer than a user. This chapter highlighted a number of stresses between the different branches of Labour thinking, such as the need for increased accountability and central control, versus the need for autonomy and devolution; the emphasis on integration and collaboration, versus the need for plurality of provision and increasing the role of the private sector in health care.

## 5.1 Introduction

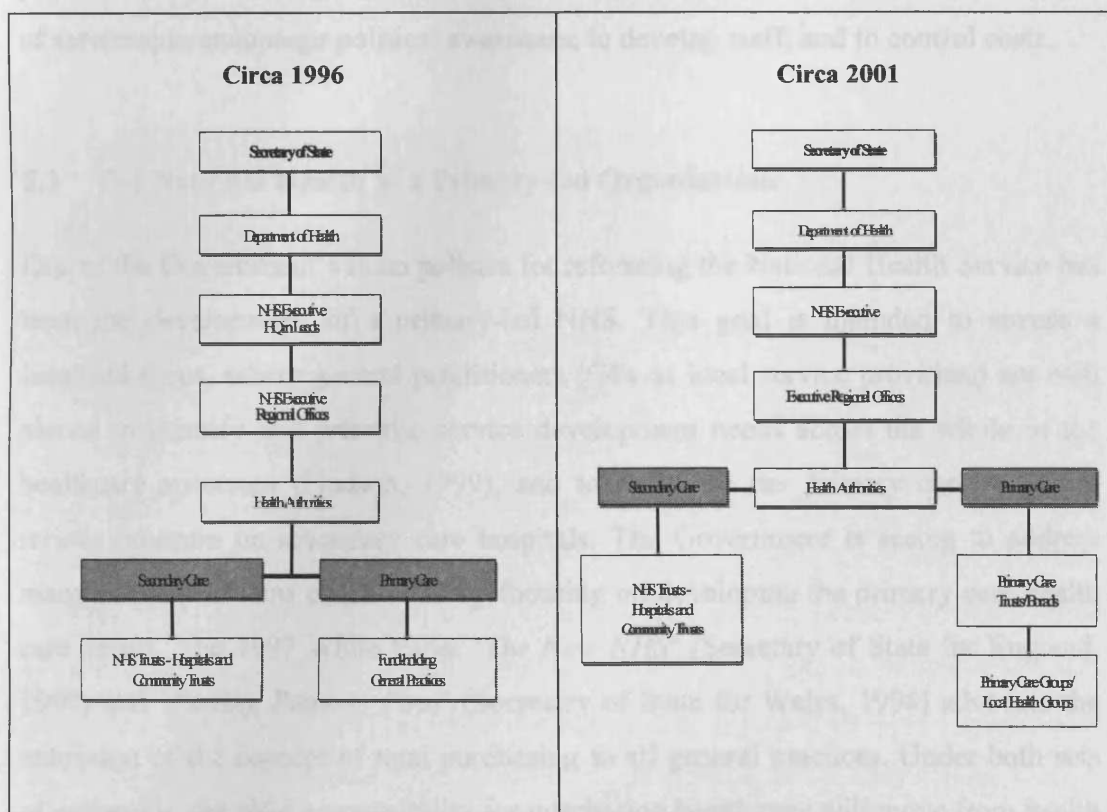
This chapter takes the research agenda forward by exploring issues of networking and organisational integration in primary health care. Primary health care has undergone considerable change and restructuring following the implementation of the 1997 White Paper on health, '*The new NHS, modern, dependable*' (DoH, 1997), and has been a central focus of health policy over the period. The reorganisation of the primary health care sector has been a central feature of the Labour Government's reform and modernisation agenda, whereby the NHS has sought to become a more primary care focused organisation. Drawing on a wide range of specialist practitioner and academic literatures, this chapter identifies the rationale behind the recent move away from internal-markets and large bureaucracy, to new and more flexible forms of working in the primary care sector. The chapter looks closely at the introduction of new primary care organisations, PCGs in England and LHGs in Wales, and at the emphasis placed on cooperative working and collaboration between local health organisations, local agencies and professional groups. The chapter outlines the role of primary care organisations in delivering a primary-led National Health Service. A critical aim of the chapter is to interpret the potential implications of network-type organisational and managerial changes, in particular implications for service provision, professional cooperation, collaborative management, and more generally for service improvement. The chapter highlights the potential opportunities created by recent changes and reflects on the likely barriers to implementing collaborative-networking in primary care.

## 5.2 The Integration of Services

The integration and coordination of public services has been a key feature of British social policy since the creation of the National Health Service in 1948, and has more recently become a major issue of contemporary health care reform. Under the Conservative Governments of 1991-1997, the locus for the planning, commissioning, and provision, of health care, centred on fundholding at the level of the general

practice. Following the election of a Labour Government in 1997 and the subsequent publication of the White Paper on reforming the NHS (Secretary of State for Health, 1997), the focus has shifted upwards to localities run by primary care level institutions. New primary care groups (PCGs), introduced in April 1997, will now be responsible for planning and providing care in the community. According to the White Paper (1997), all community based services and community based professionals will be brought together to plan and provide for the needs of the local community in a combined and inclusive form of health care delivery. Figures 1 illustrates the changing structural form of the NHS with the emphasis shifting away from the purchaser-provider split, to a new structure in health care provision, with the emphasis on cooperation between services and providers, rather than competition. The most significant and structural changes are occurring in primary care (figure 1).

**Figure 1** Changing Structure of the National Health Service



The integration of service organisations within the UK health care sector reflects a more general trend of network-based structural forms in the private sector (chapter 1). Developments in health care, such as the joining up of services, the creation of new clinical networks, and the increasing emphasis on cooperation and inter-service

working, mirror the trend of mergers, strategic alliances, and partnership-working in the private sector. As such, there has been a proliferation of alliances and networks in the NHS over the past decade. This preference for collaborative working is becoming increasingly evident (discussed in chapter 2 and 4), not only have former family health services merged with district health authorities, these bodies have also merged, and are continuing to form links with other large agencies (Crail, 1997). According to Hudson (1999), primary care organisations are a key weapon in helping to keep a community or local focus at a time of large-scale integration. Since the publication of *'Local Voices'* (NHS Management Executive, 1992), a strategy of reducing the number of agencies and then joining large agencies together, has emerged in health care, with a *'think big but act local'*, logic. Burns et al. (1994) commenting on the need for a more inclusive and integrated system of health and social care provision at the primary care level, identifies six possible motivations: to improve the quality of public services; to strengthen local accountability; to achieve the effective distribution of services; to encourage political awareness; to develop staff; and to control costs.

### **5.3 The National Health as a Primary-led Organisation**

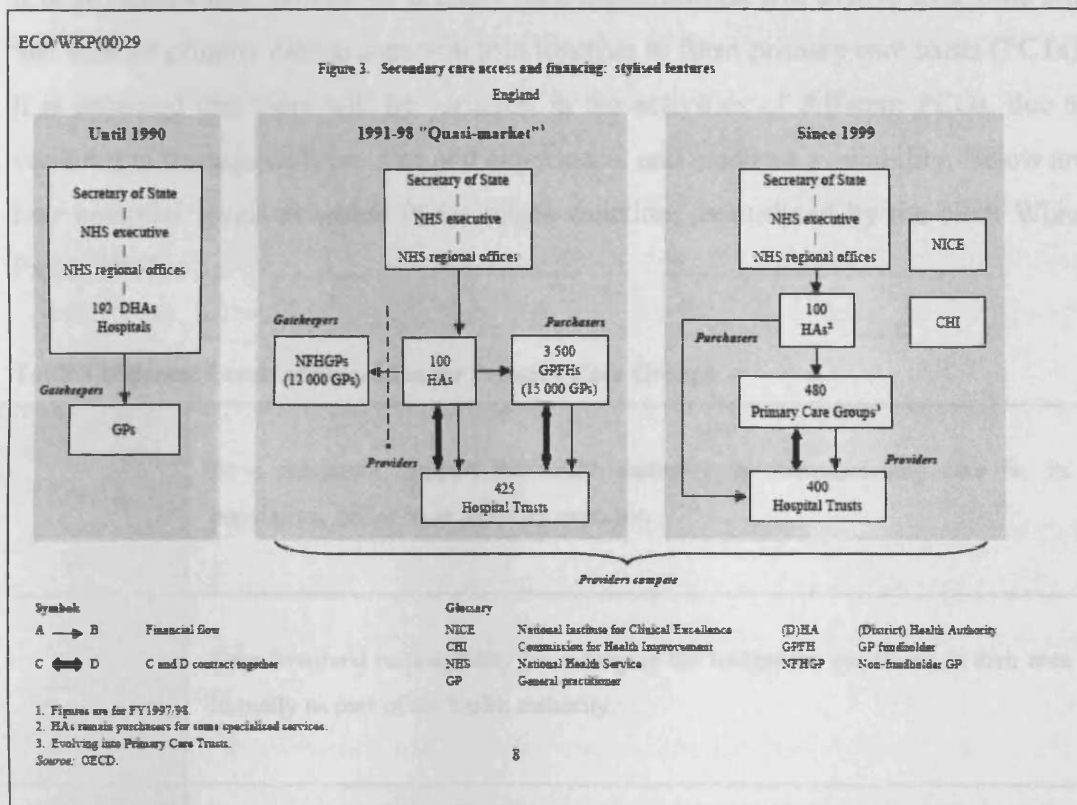
One of the Government's main policies for reforming the National Health Service has been the development of a primary-led NHS. This goal is intended to ensure a localised focus, where general practitioners (GPs as local service providers) are well placed to identify and prioritise service development needs across the whole of the healthcare spectrum (Hudson, 1999), and to revitalise the primary care sector to relieve pressure on secondary care hospitals. The Government is seeing to address many of the problems of the NHS by focusing on developing the primary care health care sector. The 1997 White Paper *'The New NHS'* (Secretary of State for England, 1997) and *'Putting Patients First'* (Secretary of State for Wales, 1998) advocate the extension of the concept of total purchasing to all general practices. Under both sets of proposals, the chief responsibility for purchasing health care will move from health authorities, fundholders and TPPs, to primary care groups (PCGs) in England and to local health groups (LHGs) in Wales. In Scotland, the White Paper *'Designed to Care'* (Secretary of State for Scotland, 1997) only goes as far as to establish primary care trusts, while health boards will retain control for purchasing hospital based care,

new local health care cooperatives (LHCCs) will hold budgets for prescribing and may in the future, hold budgets for the provision of community care services. In England and Wales, both White Papers (1997, 1998) emphasise the need to coordinate and develop services. Primary care organisations have been instructed to link health needs at a local level through health improvement programmes (HIMPs), to be developed in partnership with other agencies (Wyke et al., 1998). These documents also emphasise the need to break down organisational boundaries between the NHS and other agencies, and to forge effective partnerships with social services. Both the English and Welsh White Papers have made some provisions to facilitate cross-agency working, including: a statutory responsibility for English local authorities to work with other agencies; the requirement for HIMPs to be formally agreed between English health and local authorities; the requirement for chief executives of English local authorities to attend health authority meetings; and a duty of partnership for Welsh health and local authorities to work collaboratively with voluntary agencies to develop community care.

**Note: Primary Care Groups were formally introduced in April of 1999 and covered populations of approximately 100,000. Over 500 PCGs were established in England over the first phase of the plans (1997, White Paper).**

The Health Act of 1999, set about appealing the National Health Service and Community Care Act of 1990, sections 14 to 17: thus abolishing fundholding. The 1999 Health Act also set out terms for the creation of primary care trusts (PCTs) and plans for changing NHS organisation and funding arrangements, particularly in primary health care. The overall aim of such reforms has been the abolition of quasi-markets and a move towards more cooperative working practices, with strong emphasis being placed on coordinating services at the local or community level. However, despite the new approach and the emphasis of joined-up working across the NHS, the purchaser-provider split, introduced during the quasi-market era, remains in tact, where theoretically purchasers retain the right to change provider if so desired. The independent contractor status of most GPs has also remained unchanged under Labour. GPs continue to receive direct payments and allowances for the services they provide. These changing and complex funding and accountability arrangements are shown in figure 2.

**Figure 2 The Reconfiguration of the National Health Service 1990-1999**



Source: OECD (2000) *Public Expenditure Reform: The Health Care Sector in the United Kingdom*

In England, the chief responsibility for purchasing healthcare has moved from an existing 100 health authorities, 3600 fundholders and total purchasing pilots (TPPs), to around 500 PCGs, each covering a natural community of around 100,000 population. The 1997 Health White Paper states that GPs, together with community nurses, will be responsible for commissioning services for the local community, and will be accountable to health authorities concerning the allocation of resources. All general practices have been required to become part of a local PCG since April 1999. Practices are involved in the management of expenditure budgets and the management of cash-limited practice infrastructural expenses. Unlike fundholding, PCGs will be responsible for around 75% of the total hospital and community health services (HCHS) and general medical services (GMS) expenditure for the local population, with a new emphasis on collective action and responsibility for total NHS budgets. Importantly, PCGs will be more than commissioning agencies:

“...the purchaser-provider split will be conflated, since the key participants –

*GPs and community nurses – are also providers” (Hudson, 1999: 162-163).*

It is envisaged that the role of primary care organisations will evolve over time and that smaller primary care groups will join together to form primary care trusts (PCTs). It is expected that there will be variation in the activities of different PCGs, due to variation in management practice and experience, and resource availability. Below are four potential levels at which PCGs might function, as outlined by the NHS White Paper, 1997.

**Table 1 Different Levels of Operation for Primary Care Groups**

<b>Level 1</b>	At a minimum, support the health authority in commissioning care for its population, acting in an advisory capacity.
<b>Level 2</b>	Take devolved responsibility for managing the budget for healthcare in their area formally as part of the health authority.
<b>Level 3</b>	Become established as free-standing bodies accountable to the health authority for commissioning care.
<b>Level 4</b>	Becoming established as free-standing bodies accountable to the health authority for commissioning care with added responsibility for the provision of community Health Services in the community, including running community hospitals.

Source: Adapted from NHS White Paper (1997)

The 1997 White Paper sets out plans for the development of PCGs. The role of the PCG will evolve over time, from having devolved responsibility for managing health care budgets as part of the health authority system, to become free-standing independent bodies responsible for commissioning and providing care for patients at community level as larger primary care trusts (PCTs). It is the responsibility of health authorities to establish primary care groups. Guidance on establishing groups



identifies the following important criteria and responsibilities (NHS Executive, 1998):

- Bring together the roles of commissioning secondary care with developing primary care and improving public health, thus allowing decisions to be taken by health and social services professionals within the PCG.
- Build on the strength of the practice and enable GPs and nurses to improve the quality of services within the practice and by working collaboratively with other healthcare professionals and managers, to organise and develop services in the locality.
- Build better health alliances between GPs and other agencies in the community, for example schools, voluntary bodies and local government.
- Involve and collaborate with social services to develop and provide integrated care for consumers (the general public), through the inclusion of representatives from social services of PGC governing bodies, thus resulting in a cross-service approach to primary care.
- Allow health professionals to identify and tackle the problems of variation in primary care in different localities – to provide a standard level of service quality.
- Be capable of identifying and sharing good practices (e.g. best-practice dissemination) for the benefit of all patients in the locality.
- Allow the public to participate in decisions on primary, community and hospital services (i.e. a consumer based quality initiative).
- Provide flexibility within the available resources so that services can be made available at the appropriate time and place, taking account of clinical effectiveness and user preference.
- Integrated workforce plans across primary and secondary care and reduce the isolation of health professionals in community practices

#### **5.4 The Antecedents of Primary Care Groups**

A historical view of developments in primary health care reveals that the concept and practice of cooperative working, and the development of multi-disciplinary groups, has its routes in early experiments with differing institutional formats in the primary care sector over the past twenty years, such as: district health authority locality-

commissioning; general practice fundholding; general practice commissioning groups; total purchasing projects; and primary care groups. A brief retrospective examination of these different organisations is presented below, tracking the evolution of primary care institutions over the past two decades (1980-2000). While these institutional initiatives are not presented in a strict chronological order, there is a degree of progression in the development of existing primary care groups.

The approach adopted by district health authorities (DHAs) in their commissioning activities has resulted in two principal concerns: the claim that they were becoming increasingly detached from the population they were designed to serve and anxiety that GP fundholding would undermine DHAs, as fundholders grew, authorities' budgets decreased (Exworthy, 1993). As a result, many of the localities (units) formed in the early 1990s became the platform for GPs to liaise with DHAs, and thus they bear a resemblance to PCGs.

General practitioner fundholders were self-employed primary care doctors or groups of doctors with a large enough number of patients, volunteering to take part in a scheme introduced under the umbrella of the internal-market during the 1990s, to promote differential purchasing among GPs in relation to services delivered by Trusts, in an attempt to induce competition and thus quality improvements and cost efficiencies. By 1997, they covered over half of the population in England. GP fundholders managed a budget to secure a defined set of hospital and primary care services and pharmaceuticals for enlisted patients. This budget was deducted from the one received by the health authority in the area in which the fundholder was situated. As the scheme evolved, different levels of fundholding emerged. While small practices could purchase community services, experimental 'total purchasing pilots' (TPPs) were introduced allowing practices to purchase all forms of secondary care, including accident and emergency treatment. Significantly, fundholders were allowed to keep any surplus they generated, as long as it was spent on services or facilities of benefit to patients, thus enhancing the value of the practice. Non-fundholding GPs did not hold budgets for secondary care. Their costs continued to be incurred by the local health authority. Although fundholding was initially based around individual practices, fundholders soon recognised the value of collective approaches to service

commissioning (Hudson, 1999). As a result, multi-practice organisations termed 'multi-funds' developed, providing a model for bringing together independent practices to influence healthcare strategy (Paynton, 1996). By 1996, there were 17 multi-funds in operation covering around two million patients in over 350 practices (Audit Commission, 1996).

GPs have been instrumental in turning the NHS's attention to locality-based collaborative initiatives. Groups of GPs opposed to fundholding have been attempting to organise themselves into alternative commissioning groups, leaving behind the more traditional practice orientation. In 1994, a National Association of Commissioning GPs was established to promote the involvement of GPs in healthcare commissioning. By the end of 1996, there were 109 associated groups involving some 10,000 GPs and 20 million patients (Willis, 1997). The intention to explore alternative approaches to primary care commissioning was declared in an Executive Letter [EL(97)37] issued in June 1997, which announced the introduction of a pilot scheme to develop future commissioning models (Hudson, 1999). Subsequently, approval for 42 pilot projects was given, which commenced in April 1998.

In 1993, the NHS Executive supported four GP-led initiatives to extend the fundholding scheme, which became known as 'pioneer projects', in Bromsgrove, Berkshire, Runcorn and Worth Valley. Total-purchasing meant that GPs in a locality setting could purchase all hospital and community Health Services. Total purchasing pilots (TPPs) constituted an important extension of GP fundholding, allowing GPs access to previously restricted services such as, emergency inpatient care, accident and emergency services, mental illness services, palliative care, regional expert centres and health promotion. While the emphasis of total purchasing was on the extension of fundholding in the internal healthcare market, it has also served to increase partnerships between GPs and health authorities over commissioning. These partnerships, and the role of GPs in the commissioning and delivery of primary health care services, and some secondary care services, highlighted the important role of the health professional in managerial decision-making in health care and has contributed to the concept of the primary care organisation, a managerial organisation run by primary care professionals.

## 5.5 The Emerging Role of Primary Care Groups and Trusts

Since being introduced in 1997, primary care groups have been steadily progressing from simple advisory bodies, to becoming free-standing bodies, towards level 3-4 of table 1. In 2000, the Government announced the creation of primary care trusts (PCTs), the next step in the Government's plans for restructuring primary health care. The development of PCTs is expected to have a fundamental influence on the shape of the NHS (IHM, 2000-1). The Government's national plan for the NHS (DoH, 2000) sets out a range of initiatives to modernise the NHS. In particular, the creation of PCT moves the idea of coordinating the services of general practitioners and other primary care services into a more advanced stage. The NHS Plan 2000 suggests that PCTs will take control of community health services and smaller community hospitals (IHM, 2000). Despite their continuing independent contractor relationship with the NHS, GPs will soon become full members of the mainline NHS organisation through the PCTs:

*"...which not only combines the delivery of current primary and community health services (ending the current funding division between them) but also takes over the commissioning of secondary care services currently undertaken by health authorities and some total purchasing practices"* (Rummery, 1998: 430).

There are currently 303 primary care trusts in operation in England (circa 2002). PCTs now plan and commission Health Services, a role previously carried out by health authorities. The Government has stated that by 2008, 75% of the NHS budget will be controlled by PCTs (NHS Plan, July 2000). From April 2002, England's 95 health authorities will cease to exist, whereby the functions of HA's will move to 28 new strategic health authorities and primary care trusts. It is expected that by October 2002, these strategic health authorities will begin developing strategies for local health services and ensuring high-quality performance:

*"They will manage the NHS locally and will be a key link between the Department of Health and the NHS. They will also ensure that national priorities, such as programmes for improving cancer services, are integrated into local plans"* (DoH, 2002).

The 1997 White Paper and 2000 NHS Plan, as well as subsequent policy publications on the role of primary care organisations, have tended to be more prescriptive than

instructive according to some commentators (Hudson, 1999). Government and NHS statements for PCGs and PCTs provide little in the way of management and administration guidelines for practitioners and members of PCGs/PCTs, particularly in relation to dispute resolution, unfair power distribution between groups, or professional bias. The role of the PCGs is diverse including:

- health promotion
- the commissioning of health services
- implementing the health authority's health improvement programme
- monitoring trust performance against service agreements
- the development of primary care in the community

However, there is little empirical data on the functions and operations of primary care organisations. This is partly due to the newness of these agencies. Consequently, a number of important questions remain unanswered about the management, organisation and representation of new primary care organisations.

## **5.6 The Agenda for Cooperative Working between Professionals and Agencies**

Chapter 2 and 4 showed how the policy of cooperative working has risen to the top of the reform agenda in health care. The development of general practitioner fundholding was a significant policy of the last Government's plans to move towards a primary care-led NHS, which began to appear in the late 1980s (Secretaries of State for Health, 1989) and was clearly detailed by 1994 (NHSE, 1994). One in three GP practices became fundholders by July 1995 (Audit Commission, 1995). Following the introduction of total purchasing (TPPs) in the 1990s, GPs responsibilities were further widened, particularly as GPs then received notional budgets to purchase health services for their patients (Rummery, 1998: 430). Hudson (1999) asserts that many GPs were concerned about the inequity of fundholding, the administrative workload it involved, and the ethical dilemma of generating savings in a public service. Concerns were raised about the difficulty of planning service change where the population is disaggregated into practice groupings (Audit Commission, 1996). GPs often expressed concern that holding budgets while being responsible for purchasing

secondary health care services might compromise their status as clinical advocates of patients (Singer, 1997). GPs also expressed concerns about the equity of provision between fundholding and non-fundholding practices (Glennerster et al., 1994). Fundholding and the quasi-market have been criticised for a loss of a local focus, with purchasers and providers contracting in areas that are poorly aligned geographically and functionally (Exworthy and Peckham, 1998). The inefficiencies of fundholding have made it unpopular with the Labour Government (Corney and Kerrison, 1997). The incoming Labour Government subsequently abandoned the notion of fundholding in primary care in favour of more cooperative primary care groups, as an alternative to the internal-market. Within this new wave of collaborative governance, joint-working at the level of the local community, has emerged as a major reform priority.

The anti-market context in primary care post-1997 has given rise to a range of new possibilities for the joint-commissioning and integrated provision of services, particularly within health care services at the community/local level, and has led to the introduction of primary care organisations (PCGs and LHGs) that direct and control the allocation and delivery of these services. As discussed in chapter 2, the inter-linking of organisational units in primary care, professionals and agencies, is part of the wider adoption of the network paradigm in public services. Rummery (1998: 432) states that recent moves to join-up services at the primary care level mark a move towards collaborative-commissioning and networks. The proposed benefits of collaborative-networking have already been discussed in a general sense in chapter 1 (section 1.4), and include a wide range of issues such as, improving information exchange, task duplication minimisation, improving commitment and involvement, and shared decision making.

Health authorities and public sector departments have long been under a statutory duty to jointly and strategically plan the services they provide (DHSS, 1973; 1976). Despite the efforts of the previous Conservative Governments to put in place the structures and machinery to induce effective joint-planning, by the end of the 1980s it was clear that Government policies were failing to effect change, particularly in primary care level (Wistow and Brooks, 1988). Since the implementation of the 1990 NHS and Community Care Act (DoH, 1990), the way in which health and social care

services are planned has dramatically changed (Rummery, 1998: 429). However, the incoming Labour Government has dismantled fundholding arrangements in favour of primary care teams, that hold wider responsibilities for health and social care, as well as growing influence over secondary care services (Rummery, 1998). The 1997 White Paper on Health asserts that, '*decisions about how best to use resources for patient care are best made by those who treat patients*'. The commissioning of services role, previously in the domain of health authority managers, is to move to members of primary health care teams (PHCTs). These groups will involve all GPs, unlike fundholding which only included those GP practices which choose to opt-in, and for the first time, other members of the health professions, social workers and community nurses for example. Whereas the NHS reforms of the early 1990s were focused around the creation of a producer-provider split and the introduction of market mechanisms, post-1997 policy has moved away from purchasing services, whereby greater emphasis has been given over to the commissioning of services. The importance of this move, as noted by Rummery (1998: 431), is that whereas purchasing emphasised budgetary control and the effective utilisation of scarce resources, commissioning implies having a strategic impact on the development and delivery of services without necessarily purchasing them. Primary care groups in the NHS in England, and to a lesser extent local health groups in Wales, are being modelled on a blueprint of locality-commissioning groups (Department of Health, 1995). However, unlike fundholding and total purchasing, new primary care groups and teams have the ability to overcome the old problem of multiplicity in purchasing, giving them greater power and influence over the purchasing and commissioning of services. It is within this area, that new primary care organisations are expected to make positive gains and service improvements.

While the move towards joint-working and commissioning in primary care has been welcomed by GPs groups opposed to fundholding (GMC 1995, Singer, 1997), there are growing concerns, particularly among external commentators (Hudson, 1999), that primary care groups may not have the purchasing power of stand-alone health authorities, and so the possibilities for PHCTs exerting control over the quality and cost of secondary care might be limited (Light, 1988).

### 5.6.1 Linking with Social Services

Social Services have recently undergone what is arguably its biggest change in role and responsibilities since the early 1970s. The implementation of the 1990 NHS and Community Care Act marked the beginning of radical change in the development of social services in the UK. Following the White Paper '*Caring for People*' (DSS, 1989) social services departments found themselves purchasing services from the private sector, for example, in the care of the elderly social services became purchasers in a mixed economy, whereas health remained in an internal market. More recent policy initiatives have sought to improve partnership working between health and social service departments and agencies, in an effort to improve the nature of care management and delivery by combining services and professionals. One of the defining features of new social services policy is that services should now be 'needs led' (SSI/SSWG, 1991). Rummery (1998: 431) citing studies of social service provision (Ellis, 1993; Davis et al., 1997) suggests that until recently, the allocation of services has not been based on need, but appropriateness. According to Rummery (1998: 431) these findings echo concerns voiced by service users that:

*"...service packages purchased by social services do not necessarily meet their needs or aid their independence".*

The result of recent changes in social services is that practitioners are now limited to commissioning social care services through their new role as care managers. This managerialisation of the profession may reflect the lessening importance attached to professional training and values (Cheetham, 1993), but most probably stems from the recognition that social services departments and social workers, have until now, largely defined the problems of their clients rather than providing effective, in terms of quality, targeting and cost, services based around actual needs (Jones, 1999: 49).

Another driving force behind change in social services has been the overriding consideration of cost minimisation (Lewis and Glennester, 1996). Prior to the implementation of the 1990 Community Care Act, residential care was available on the basis of financial need, and paid for through the social security system, rather than a need for care, which according to has led to an unrestricted rise in spending (Lewis and Glennester, 1996). A recurrent theme of Labour health and social care policy since 1997 has been that health and social services reflect the complex needs of



patients, thus removing the artificial boundaries that exist between services (Twigg, 1997). Accordingly, seamless services may achieve full population coverage. At present, demarcations between services provided by the NHS and Social Services leave coverage 'black-holes,' where vulnerable users may fall through gaps left by the failure of services to coordinate. Non-specific patients, such as those patients that tend not to use GPs or other available services, are the target group to be reached through new joint health and social service initiatives. Traditionally, the NHS and Social Services have failed to coordinate effectively with each other, resulting in a number of commissioning dilemmas, including bed-blocking, unnecessary admissions to hospitals, and instances where services dispute responsibility over the payment of out-of-hours services (Rummary, 1998: 432). As the responsibility for commissioning moves from health authorities to PHCTs, there is more emphasis placed on effective collaboration and for social service departments to engage with health care agencies to jointly develop and provide more integrated and targeted services. The means by which this is to be achieved has not been fully articulated however, the involvement of social services in new primary care groups and local health groups is likely to offer one possible bridge between health and social care.

## **5.7 Key Considerations in the Management of Primary Care**

While the potential benefits to collaborative working and commissioning in primary care are well established and the infrastructure in primary care is now being redesigned around primary care groups, the realisation of these benefits is less clear. The financial framework for funding primary health care is remarkably different from that for financing social care services. These separate budgetary cycles have an effect on the perceived accountability of each organisation. For instance, whereas primary health care is funded through national taxation, social services are funded through local taxation, and thus are accountable to local council members. In addition, PHCT members are also funded differently; GPs being independent contractors, while nurses remain employees of hospitals, practices, or community trusts. It is worth noting that these varied lines of accountability may also generate distinctively different forms of organisational loyalty, remembering that each member is bound to possess an intrinsic loyalty to their profession (Friedson, 1970, Abbott, 1988). Social workers, GPs and

nurses, possess very different professional identities, with GPs and nurses having their practice regulated through national professional bodies, like the British Medical Association (BMA) and the General Medical Council (GMC) for doctors, whilst social workers have their professional standards set by senior members.

It is also conceivable that change itself might, “*undermine good working relationships because of a lack of staff continuity and the additional pressure of coping with change*” (Rummery, 1998: 432). Since 1997, there has been an increase in the pace of change in the NHS, particularly in primary health care. There is some suggestion that the pace of change is too rapid and might be perceived as a threat to professional status, and as such has increased levels of resistance and apathy among health care professionals and health managers (Hudson, 1999). The need for change in the Health Service is now widely recognised by NHS managers, professionals and the Government. The NHS Plan 2000 (DoH, 2000) specifically calls for a more strategic approach to the implementation of the health plan over the ten years between 2000 and 2010. The National Health Service has begun to view change management as an important element of service modernisation. In response to the White Paper ‘*A First Class Service*’ (DoH, 1998), the National Coordinating Centre Strategic Development Organisation (NCCSDO) of the NHS commissioned a review of the evidence in the field of change management, citing the following (NCCSDO, Section 5.14):

*“Change may be an imprecise science, but evidence is available on what works and what does not, and the NHS must make use of this. The [NCCSDO] will review existing research findings of relevance to change management and quality improvement in the NHS. It will also commission new studies to improve the knowledge base. This work will be made available in a user-friendly format for the whole NHS to draw on”.*

During the autumn of 1999, the SDO programme carried out a consultation exercise to identify within the NHS, members that might require change management training and expertise (Fulop and Allen, 2000). Fulop and Allen (2000) found a lack of understanding among NHS professionals about how to manage change, but also a clear desire among professionals to adopt the principles of change management. In response, the NCCSDO commissioned research into the science of change management. Iles and Sutherland (2001) subsequently carried out a review of the change management literature and compiled a reference document for dissemination

among NHS professionals. Iles and Sutherland (2001: 7) summarises the problem of change management in the NHS as follows:

*“The challenges for those working towards meeting the Plan’s ambitious change agenda are clear. We know that practising managers and professionals are keen to meet these challenges, to improve services by learning from the research literature and to base their decisions in evidence where possible. Many people in the NHS, however, are not familiar with the thinking about management of change which has come out of schools of management, psychology, sociology, and economics, over the last fifty years. Many who are aware of some of the concepts do not appreciate the contexts in which they were developed, nor the purposes to which they may be put in the process of managing change. Important insights and guidance which the literature offers are thus not being used to maximum effect”.*

The diversity of organisational and professional loyalties that exists within the NHS presents an additional and unique managerial challenge. There is some suggestion that the NHS is a difficult environment in which to impose change on professionals, and that managers need to overcome the potential problem of professional mistrust (Rummary, 1998: 432). It is well documented in organisational behaviour literature that rivalries often exist between professional groups, something Dalley (1989) terms ‘*professional tribalism*’. In part, this shared mistrust originates from a lack of understanding of the organisational context within which each professional works. For example, Dalley (1989) suggests that social workers have to arrange packages of care that conform to strict budgets while working under close supervision, hence develop a perceived lack of cooperation and independence. GPs are often busy with surgery or call-outs and are often expected to be paid for non-core services, something that enhances their status and perception as inaccessible. The manifestations of professional rivalry between health professionals may in some way disrupt the ability of primary care organisations to achieve effective and speedy outcomes, yet this subject is often omitted from policy publications and is rarely discussed or addressed by initiatives to integrate primary care professionals. There is some suggestion that new primary care organisations might address traditional professional rivalries by bringing together multiple groups of professionals, and by offering a forum for cross-professional communication and multi-professional decision making.

## 5.8 Opportunities for Primary Care Teams and Groups

The potential of joint-working to overcome new and old barriers to inter-professional working in primary health care, arguably comes from the opportunity that participants have to learn about the roles and responsibilities of these different professional groups. Many, if not all, of the obstacles to effective joint-working, both within agencies and across professional and service boundaries, can be traced back to a lack of knowledge and understanding on the part of all sides. Rummery's (1998) study of joint-commissioning suggests the benefits of joint-working may be limited to those partners directly involved. In locality area-based commissioning, partners benefited from coordination at the strategic level. While the practice and individual-based models of commissioning (Rummery, 1999: 433) offered the most for professional collaboration, it failed to offer opportunities for strategic commissioning responsibilities, nor did it offer scope for service development (Rummery, 1998: 435). This offers some lessons for future developments in service commissioning, particularly for PCGS and LHGs. Not only should commissioning be strategic, viewing the macro needs of the community, it must also be flexible enough to allow for micro level initiatives designed to commission and provide care on the ground.

New forms of joint-working in primary care offer new opportunities to further engage with community nurses. Community nurses were largely excluded from commissioning responsibilities during the internal-market (1979-1996). As employees of Trusts, community nurses were perceived as providers, and consequently, were excluded from purchasing roles. Despite a history of low involvement, the new Labour Government has sought to include community nurses in its most recent vision for commissioning services. The 1997 White Paper on Health and the NHS Plan 2000 explicitly tackle this exclusion by placing nurses at the heart of primary care policy:

*“Primary Care Groups will...bring together GPs and community nurses in each area to work together to improve the health of local people...by better integrating primary and community Health Services and working more closely with social services on both planning and delivery” (Secretary of State for Health, 1997: 33/34).*

While there has been no formal involvement of the nursing profession in the management of fundholding, The 1997 White Paper *‘The New NHS’* (Secretary of

State for England, 1997) has given community nursing a representative position on the governing bodies of primary care groups. This policy has moved nurses from a peripheral position to a central role in the commissioning and provision of services. This managerialisation of nursing has generated some argument concerning collaboration and professional rivalries within primary care teams (Hudson, 1999: 167). The problem of inclusion and exclusion arises as a contentious issue. For instance, the justification for the inclusion of nursing versus the justification for the exclusion of other care workers, such as physiotherapists, occupational therapists, speech therapists, dieticians and chiropodists. Another problem evolves from the diversity of the nursing profession, including practice nurses employed by GPs, community nurses from Community Trusts (CTs), and midwives and nurses from Acute Trusts (ATs). These issues raise some interesting questions concerning the selection of members and the representativeness of new primary care bodies. However, the reform agenda in health care does challenge traditional divisions between nursing and medicine and offers new opportunities for professional collaboration and enhanced joint-working, particularly in primary care.

Collaborative arrangements with Social Services has been identified as a notable weakness of TPPs, which were found to be making little progress towards national community care policy initiatives and had 'blocked back' service commissioning for continuing care to their health authorities (Myles et al, 1998). One reason given for this was the complexity of inter-agency politics, and early perceptions of PCGs (Marks & Hunter, 1998). The potential for conflict arises from the clear power differentials between, for example, health care professionals and social workers. The Green Paper on Public Health (Secretary of State for Health, 1998) highlights the need for effective 'corporate collaboration' at the macro level, across all local authorities.

While the main emphasis of cooperation has focused upon GPs, community nurses, and social services, there are other intra-NHS relationships which will need to be addressed, such as the acute health care sector (Hudson, 1999: 167). In principle, PCGs have the potential to oversee the whole process of care, covering pre-admission, admission, treatment, discharge, and post-discharge care. Surprisingly, hospital

consultants have not been given places on PCG boards, and there is some evidence to suggest that health professionals in acute trusts feel disenfranchised (Christie and Blades, 1998). In addition, the health authority gains membership through a single HA non-executive director. There is some argument that PCGs are not representative of the whole primary care sector. Primary care groups have been instructed to address the significant lack of user and carer involvement in the provision and determination of services provided to patients. One of the central policies of primary health reforms and the development of community level health care commissioning and provider agencies is to involve health care users, to allow users to determine health care needs. Primary care groups are under an obligation to “*have clear arrangements for public involvement*” (Secretary of State, 1997: 36). Local health groups in Wales are under a similar obligation. However, despite the new emphasis on user involvement, recent White Papers offer little explanation of the incentives to involve the public in commissioning services. It is envisaged that as primary care groups move to become primary care trusts (PCTs) this will go one step further towards the abolition of divided services, perhaps towards some form of holistic service integration. The requirement for all GP practices to be involved in the PCG forum may generate a greater degree of stability and certainty, often lacking under fundholding or total purchasing. The 1997 White Paper (DoH, 1997) states that the new NHS is to be built around partnerships and alliances between service providers and service commissioners. Primary care organisations and teams, PCGs in England and LHGs in Wales, have been charged with fulfilling the array of goals set for the NHS, and moving the UK National Health Service towards a more integrated primary care-led health care system.

## **5.9 Potential Barriers to Joint-Working in Primary Health Care**

Recent developments and restructuring in the primary health care sector of the UK NHS have raised a number of potential barriers, obstacles or challenges, that might impede the effectiveness of network-based organisational collaboration between services and agents in a primary health care setting. While two of the clear benefits of primary care groups are the involvement of professional groups such as community doctors and nurses, and the enhanced coordination of services, there are a number of

concerns. Firstly, there are no clear incentives for primary care groups or local health groups to collaborate with social services. Secondly, there are no signs that the mixed market in social services is to be abolished; as assessment and care management are to remain part of social services tasks (Rummery, 1998: 436). Finally, it is likely, as with any reorganisation, that there may be some adverse reactions to changes and that PHCT members' time will be preoccupied in coping with change during initial transitional periods, as they attempt to adjust from the fundholding era, to new primary care team-work.

While the concept of 'localisation': moving towards a community-based health care system, commands wide spread support among health care practitioners and policy makers, efforts to apply localisation, such as devolving power to lower-level organisational units and involving providers at the inter-face level, may reveal two underlying dilemmas according to Hudson (1999: 167-168). Firstly, logistical and administrative issues related to the population size covered, and secondly, choice of organising unit. Hudson (1999) points to an inconsistency in previous and existing localisation initiatives, in terms of population coverage. In local government there have been developments serving populations as small as 6,500 in Islington and 25,000 in Tower Hamlets in London (Burns et al, 1994). In health, TPPs ranged from between 12,000 and 85,000 with a mean population of 33,000 (Mays et al, 1998), while a study of local commissioning in 28 health authorities across Scotland and Northern England found most localities in the 40,000 to 60,000 range (Hudson-Hart et al, 1998). Local level administrative health institutions have little experience of operating larger localities of 100,000 population as required by PCGs. In addition, plans to network primary groups to each other and to develop primary care trusts (PCTs) will increase the size of localities. The paradox is that as PCGs increase in size, they will move further away from small-scale community operations, and thus may lose a community or local focus:

*“There is a paradox between the merging of local level health care bodies, particularly the development of Primary Care Trusts, and the desire to maintain a community or local focus” (Hudson-Hart et al., 1998).*

There are several potential organising principles for primary health care, including local authority electoral wards, GP practices, conformity to natural population centres,

and demographic homogeneity based upon such features as age, ethnicity and deprivation. Organising primary care around a particular unit may result in overlaps between organising variables, or gaps between units. For example, GPs may seek to preserve practice-based populations and boundaries, even if this conflicts with other organising variables (Hudson, 1999). Evaluations of TPPs points to problems in developing relationships with local social services departments, which cover distinctively different communities (Mays et al., 1998). Since GP lists are based on individual households, it may be very difficult to aggregate these lists into distinct geographical boundaries, indeed it is estimated that up to 25% of a total practice population may reside outside the PCG zone to which the practice is formally attached (Hudson-Hart et al., 1998). The task is therefore, how to capture the total population within the primary care locality? Localised HNS initiatives based around aggregations of general practice populations can also create other difficulties, especially in relation to commissioning. Hudson (1999: 164) states:

*“Routinely collected socio-demographic data, for example, tends to relate to postcodes or local government boundaries, while the focus on morbidity at the level of groups of practices may result in an undue focus upon a medical perspective, at the expense of the social model”.*

Marks and Hunter (1998), report that GPs are concerned that existing groups, consortia, and multi-funds, may be dismantled or adversely affected by an unwillingness to work with other practices. Collaborative primary care teams may have to coordinate and integrate unwilling partners. There are therefore, several serious difficulties with the organisation of primary care groups in artificially created localities based upon aggregates of GP practices.

Devolution of power and authority to PCGs represents an area of contention in public sector management thinking. Devolution generally involves the relocation of tasks and functions generally undertaken centrally, including a range of functions such as budgetary controls, decision-making, administration and an array of service activities. Devolution is especially real where it is matched with authority. There is some concern that devolution of power to PCGs might increase the power of GPs, which can only come from a loss in, or a transition in, health authority control. Shapior et al. (1996) point out that while a health authority has the negotiated power associated with



budgetary control, GPs have the ability to direct services due to their detailed clinical and local knowledge. Critics of health authorities view them as out of reach and bureaucratic (Glennister et al., 1994). One of the key criticisms of fundholding for example, was that practice-based needs assessment and subsequent purchasing was limited in its vision (Hudson, 1999: 167). The Audit Commission (1996) noted that while fundholding brought GPs closer to their patients and their needs, published research showed a divergence of opinion between patients and GPs. It could therefore be argued, that health authorities serve an important role in viewing health care from a more strategic vantage point, something primary care organisations may find hard to achieve. Therefore, the devolution of power away from administrative bodies such as health authorities may result in some loss of independent strategic decision-making. However, while PGCs are viewed as the solution to the problems of fundholding, it is unlikely that health authorities will freely devolve responsibility to GP-led localities. Hudson (1999) suggests that health authorities will find it difficult to devolve power to GPs, since GPs may not be willing to acknowledge accountability to the health authority. Health authorities will undoubtedly view devolution as a risk (Smith and Shapiro, 1997). This explains why locality commissioning has rarely involved total budget devolution. In their study of 28 health authorities, Hudson-Hart et al. (1998) found only four examples where budgets were about to be devolved to localities. Marks and Hunter (1998) also reported dramatic differences in the extent that HAs have been supportive of early PCG development. Overall, very few localities have gone beyond level 1 and 2 of operations (table 1), although the Government view level 3 as a minimum medium-term requirement. There is some evidence of variability in GP involvement. Variation in PCG development may create problems for HAs in negotiating with the wider health improvement programme, since different groups within the boundaries of a HA may be working at different levels. Marks and Hunter (1998) reported that previous fundholders were keen to start at level 2 or above. In particular, level 4 is viewed as the best in terms of the acquisition of personnel, knowledge, management and IT skills, to facilitate a better team approach.

The devolution of power away from health authorities to new primary care groups reflects a democratisation movement in primary health care. This democratisation is aimed at achieving a higher degree of participation in localisation initiatives. This

marks a shift in healthcare policy, from an emphasis on accountability to the centre, to the localisation of healthcare management. PCGs and LHGs will be exercise local accountability and professional judgement. However, Hudson (1999: 168) identifies a number of obstacles to achieving these two aims, including a lack of user sensitivity in health purchasing and a failure to engage with localities. A crucial prerequisite for effective decentralisation is the active engagement of users in the devolutionary process. Mays and Dixon (1996) set out some of the policy requirements and objectives of primary care organisations:

- Assessing patient needs
- Setting appropriate priorities
- Obtaining and using adequate information about services
- Informing and involving patients in purchasing decisions
- Monitoring and maintaining equity
- Minimising transaction costs
- Managing financial risks
- Managing budgets

According to Hudson (1999: 168), the evidence from previous locality initiatives suggests that PCGs/LHGs will also fail to meet these objectives, where historically patient consultation and involvement has been particularly weak. While GP fundholders were obliged to produce an annual plan of needs-based purchasing, they often ignored this requirement, viewing it as bureaucratic, which only served to further exclude patient involvement (Audit Commission, 1996). The Audit Commission found that only 4% of fundholders' plans included a description of patient feed-back on the quality of practice, hospital, or community services. In addition, such plans rarely mentioned how patient involvement would be used to improve services. Multi-funds or TPPs also failed to meet these requirements (Hudson, 1999: 169). The development of the internal-market in healthcare promoted the idea of involving the public (consumers) in healthcare purchasing (Lupton et al., 1998). In addition, guidance in '*Local Voices*' (NHS Management Executive, 1992) stressed the need for local views to be utilised in relation to health needs assessment and in the development of service specifications. The evidence suggests that there has

been some effort to respond to these demands, by means of focus groups, patient participation groups, questionnaires, open meetings and public panels (Hudson-Hart et al., 1998). However, Hudson (1999:169) states that such approaches are neither widespread nor necessarily effective. For example, one study of locality commissioning in the West Midlands found a conspicuous absence of user involvement (Smith et al., 1997), while another study reported little success in consulting the public (Redmayne, 1995). Hudson-Hart et al. (1998), arrive at a similar conclusion stating that:

*“...while health authorities appear to be increasingly attempting to consult the public, not much of this is done on a locality basis. Furthermore, the evidence does not indicate that information obtained is then incorporated into purchasing strategies”* (Hudson-Hart et al., 1998: 11).

GPs have also been criticised for their inability or unwillingness to collaborate with community groups. It is argued that there is a tendency by GPs to undermine patient involvement (Mays et al., 1998a; Taylor et al., 1998). This is worrying given their vital and central position as champions of user (patient) involvement in PCGs. Hudson (1999) comments that GPs may feel that they are best placed to understand patients' needs, resulting in GPs viewing a wider consultation process as unnecessary. Myles et al. (1998) study of TPPs criticises the GP position, concluding that:

*“... it is no longer sustainable for GPs to consider themselves to be reliable proxies for their patients, or to be confident that they are aware of all their needs.”*

Whilst PCGs are required to involve service users, the evidence so far suggests that this will be difficult to achieve. Marks and Hunter (1998) revealed that many groups are confused about the level of involvement required and the methods they must employ to be effective. As a result, public involvement is expected to be well below that required by either Government, or primary care organisations.

## **5.10 Achieving Effective Collaborative-Networking**

A number of broad areas of management emerge as areas for appraisal and consideration in the implementation of health policy, if the proposed benefits for service delivery are to be realised. There are two key areas of management in primary

care: the management of inter-organisational collaboration and the management of inter-professional collaboration. The Government's third-way approach to public sector management has brought with it a change in cultural orientation, towards dynamic inter-agency collaboration across occupational boundaries and organisational structures. While the NHS has been historically dominated by centralised hierarchical management and a cultural orientation of valuing uniformity and consistency, new localisation initiatives imply an acceptance of diversity and creativity, that goes beyond traditional ways of working and administering services. One of the key elements of the reform agenda in primary care post-1997, is the need for more flexible forms of working. This need for flexibility has led to moves away from the managerialist approach of health authorities. Smith and Shapiro's (1997) study of locality-commissioning, ' *Holding on While Letting Go,*' encapsulates the dilemma of changing relationships between the power-base of the health authority and the general practice. Despite the potential for resistance to change by health authorities, the emphasis for change is towards new models of locality-commissioning and integration in health service delivery that promote flexibility in primary health care (Shapiro et al., 1996). A study of total purchasing pilots by Mays et al. (1998a), report that TPPs (the precursor of PCGs) exhibited significant variances in the level of service delivery and integration:

**Table 2 A Typology of Variation in Total Purchasing Pilots**

<b>Under-Performer</b>	TPPs not achieving or intending to achieve high performance
<b>Developmental</b>	TPPs in a preparatory stage – placing emphasis upon needs assessment and infrastructural development
<b>Co-purchasing</b>	TPPs influencing local provision through partnership with HA and/or in collaboration with trusts
<b>Primary Care Developer</b>	TPPs with a focus upon primary care – but no changes in secondary care

<b>Commissioning</b>	TPPs that directly purchase to achieve changes in both secondary and primary care
<b>Integrated</b>	TPPs that directly purchase and influence both secondary and primary care provision

Source: Constructed from from Mays et al. (1998a)

The importance of table 2 is that this typology may be helpful in analysing new primary care organisations, PCGs and LHGs. Mays et al. (1998a) suggest that the changes brought about by TPPs focused attention more on local health service issues and upon practice-based problems, rather than strategic issues. Hudson (1999) concludes that a lack of interest in implementing specified goals accounts for organisational diversity, and that central Government and local health authorities may find similar degrees of diversity among PCGs unacceptable.

The management of professionals within the primary care setting is another important component in the development of primary health care. GPs have traditionally been accorded a high degree of autonomy and flexibility in the way they work, a product of the strength of the medical profession and a product of their specific role in both society and within the National Health Service. The pursuit of increased accountability under the NHS Plan (DoH, 2000) may result in some conflict between the need for accountability and the autonomy of individual professionals, particularly independent status general practitioners. There are two possible outcomes: professional resistance to change, or professional engagement with change. In the first scenario, recent restructuring in primary care and the introduction of new multi-professional primary care organisations might be viewed as a threat to GPs strong professional identity; there is a theoretical argument that professional groups seek to protect their professional jurisdictions (Abbott, 1988; Dalley, 1989). The risk is that professional commitments might supersede organisational or managerial objectives. In the second scenario, doctors might engage with change and become champions of reform. There is increasing speculation that the medical profession is undergoing a period of significant change, in terms of roles and responsibilities. There is some

suggestion of the 'managerialisation' of the medical profession (Ferlie et al., 1996; Flynn, 1998; Exworthy and Halford, 1999). Medical professionals are increasingly involved in managerial functions, such as budgeting, allocating resources and evaluating performance, such as the clinical audit. According to Hudson (1999: 165), the origins of the doctor as manager lies in the implementation of the 1990 national GP contract, which introduced the concept of performance management, and linked pay to achievement targets. The 1997 Primary Care Act also removed many of the legislative and budgetary barriers to innovation in medical management. Health authorities have been able for the first time since the creation of the NHS in 1948, to suspend the national contract for GPs and commission their services directly (Hudson, 1999: 165). New pilot schemes based around the integration of medical and non-medical professionals points to a clear shift towards a 'mixed economy' of GPs subject to a range of contractual options. The development of new primary care initiatives will accelerate this trend, as some GPs will be forced to take on new responsibilities, including representing groups, communicating and soliciting agreement from colleagues, and other professionals, concerning commissioning decisions. This raises a number of socio-political issues concerning the politics of decision-making, power relationships within groups and changing occupational and professional roles, within the multi-organisational, multi-professional context. Marks and Hunter's (1998) survey evidence shows GPs are both optimistic and pessimistic about their new responsibilities. New primary care organisations are seen as more democratic and egalitarian by giving a voice to all GPs and primary care teams, but alternatively there is concern that accountability will be difficult to achieve within groups without sanctions for 'non-conforming' GPs who might attempt to remain outside the 'accountability culture' (Marks and Hunter, 1998: 21).

As highlighted throughout this chapter, and in earlier chapters, the development of cooperative relationships across organisational and professional boundaries is at the heart of the Government's health care reforms. GPs will be expected to work in partnership with the wider primary care team, and to work more closely with social services, carers and patients, in the planning and commissioning of services. While the TPP experience showed little evidence of working across the health-social care boundary (Myles et al., 1998), it did contribute to an overall improvement in the level

of communication between primary and secondary care providers, as noted by Robinson et al. (1998). More recent primary care initiatives aim to achieve a much higher level of collaboration. Guidance from the NHS Executive for primary care groups specifically emphasises the importance of joint-working noting that:

*“No one agency or group of staff is likely to be able to achieve all that is being asked of PCGs on their own. Successful PCGs will be those that can harness the range of skills necessary to learn and work together for an effective partnership which will improve patient care.... The benefits of PCGs will only be achieved if GPs, nurses, other health professionals, managers, social services, Health Authorities, NHS Trusts and the public are able to develop an effective partnership”* (NHS Executive, 1998: Paragraphs 8 and 9).

According to some commentators, such collaborative initiatives represent a distinct threat to professional autonomy (Hudson, 1999: 169). By organising services around a locality-based unit, professionals might become subordinated to the localisation imperative. This is likely to lead to professional resistance, as observed by Exworthy (1994) in a study of community health services, and similarly by Burns et al. (1994). The incongruity here is that while GPs would be the main beneficiaries of devolution and decentralisation, they are the main potential source of professional resistance. Hudson (1999: 166) concurs with this view, asserting that:

*‘...while the partnership role looks formidable, it is important to note that the lead role has been given to a professional group,...which has yet to exhibit strong collaborative tendencies beyond its own professional concerns...’:*  
general practitioners.

It is difficult to foresee how the medical profession will succeed in achieving equitable and egalitarian collaboration with a range of other health and non-health parties. Normative arguments suggest that GPs may perceive multi-agency primary care groups as something of a threat to GP independence, particularly in terms of GP-patient relationships, as something that will increase workloads, and as a threat to GP financing. The PCG might be perceived as a threat to the long-standing independence of autonomous general practices. Unlike fundholding, where GPs and practices were free to remain outside, with voluntary options resulting in only positively minded GPs entering: full participation in PCGs is statutory. Hudson (1999: 170) comments that, *“many GPs fear that the hidden agenda is the demise of independent contractor status”*. Some GP fundholders, faced with the prospect of losing their budget-holding status, have critically claimed that the forcible corralling of GPs into PCGs could lead

to the break-up of the NHS (Shallcross, 1997). It is interesting to note that the GMS Committee of the British Medical Association (BMA) was initially favourable to the idea of PCGs however, by May 1998 the BMA was warning that it might ballot doctors on whether to withdraw cooperation unless the Government gave assurances on issues such as the freedom to prescribe, the avoidance of inherited debts from the health authority, and the avoidance of forced rationing of healthcare (Hudson, 1999: 170).

There is also some argument that GPs are more comfortable dealing with other medicine-based health care professionals, for example with secondary care medical consultants, than with other non-medicine-based Health Service practitioners, or with social services departments (SSD), local community groups, or patient representative groups (Ferlie and Pettigrew, 1996: 90). The development of new primary care organisations presents some opportunities for GPs, but also a number of threats to their status as self-governing and self-regulated independents. Of particular concern for GPs is the likely change to the doctor-patient relationship. For example, GPs have expressed anxiety about the affect of budget shortfalls and on how this might be viewed by the public. As decentralisation and devolution pushes responsibility down the healthcare chain-of-command, general practitioners are finding themselves in the front line of decision-making, especially in terms of resource rationing. Clearly, GPs are fearful that their position as patient advocate is threatened, as the boundaries of the medical profession are continuously forced into the realms of a managerial function. PCGs will be financially accountable to a health authority, but there is concern among GPs about overspending and resource allocation. There is some uncertainty surrounding penalties or health authority intervention for PCGs that overspend. Marks and Hunter (1998) found that many GPs were uncertain about the extra demands on time that would arise from involvement in new initiatives. In addition, many GPs pointed to a lack of reward or incentive for involvement. Such concerns raise some doubts concerning both GPs perceptions of primary care initiatives and their likely level of participation and involvement. GPs may express the view that PCGs are just another symbolic political attempt by Government to right the wrongs of the NHS.



## 5.11 Summary

This chapter has taken the research agenda forward by exploring issues of networking and organisational integration in primary health care. The chapter detailed the reform agenda in primary health and showed how the sector has undergone considerable change and restructuring following the election of a Labour Government in 1997 and the implementation of the White Paper on health, '*The New NHS, modern, dependable*' (DoH, 1997). During this period, the development of a primary care-led National Health Service has been a central focus of new Labour's health policy and modernisation programme, that has resulted in the abolition of fundholding arrangements and a move away from internal-market mechanisms towards more collaborative governance methods of primary care commissioning and provision. The most prominent and revolutionary aspect of change over this time has been the introduction of new primary care organisations, primary care groups in England and local health groups in Wales, with equivalent arrangements for Scotland and Northern Ireland. The PCG reflects the current trend in health care towards more cooperative and integrated working methods. PCGs are a new tier in the primary care hierarchy and are the focal point for an array of inter-professional and inter-agency relations. The primary care group reflects an attempt to keep a community or local focus at a time of large-scale integration and a means of engaging with health professionals that are often working alone in community care. PCGs aim to better integrate health professionals, link-up with allied agencies, such as local government and social services, and to interact with user groups and the voluntary sector. In this respect, the PCG represents an ambitious and innovative project of networking in primary health care.

This chapter also outlined the complex nature of the primary health care setting, with the general practitioner as the central figure in health care provision. The shifting of power from health authority to practitioner groups like primary care groups, represents an experiment in health care commissioning and provision, where the PCG is the organisational coordinating mechanism for integrating services and professionals. This collaborative organisational form and mode of working presents a unique range of challenges for policy makers, NHS managers, and health professionals. This chapter highlighted a number of potential opportunities created by

the introduction of primary care groups, such as increasing autonomy at the health care interface, involving a wider range of professionals in health care decision-making, particularly community nurses, and involving users. The chapter also highlighted a number of potential barriers to implementing collaborative-networking, the potential for professional resistance, the potential for GP dominance and a lack of experience and training in such working practices. Together, the challenges outlined above reflect the complex nature of the primary health care setting, with the general practitioner as the central figure in health care provision. The shifting of power from health authority to practitioner groups such as primary care groups in England and local health groups in Wales represents a shift in health care commissioning and provision, away from bureaucratic health authorities, to community professionals. The PCG or LHG, reflects the central organisational coordinating mechanism in a complex network of inter service and inter professional relations, integrating services and professionals. This collaborative organisational form and mode of working presents a unique range of challenges for policy makers, NHS managers and health professionals.

## 6.1 Introduction

This sixth chapter reports on the next phase of the research design, an investigation of change and policy implementation at the regional level of the National Health Service in Wales. The chapter focuses on the implementation and adaptation of health policy in primary health care in Wales. The chapter presents and interprets data extracted from an extensive review of secondary data and primary policy sources, and is informed and supported by field investigations, including specialist interviews with practitioners and policy makers. The aim of this review is to record and evaluate the application of central policy at the regional level and to identify key amendments and additions to national level health policy. An additional objective is to further explore the specific research context of primary health care within the regional context of Wales, specifically the emerging role of new local health groups in the commissioning and delivery of primary care services.

## 6.2 The National Health Service of Wales

The National Health Service in Wales provides a comprehensive range of health care services to members of the population in Wales. Care is provided on the basis of clinical need, as opposed to ability to pay. The majority of the population of Wales are concentrated in the southern counties, with over one tenth of inhabitants (295,600) situated in Cardiff, the Capital of the principality since 1955. The second most populated city is Swansea (189,400), some forty miles to the west, followed by Newport (137,200), a town twelve miles east of the Capital. In the north, Wrexham has the greatest number of citizens, with a population of 117,200. The population of Wales is rising steadily. In 2000, it stood at approximately 2.95 million, having increased from 2.89 million in 1991. By 2005, the population is projected to increase to 3 million. Almost 17% of the population are aged over 65. It is projected that 18% of the Welsh population will be aged 65 or over by 2011, and 20% by 2016 (Data are principally derived from '*Health in Wales: Chief Medical Officer's Report*,' 2001-2002). NHS Wales is currently expending a budget of almost £2.6 billion per annum,

which is due to rise to £3.6 billion by 2003-04 (National Assembly for Wales, data outputs 2002). The NHS is the largest employer in Wales, with 60,000 staff, representing more than 7% of the total workforce<sup>1</sup>. The functions of the NHS in Wales are divided into two main provisions, *primary* and *secondary* care. Primary care includes a range of services provided at local and community level, such as general practice services, dental services, local pharmacy, and additional medical and non-medical services. Secondary care generally refers to hospital-based services, but also includes emergency services. In addition, there are *tertiary* and *community* care services. These include specialist services provided by hospitals, such as dermatology, cancer and other specialist treatments. Community care generally involves the provision of health care by the NHS in partnership with local social services, and includes a range of services designed to meet the needs of local communities, for example, home-help for the elderly and services for persons with disabilities. The Wales NHS also provides specialist services to support medical diagnosis, treatment, and disease prevention, such as mobile breast cancer screening services.

The NHS in Wales is principally funded from direct taxation, with a small proportion of income derived from direct charges, commonly for NHS prescriptions and NHS dental treatment. In accordance with national legislation, NHS Wales provides a range of exemptions from charges, designed to ensure that health care is provided free of charge at the point of delivery. The National Assembly for Wales, the central Government body in Wales established in 1999, is responsible for policy direction and for allocating funds to the NHS in Wales. The Assembly allocates funds annually to each of the five regional health authorities: Bro Taf Health Authority, Dyfed Powys Health Authority, Gwent Health Authority, Iechyd Morgannwg Health Authority and North Wales Health Authority. The role of each health authority is to purchase health services from professionals within primary care, such as family doctors, dentists and opticians, and from the NHS Trusts that provide secondary and community health care services (the purchaser-provider split). In primary care, local health groups (LHG's) were established in 1999 within each health authority area, to provide a local focus for the development and improvement of Health Services (detailed in chapter 5). The National Assembly for Wales assert that the introduction of LHGs will make a

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<sup>1</sup> Internet Source: [http://www.abpi.org.uk/wales/wales\\_nhs.asp](http://www.abpi.org.uk/wales/wales_nhs.asp)

major contribution to the health and well-being of the population in Wales by participating in three main areas: the development of health improvement programmes (HIPs); developing the principles of clinical governance to improve the quality of primary health care; and informing and developing the commissioning of hospital and community Health Services (*'Improving Health Care in Wales'*, NAW, 2001a).

The range of primary and secondary care services provided by NHS Wales are administered and delivered by six important sub groups or divisions: local health groups, general practitioners, other community health providers, community health councils, and NHS Trusts. According to recent figures from the National Assembly for Wales (NAW, 2001d), there are approximately 1,900 family doctors in Wales, almost 1,000 dentists, and some 600 opticians represented by LHGs. The family doctor or general practitioner (GP) plays a pivotal role in health care access. The GP acts as a gateway to the NHS and its services. Following a consultation with a general practitioner, a patient may be referred to hospital or other specialist treatment centre (secondary care provider), where necessary. In addition to GP services, the NHS provides a range of additional community-level services, provided by health care providers working in the community, including: health visitors, midwives, community nurses, physiotherapists, occupational and speech therapists. There are also 22 community health councils in Wales, based roughly on local authority or historic county areas. Community health councils (CHCs) are statutory bodies representing the interests of patients and the public in the NHS in Wales. CHCs take up a wide range of health issues on behalf of the public. Health authorities are required by law to consult their local CHC if they propose major changes in the pattern of services. Unlike in England, CHCs are to be retained in Wales, although their functions and membership may be changed. The Assembly is currently looking at ways of doing this. Statements from the National Assembly suggest that community health councils will play a leading role in the new structure of the NHS in Wales (Welsh Health Minister, December 2001). Following a review of community health councils in Wales, Minister for Health Jane Hutt announced that:

*"The new structure of the NHS in Wales will provide an opportunity for local people to participate in decisions on the delivery of health care to local*

*communities. The existing network of CHCs is already well integrated and locally based, it is already well placed to fit into the new structure and play a leading role in it...I want to see the role of CHCs in Wales strengthened. The work that the councils do and the potential that exists for strengthening their roles is a central component of our public involvement strategy as set out in the health plan Improving Health in Wales...I will be consulting on my proposals for the future strengthening of CHCs in Wales in the New Year, but I do not intend to change the number of CHCs in Wales. They have an important role to play in representing the public and I want to see that role enhanced so that they will better meet the needs of patients and of the Health Service.”<sup>2</sup>*

Secondary care services in NHS Wales are administered and provided by 15 NHS Trusts, including one All-Wales Ambulance Trust. Each NHS Trust is responsible for managing hospital and secondary care services. There are a total of 135 hospitals in Wales, with a capacity of some 15,000 beds. Over half a million people, one sixth of the total population of Wales, are admitted to hospital each year (*Health in Wales: Chief Medical Officer’s Report*, 2001-2002).

### **6.3 Health Policy in Wales: 1997-2003**

The 1998 White Paper, *‘NHS Wales: Putting Patients First’* (Welsh Office, 1998a), set out the framework for the development of Health Services in Wales. In policy terms, the 1998 White Paper broadly follows the same themes of the 1997 White Paper for England. However, the modernisation agenda in Wales has led to some amendment of central health policy. The National Assembly has specifically set out policies to tackle social and economic deprivation across Wales, as part of broad spectrum of health and social care reform. In particular, the publication of the Green Paper, *‘Better Health Better Wales’* (Welsh Office, 1998f), in conjunction with the Strategic Framework document (Welsh Office, 1998e), set out the Assembly’s plans for improving health care via LHGs.

Local health groups in collaboration with other agencies, particularly local authorities, have been tasked to take a central role in promoting social inclusion and strategies aimed at improving health and social services at community level. *‘Better Health Better Wales’* (1998f), *‘Developing Local Health Alliances’* (NAW, 1999a) establishes

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<sup>2</sup> Internet Source (21 December, 2001) <http://www.wales.nhs.uk/pressnotices/health-councils-e.htm>

a best practice framework by which local authorities need to focus attention on action to improve the social, environmental and economic determinants of health. Following *'Improving Health in Wales: A plan for the NHS with its partners'*, the NHS Plan for Wales (NAW, 2001a), local authorities and local health alliances are to coordinate with local health groups to *'tackle health inequalities and the wider issues that impact on peoples' health including: housing, education, and economic development'*. Accordingly, the building of effective collaborative joint-working relationships, are a prerequisite for identifying needs and as a mechanism for addressing inequality. As such, the collaborative governance philosophy has been strongly evident in health policy in Wales since 1997, perhaps at a more concentrated level than in England (reference to chapter 4). As in England, the focus of the modernisation agenda in Wales has been directed towards primary care and the development of a primary care-led NHS. This parallels the rationale of the 1997 Health White Paper (DoH, 1997) and the NHS Plan (DoH, 2000). Table 1 below lists some of the important policy documents and developments in health care in Wales between 1998 and 2002. Table 2 below illustrates the major themes and objectives for reforming the primary care sector of NHS Wales, and to a greater extent the entire NHS Wales.

**Table 1 Major Policy Publications and Events in Wales (Circa 1998-2002)**

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15/01/1998	Putting Patients First - White Paper
14/05/1998	Better Health Better Wales - Green Paper
15/10/1998	Better Health Better Wales - Strategic Framework
01/02/2001	Improving Health Care in Wales: A Plan for the NHS with its Partners
16/07/2001	The Future of Primary Care: a consultation document
19/07/2001	Improving Health in Wales: Structural Change in the NHS in Wales
12/09/2001	Directions by the National Assembly to Health Authorities - functions of LHGs
15/01/2002	Improving Health in Wales: From Plan to Action
29/01/2002	Structural Review in the NHS – Summary of Decisions

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Source: Welsh Office; National Assembly for Wales; and NHS Wales

**Table 2 National Assembly for Wales Policy Aims**

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1. To address the relative under-development of primary care in Wales, through investment in staff, capital projects, and organisational development.
  2. To reduce the demand on primary care professionals by increasing staffing numbers, in primary care medicine, nursing, and in professions allied to medicine.
  3. To develop primary care teams, to work closely with public health, health promotion and appropriate secondary and tertiary services.
  4. To further develop primary care as part of a 10 year plan for improvement.
  5. To develop primary care resource centres to support existing practice-based models, by providing a range of local services, dietetics, physiotherapy, chiropody, speech therapy, and occupational therapy, as part of a 'new model of primary care'.
  6. To address inequality in service provision, by providing generalist care via an integrated team of primary care professionals, to work closely in partnership with social care and the voluntary sector.
  7. To restructure professional training and development and to disseminate 'best practice'.
  8. To promote new modes of entry or access to primary health care services, as through NHS Direct.
  9. To prioritise the development of primary care information, information technology and communication systems infrastructure, as part of the National IM&T Development Plan for the NHS.
  10. To support an evidence-based learning culture within primary care in Wales to improve service effectiveness.
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Source: Revised Executive Summary of 'Key Themes and High Level Objectives' from the July 2001 consultation document on '*The Future of Primary Care*' (National Assembly for Wales, 2001c)

#### **6.4 Networking: An Emerging Theme and Practice across NHS Wales**

In Wales, the integration of service providers and health professionals via collaborative networks has become an increasingly important agenda item for the regional Government of Wales, the National Assembly for Wales. According to the Chief Medical Officer's report (2002), understanding of what makes a good network includes:

- ownership of the network and its work by all stakeholders, or a clearly identified 'client'; the purpose of the network being agreed by all stakeholders
- the network should have clearly defined aims and a strategy to realise them
- its activities must form an integral part of the work of each stakeholder



- there must be coordination and a clearly identified lead individual
- stakeholders must be clear as to, and committed to, delivering their individual role
- there must be appropriate resources, good communications, and expert, administrative, secretarial and information support
- evaluation to test whether the network adds value at a reasonable cost

The Chief Medical Officer for Wales, Dr. Ruth Hall, explicitly highlights the emergence of networks in the delivery of health care in Wales, stating that:

*“One way of addressing shortages of expertise, as well as raising standards, is by medical and other staff working together in networks. Networking can assist with the optimal deployment of resources and skills and the avoidance of duplication of effort. It can also allow more uniform provision of essential services and specialist expertise, and can improve training, professional development and job satisfaction”* (‘Health in Wales: Chief Medical Officer’s Report’, 2002a).

In Wales, there has been some effort to establish and invest in managed clinical networks. The main aim of more integrated working practices is to make optimal use of resources, particularly with respect to specialised staff, and to integrate care across various organisational boundaries. Networks are also viewed as a means of improving access to care and as a mode for ensuring consistent and agreed clinical standards, based on national service frameworks or their equivalents, and guidance from the National Institute for Clinical Excellence to improve the outcomes of treatment. These networks are made up of NHS partners and health professionals from within each network area. The NHS Plan for Wales (NAW, 2001a) has called for managed clinical networks to be established for cancer and coronary heart disease. The emergence of such managed networks in clinical settings may hold lessons for other areas. Indeed, the potential for a managed public health network is to be considered as part of the review of the public health function in Wales.

The ‘network paradigm’ is also evident in policy discourse and practices in primary health care in Wales. The 2001 consultation document on ‘*The Future of Primary Care*’ (NAW, 2001c) introduces a number of important recommendations for developing primary care in Wales. At the heart of the reform programme is a message for all health care agencies and professionals to work together in a more integrated

fashion, to be collaborative and to make new partnerships with providers, users and stakeholders. Jane Hutt, the Minister for Health and Social Services, states that:

*“Our aspiration is to turn the objective of a primary care led Health Service into a reality through investment in and development of primary health care teams throughout Wales” (July, 2001).*

In addition, in primary care there are increasing efforts to form new relationships and linkages with a range of agencies and stakeholders. Local government has been given a wider role in improving health care in Wales over the last two-four years. Addressing the Welsh Local Government Association (WLGA) conference in September 2002, Jane Hutt, Minister for Health, stated that:

*“Local Government has key responsibilities for social care, for children’s services and for housing, and these also support public health protection. Its vital role in the prevention of ill-health and promotion of better health has long been recognised...one of the key ways in which things are going to be different in Wales, after next April, is that our new structures are designed to bring together local government and health interests, at the point where essential decisions are made”<sup>3</sup>.*

The promotion of partnership between NHS health care agencies and health care interest groups is clearly evident in the relationship between the NHS and the voluntary sector. Partnership and inclusiveness between main stream health care providers and voluntary groups, particularly carers and community health groups, has emerged as an important topic in recent policy publications by the National Assembly for Wales. Again, cooperation rather than competition, is at the heart of the Welsh Assembly’s aims and values. Minister for Health, Jane Hutt suggests that in future relations will form the core of the work of the NHS in Wales:

*“The voluntary sector, business and local government are right at the centre of the Assembly’s policy making. They form the three core partnerships that underpin all the Welsh Assembly Government’s work. Partnerships are fundamental to all our work and we are particularly keen to forge a strong partnership with the voluntary sector. We are not just committed to making partnerships work, we are committed to making them work more effectively for the people of Wales. Partnership and dialogue are the key to the future, by working in partnership we can achieve far more than by working in isolation. It is important that we continue to work together, to share ideas and experience. Only by discussion and dialogue can we move forward constructively” (Press*

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<sup>3</sup> Internet Source: (September 6, 2002) <http://www.wales.nhs.uk/documents/Local-Government-has-key-role-in-improving-health-says-Jane-Hutt-e.htm>

Release, 6 June 2002).

Since the election of the Labour Government, there has been increasing emphasis on developing links between the public and private sectors, such as public-private partnerships (PPP) and public financing initiatives (PFIs). In Wales, there has been less emphasis on such public-private collaborations. The thrust of the reform agenda has been directed at evolving more inclusive and responsive services; that provide a broad range of joined-up services, whereby the gaps between health, social care, and public health, are eradicated, and whereby the user is involved in service development. Importantly, newly introduced local health groups are the manifestation of this collaborative policy and practice, and are the focal point for the delivery of the goals set by the National Assembly for Wales. It is the task of local health groups, and their successor local health boards, to deliver on the promises of '*Better Health, Better Wales*' (Welsh Office, 1998f).

## **6.5 The Emerging Role of Local Health Groups**

Local health groups were established in Wales in April 1999 as the formalisation of the Welsh Assembly plan to improve primary health care by promoting primary care-led commissioning and provision, as set out in the White Paper '*Putting Patients First*' (Welsh Office, 1998a). Local health groups (LHGs) are multi-disciplinary primary health advisory and delivery bodies. There have been 22 LHGs in operation across Wales since 1999. Each LHG acts as a forum for inter-professional and inter-agency working. Each LHG is controlled by an executive board comprising of: one general manager, six general practitioners (GPs), two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member and one lay person from the community. LHGs also have the option to include additional co-opted members to advise them on specific issues. The key strategic role of the LHG is to give a more local focus to health planning and to develop integrated health and social care services that better meet the needs of local communities. The most distinguishing feature of the policy that helped create LHGs, is the new level of emphasis placed on partnership and cooperation between primary health care providers. As such, LHGs are under a statutory obligation to develop collaborative partnerships with other relevant stakeholders. In

January 1998, the White Paper, *'Putting Patients First'* (Welsh Office, 1998a), described the Wales Assembly's goal for restoring the NHS in Wales *'as a genuinely public service of high quality, delivered in cooperation with others to protect and improve health as well as respond to illness and disability'*. These plans, elaborated in *'Better Health, Better Wales'* (1998f) and subsequent strategy papers, established seven core values that were to underpin the development of health care services in Wales. The seven values are:

- Fairness
- Effectiveness
- Efficiency
- Responsiveness of care to individual needs
- Service integration
- Accountability
- Flexibility of approach
- Promoting independence<sup>4</sup>

The role of the LHG is wide, involving a range of tasks and objectives relating to the planning and service development of primary health care at a community level. One of the key objectives of LHGs is to work with other agencies to improve health care for local populations. LHGs were established as the focal point for integrating health and social care provision for community-level populations. Welsh LHGs have been expected to encourage a high degree of partnership and inter-agency collaboration (Wyke et al., 1998), such as devising and implementing local health improvement programs (HIPs), in accordance with national guidelines and health improvements targets. Specifically, LHGs are to engage in contributing to a health improvement programme (HIP), developing primary care, integrating care delivery, and future commissioning of services (*'Putting Patients First'*, 1998a; 1998b).

There are a number of observable differences between the focus and composition of LHGs in Wales and primary care groups (PCGs) in England. In particular, LHGs encompass a broader approach than that of the 'primary care lead' role of PCGs

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<sup>4</sup> Since 1998, *promoting independence* has been added as an additional value.

(Audit Commission, 2000: 1). In addition, LHGs are seeking to tackle a wider prescribed list of health care issues, a direct result of the localised initiatives of the National Assembly for Wales. In structural comparative terms, LHGs involve a larger board of executive members, representing a wider collation of primary care professionals. Lastly, the LHG maintains common boundaries with unitary local authorities, whereas PCGs cover general practice zones. In policy terms, the aims of both LHGs and PCGs are similar. However, in operational terms, there are number of relevant and informative differences between the two. Geography: the geography of Wales and England differ considerably. The population of Wales, approximately 3 million, is considerably smaller than the population of England, at almost 50 million (Office of National Statistics, 2001: table A). Mortality and Morbidity: Wales continues to experience higher mortality and morbidity instances than recorded in England (*'Health in Wales': Chief Medical Officer's Report, 2001-2002*). In 2000, there were 33,500 deaths in Wales, a mortality rate of 711 per 100,000 population. Financial Deficits: the Wales NHS is comparatively in more debt than the NHS in England (Audit Commission, 2000: 4) although it is noted that funding arrangements are not easily comparable. Overall, differences in geography, financing, prevalent health problems of mortality and morbidity, and differences in size and infrastructure, have resulted in relatively extensive reconfigurations in NHS Wales. In particular, policy developments since 1998 in Wales, such as *'Better Health Better Wales'*, have placed greater emphasis on fostering new partnerships to tackle wider public health issues, as opposed to the primary care lead strategy of PCGs in England. LHGs in Wales, in cooperation with health alliances, tackle wider health and social care issues in a more inclusive and cooperative framework than in England. Of particular importance is the role of LHGs as interim configurations, developed to create a period of stability before abolishing health authorities and devolving HA responsibilities to local health boards, introduced in 2003. The wider and more inclusive approach taken by LHGs in Wales is clearly evident in the composition of LHG boards. LHGs have a more diverse membership than PCGs, including a range of primary care professions other than medicine: a community pharmacist, a dentist and an optometrist, a second local authority (LA) representative, two officers, one from social services and one from another department such as environmental health, environmental safety, housing or strategic planning; and a representative of a local voluntary organisation; and a lay

LHG board member, specifically appointed to represent the local community (figure 1 below).

**Figure 1 Board Composition of LHGs and PCGs<sup>5</sup>**

	Local Health Group		Primary Care Group
	Executive	Other	
<b>GPs</b>	2	4	6-7
<b>Dentist / Pharmacist / Optometrist</b>		3	None
<b>Nurses</b>		2 (including 1 practice nurse)	2 (community or practice)
<b>HA</b>	1	1	Non-executive Member
<b>LA</b>	1 (from social services)	1 (from another department)	Social services Officer
<b>Local Voluntary Organisations</b>		1	None
<b>Lay Member</b>		1	1
<b>General Manager / Chief Executive</b>	1		1
<b>Total</b>	17-18		10-13

Source: From National Assembly for Wales (NAW) and National Health Service Executive (NHSE) guidance notes

For each LHG in Wales, joint-working takes place across a number of levels, from the internal relationships between members, to the external relationships between LHGs themselves and between LHGs and other agencies, such as social services or local government. In Wales, local health groups were established to promote joint-working

<sup>5</sup> LHGs have a wider board membership than PCGs and are required to have an executive committee.

initially, however the plan is for local health groups to become independent joint-commissioning bodies. The inclusive representation of LHGs reflects the new emphasis placed on cooperation in primary health care. Since 1999, LHGs have been steadily building new partnerships with a range of agencies and professional groups. Notable links are being formed between LHGs and the following agencies or services as part of the new remit of LHGs:

- Local Community Professionals: GPs, nurses, optometrists, dentists, pharmacists
- Local Government and Local Authorities
- Health Authorities
- NHS Trusts
- Secondary Care Hospitals and Specialist Care Services
- Social Services
- Patient Advocacy Groups
- Voluntary Groups
- Public Health
- Police, Fire Services, Ambulance Services<sup>6</sup>

The expectation is that almost 75% of the health budget will be devolved to LHGs, or their successor groups (LHBs), to jointly tackle local health and social care needs in cooperation with the partners outlined above (NAW, 2002b). A major part of the new collaborative agenda of LHGs is the joint-commissioning of health care. Joint-working in primary health care is commonly viewed as a process involving a range of activities, including exchanging information, shared decision-making, or joint service delivery. *“The strategic activity of assessing needs, resources and current services, and developing a strategy as how best to use available resources to meet need”*(Department of Health, 1995a). The term joint-commissioning has been the source of debate. Joint-commissioning general refers to activities of cooperation across health and social care and is focused on the joint-delivery of services. *“The process when two or more commissioning agencies act together to coordinate their commissioning, taking joint responsibility for translating strategy into action”*(Department of Health, 1995b).

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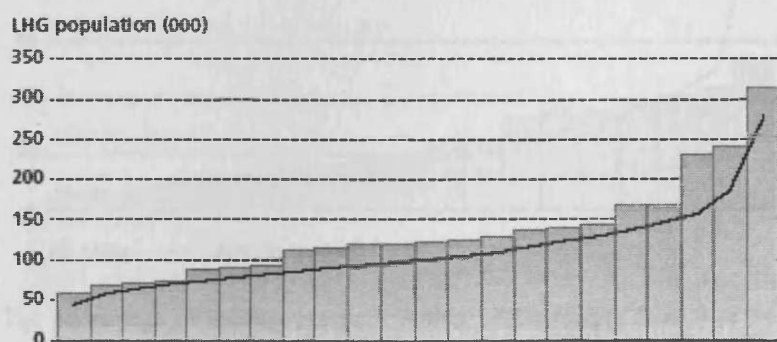
<sup>6</sup> Point made about LHG networking ties using insights from data in chapter 7

## 6.6 Data on Local Health Groups in Wales

This section presents a range of data derived from multiple sources to assess the magnitudes and variances between LHGs in operation across Wales and to illustrate the range of health activities currently undertaken by local health groups.

There have been 22 local health groups (LHGs) in operation in Wales since April 1999. They are defined in terms of unitary authority boundaries. Each LHG covers the same area as a unitary local authority. This congruence between existing health and local authority zones and LHG areas of coverage arguably provides LHGs in Wales with considerable advantages for joint-working and integrated planning of local services, as compared to PCGs in England operating according to geographical and population boundaries. However, this does mean that LHGs vary in considerably in size, containing large variations in numbers of general medical practices, Cardiff having the largest number of practices with 56 and the Isle of Anglesey with 11 (NAW, 2001c; table 3 below). In addition, LHGs cover areas with populations ranging from 58,000 to 315,000, with an average population of 133,000, approximately 25% larger than PCGs with more homogenous 100,000 populations covered. Finally, this diversity among LHGs also means that LHGs vary in the extent to which GP members' experiences of working in commissioning, either through former fundholding arrangements, or locality commissioning groups.

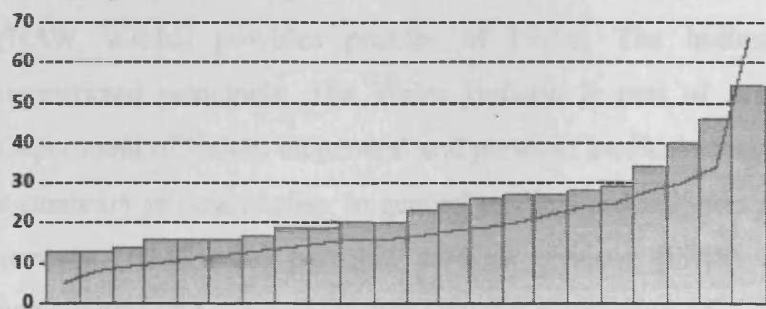
**Figure 2 Data on the Composition of LHGs in Wales Compared with PCGs**



LHG populations range from 58,000 to 315,000. On average, they are 25 per cent bigger than English PCGs.

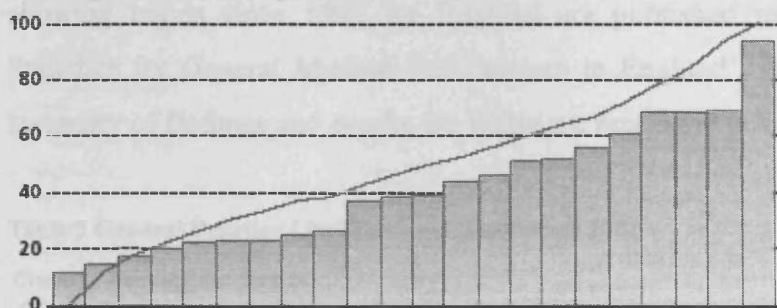


Number of general medical practice



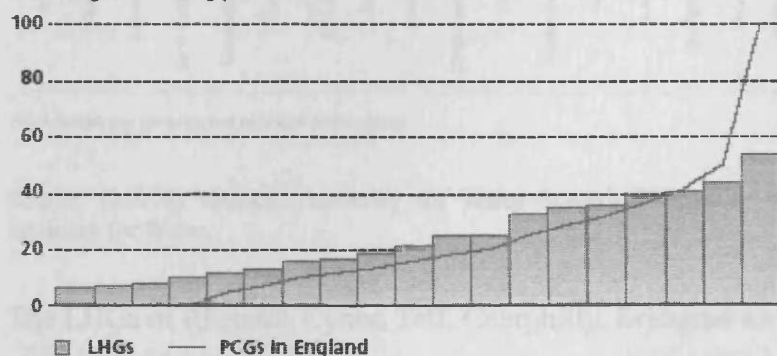
Each LHG covers between 11 and 56 general medical practices; more on average than English PCGs...and unlike PCGs, LHGs also cover community dental practices, opticians and pharmacies.

Percentage of ex-fundholding practices



The percentage of ex-GP-fundholding practices in LHGs ranges from 12 to 94 per cent. However on average there were fewer fundholders in Wales than in England and fewer general medical practices across Wales had prior experience of collaborating to commission services, (although in 2 LHGs, all participated in locality commissioning).

Percentage of training practices



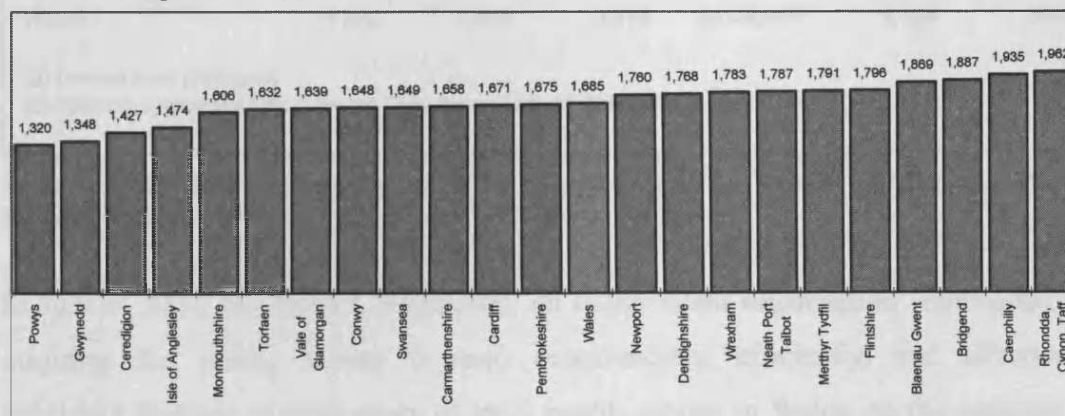
The percentage of training practices within LHGs ranges from 7 to 54 per cent: this is a more even distribution than across PCGs in England

Source: Findings from the Audit Commission Survey of LHGs – Audit Commission (2000: 6).

The National Assembly for Wales 'Statistics Directorate Bulletin Report' on LHGs (NAW, 2001d) provides profiles of LHGs. The bulletin concentrates data on unrestricted principals. The Wales Bulletin is part of a larger publication by the Department of Health on general and personal medical services statistics, and contains a summary of data relating to general medical practitioners providing general medical services (GMS) and personal medical services (PMS) in Wales, their patients, partnerships and services. It also includes a summary of data relating to GP practices below a minimum standard and removals and transfers of patients on GP's lists. The data collected within the GMS and PMS census mainly originates from the GP's quarterly payments and registrations system. Summary statistics based on these data, showing trends since 1991 for England are published in the 'Statistics Bulletin: Statistics for General Medical Practitioners in England' (DoH, 1991-2001). A brief summary of findings and results for Wales are presented below:

**Table 3 General Practice List Sizes as at September 2001**

**Chart 1 Average list Size (a)**



(a) Average per unrestricted principal within group.

Source: (2001d) National Assembly for Wales Statistical Bulletin: General and Personal Medical Statistics for Wales.

The LHGs of Rhondda Cynon Taff, Caerphilly, Bridgend and Blaenau Gwent have the four of the largest average list sizes. Merthyr Tydfil and Blaenau Gwent LHGs have the largest percentage of GPs aged 55 and over. Blaenau Gwent have the largest percentage of GPs practising single-handed. Dispensing doctors are concentrated in rural LHGs. Cardiff has the highest number of general practitioners, with 58 practices serving 339, 531 patients (table 4).

**Table 4 Bulletin Report on LHGs in Wales as at 30 September 2002**

<u>Local Health Group</u>	<u>Number of GPs (a)</u>	<u>Estimated Wte</u>	<u>Practice staff (Wte)</u>	<u>Registered patients</u>	<u>Average list size (b)</u>	<u>Number of practices</u>
Blaenau Gwent	36	34	100	74,714	2,075	20
Bridgend	82	78	177	154,764	1,887	20
Caerphilly	94	90	234	179,140	1,906	34
Cardiff	201	178	467	339,531	1,689	58
Carmarthenshire	101	94	239	166,609	1,650	26
Ceredigion	65	60	129	92,372	1,421	16
Conwy	67	62	150	113,645	1,696	19
Denbighshire	54	52	137	96,442	1,786	14
Flintshire	75	72	183	142,086	1,894	26
Gwynedd	92	85	180	126,630	1,376	29
Isle of Anglesey	44	40	135	64,941	1,476	11
Merthyr Tydfil	33	31	78	57,168	1,732	13
Monmouthshire	56	51	125	92,348	1,649	14
Neath, Port Talbot	75	73	175	134,476	1,793	23
Newport	82	75	181	141,772	1,729	23
Pembrokeshire	67	63	155	113,435	1,693	18
Powys	95	84	206	131,201	1,381	17
Rhondda, Cynon, Taff	120	115	349	239,204	1,993	44
Swansea	140	129	274	232,963	1,664	37
Torfaen	57	50	111	92,860	1,629	14
Vale of Glamorgan	71	64	32	115,015	1,620	18
Wrexham	75	70	157	135,143	1,802	22
<b>Wales</b>	<b>1,782</b>	<b>1,649</b>	<b>3,973</b>	<b>3,036,459</b>	<b>1,704</b>	<b>516</b>

(a) Unrestricted principals.  
(b) Patients registered with relevant GPs irrespective of where the patient lives.

Source: (2002) National Assembly for Wales Statistical Bulletin: General and Personal Medical Statistics for Wales.

In July of 2000, the Audit Commission, an independent organisation responsible for ensuring that public money is used economically, efficiently, and effectively, published findings of their study of local health groups in Wales, on the progress of LHGs. The report, '*Local Health Groups in Wales, The First Year*' is the first Audit Commission publication on LHGs and follows two earlier reports on the progress of PCGs in England (Audit Commission 1999; Audit Commission, 2000b). Findings from the Audit Commission's study of LHGs over their first year (April 1999 –April 2000) reveal that LHGs have devoted considerable effort to building new collaborative relationships with local clinicians, healthcare providers, voluntary organisations and local authorities. LHGs have been instrumental in contributing to the newly formed local health alliances and in setting clinical governance baseline assessments and structures, embracing all local health care providers. However, LHGs have made less initial progress than many PCGs on specific aspects of clinical

governance, primary care development and commissioning. The Audit Commission report concludes that the overall performance of LHGs has been positive. The Commission recorded LHG boards appear generally to be working well on issues of inter-professional working and clinical governance, wider local health needs assessment, care pathways, and on collective decisions on the future of practice-based services. The Audit Commission concluded that:

*“LHGs have yet to face the most difficult issues...their accountability to the health authority (HA) and the public must also now be put on a firmer footing and efforts to involve patients and the local community strengthened” (2000:1).*

A survey of managers revealed a number of factors inhibiting LHG development including: time pressures and inadequate staffing (averaging 8 WTE); poor information and IT; insufficient funds to facilitate change; loss of interest due to a perceived lack of influence and of clarity as to future LHG roles. The Audit Commission Report (2000) suggests the development of LHGs over the next five years may be varied, depending on two critical factors, the size of the LHG, and existing experience of joint-working or joint-commissioning among members. Overall, the report concluded that LHGs need to make effective use of their resources and that members should work collaboratively to formalise support arrangements with HAs and NHS Trusts. The Audit Commission report also concluded that LHGs require an agreed development path, involving organisational audits to identify development needs, and clear delegated responsibilities, in conjunction with clear long-term goals that can be tailored to local circumstances.

There have been relatively few studies of joint-working initiatives in NHS Wales, as compared with England. This is partly a consequence of scale and resources, but is also explained by the rapidly changing context of health care in Wales. A number of studies have attempted to examine the joint-working and inter-agency capabilities of health and social care agencies, with particular emphasis now placed on new local health groups. Of particular interest are projects by Lyne et al. (2000), on the effectiveness of interventions designed to reduce or remove barriers to change in inter-agency working; by Hayes et al. (2000), an assessment of health care outcomes from collaboration between health and local government agencies; by McClelland et al. (2001), on the effectiveness of models of primary and community care

commissioning, and more recently; and by Link et al. (2001), a study of the inter-agency working capabilities of local health groups.

The study by Lyne et al. (2000) considered the effectiveness of interventions designed to reduce or remove barriers to the changes needed if health and social care agencies are to work collaboratively. As in earlier studies in this area, the methodology of the study involved a systematic review approach, covering a wide spectrum of literature, including social care, health care social science, social occupational psychology, management and organisational studies. Lyne et al. (2000) reviewed the evidence originating from the level of the practitioner. The study records a number of principal findings. First, that there is very little evidence of effectiveness of methods to overcome the barriers to change, from either well-designed trials or from experimental trials. Second, there is some evidence that shared learning is an effective way to reduce inter-professional stereotypes between doctors and social workers. Third, there was weak evidence of the effectiveness of quality improvement programs and inter-agency training. Fourth, critical success factors for programs designed to remove barriers to change can be inferred from experience of those who have tried them. Fifth, the reporting of program evaluations requires methodological and policy improvements. Lyne et al. (2000) suggest that ‘in the absence of strong evidence of effective inter-agency learning environments...some form of reporting and evaluation device should be incorporated, for example programs dealing with communication barriers should use communication audits as part of their evaluation, similarly quality improvement programs should be supported in a consistent and sustained manner over a period of time’. The reviewers state:

*“Planned programs should take into account the factors necessary for success which are suggested by practical experience, such as the need to prioritise changes, to introduce change incrementally rather than suddenly and to support those who are involved in the change during the time necessary to establish the change in the organisation”* (Lyne et al. 2000; Report Conclusion).

Lyne et al. (2000) conclude important aspects of health and social care require non-experimental investigation.

The study by Hayes et al. (2000) aimed to identify if collaboration between health and local government agencies affects health, and if so, which configurations of

collaboration are most likely to effect health improvements. Collaboration between agencies was viewed in terms of ‘working together towards an agreed set of goals’. The study adopted a systematic review methodology, involving a literature search to identify research papers from 1974-1999 reporting comparative trials of interventions between relevant agencies that included health outcomes in their results. Data collected from primary research papers were used to define and identify health outcomes, which were later categorised into mortality, morbidity, and lifestyle outcomes. The study reported 11 systematic reviews, of which 6 focused on health promotion campaigns, 4 examined some form of chronic disease management, and 1 explored health benefits arising from school nursing. The results showed that only 4 recorded health benefits, however none of these could be linked to collaboration as a direct cause. 52 papers on comparative trials were also included. This included 32 health promotion initiatives and 20 relating to chronic disease management. 27 papers reported health benefits, but 16 of these expressed concern about the quality of work and a further 6 used enhanced services. Only 5 papers reported health gains that could be attributed to collaborative initiatives. Hayes et al. (2000) broad systematic review failed to identify clear evidence supporting the idea that ‘collaboration leads to health gains’. The reviewers concluded that:

*“More research is needed on how to make collaborative working arrangements successful. All work where an agency is committing resources to a service should include a measure of some form of outcome relevant to that agency, to monitor progress”* (2000: 10-15).

The systematic review of health outcomes from collaboration between health and local government agencies conducted by Hayes et al. (2000), suggests that while there is little conclusive evidence of any health gain from inter-agency collaboration, this does not imply that collaboration is benign in effect, rather on balance *‘it is likely that other variables are more significant for effects on health gains than the presence of collaboration’* (2000: 10-15).

A more recent study by McClelland et al. (2001), aimed to identify the extent to which existing research into the effectiveness of primary and community care commissioning can guide future policy and organisational developments. The methodology of the study also adopted a systematic review of all major health and

social care electronic databases. Over 25,000 references were initially retrieved and were assessed for inclusion in the review using pre-determined selection criteria for judging the quality of studies, and this aided in the selection of 45 secondary studies for further examination. Data extracted from the 45 studies were synthesised to produce a set of themes, which were presented as findings. A wide variety of models of commissioning emerged and the following types were characterised as part of the review:

- Health Authority Commissioning
- GP Fundholding
- GP Commissioning
- Locality Commissioning
- Joint-Commissioning
- Care Management/Local Authority Commissioning
- Total Purchasing Project

A number of important outcomes emerge from the study. Firstly, there is some suggestion that newly formed local health groups continue to suffer from the problems of transaction costs, where consideration needs to be given to demonstrating that the benefits of new models outweigh the costs. Second, in order to retrieve some benefit, the evidence suggests that models need to exist for a sufficient period of time and require clear objectives. Third, GP-lead commissioning models have effected some changes in the delivery of primary care based services, but few changes have been made to hospital services, and consideration needs to be given to developing levers to affect secondary care services. Fourth, issues of equity between commissioning models were of concern and mechanisms should be considered to ensure equity for those served by different LHGs. Fifth, responsiveness and accountability to service users and the general public remained under developed and efforts and tools need to be developed to involve key stakeholders. Sixth, partnership with other agencies remained difficult to achieve in all models with exception of joint-commissioning, where lessons can be drawn in the developing joined-up working arrangements. McClelland et al. (2001) provide a range of conclusions and recommendations relevant to the future development of commissioning at primary

and community care level, that highlight the importance of professional engagement and cooperation between agencies and professionals.

The study by Link et al. (2001) is the most recent of the studies presented here. The study investigated how local health groups can collaborate effectively with other partners to improve health in line with the combined health and social care agenda espoused in '*Better Health Better Wales*' (Welsh Office, 1998f). Phase I of the study is divided into two principal sections. Section 1 reviews the literature to identify best practice in inter-agency working, while section 2 reports on findings from a postal survey of all LHG board members in Wales to identify methods of inter-agency working used by LHGs. Approximately 393 questionnaires were distributed and 143 of these were returned; a response rate of 38%. Findings from the study revealed that 70% of LHG members were fully involved in setting LHG objectives and agreed with these objectives. Almost 45% of members were satisfied with the achievements of their LHG to date, and 57% indicated that health authorities were reluctant to devolve responsibilities to LHGs. More than 52% felt that their LHG influenced the planning of services (*'Interim Report to the National Assembly for Wales Office of Research and Development'*, May 2001).

In terms of networking capabilities and inter-agency collaboration, the Linck et al. (2001) study provides initial insights into the operations and functions of local health groups. Findings from the study show that LHGs are most commonly collaborating with primary secondary health care and health promotion agencies, followed by local authorities and the voluntary sector. The vast majority of respondents indicated feeling that their LHG was collaborating effectively with other agencies and that good relationships had been built up with other agencies (69% and 67% respectively). However, a larger proportion (89%) suggested that there was considerable room for improvement in LHG inter-agency working. Time and resource constraints were cited as major inhibitors of relationship building. 61% of members considered training and joint-working with other agencies as useful for developing and forming relationships.

The above studies take a predominantly 'systematic review' approach. Research has focused on collecting and reviewing secondary findings and drawing inferences about



possible consequences for inter-agency working. There is a clear lack of rigorous empirical research that provides in-depth primary data on the processes and issues effecting collaboration in health care. All four studies: Lyne et al., 2000; Hayes et al., 2000; McClelland et al., 2001; and Link et al., 2001, assert a need for further research into collaborative working in primary health care and call for a wider methodological research approach. In particular, Hayes et al. (2000) and McClelland et al. (2001) recommend that the systematic review method taken by many health and policy researchers be widened to include non-experimental and qualitative evaluations. McClelland et al. (2001: section 1) state that:

*“Systematic reviews are a useful first step in management and policy research as a means of identifying gaps and drawing together evidence”.*

An additional problem reported by all the above studies concerned researching a ‘dynamic environment’ of health care, in which change occurs rapidly and often without clear guidelines or objectives, making comparable evaluation difficult. Overall, the above studies demonstrate a scarcity of evidence on collaborative working within health and social care at the primary care level in Wales. There is a particular lack of evidence on collaborative working at the strategic level. None of the above studies adopted a network analytical approach to the study of cooperative working in the NHS in Wales. While, the majority cited networking as a central feature of collaboration, none of the above studies explored the many central features and processes of network ties or relations (as identified in chapter 1).

## **6.7 Moving from Local Health Groups to Local Health Boards**

In July of 2001, the National Assembly for Wales published its strategy plan for the future development of the National Health Service in Wales titled, ‘*Improving Health in Wales: A Plan for the NHS with its partners*’ (NAW, 2001a). The overall objectives of the 2001 Plan are to achieve wide scale improvements in patient services and to raise standards in quality of care. To achieve these aims the National Assembly for Wales has followed the model set by the NHS in England, however the main divergence from England has been the plan to abolish health authorities and move HA responsibilities to new local health boards (LHBs), the equivalent to English PCTs. The Welsh Plan is based around a number of changes to NHS structures, principally in

primary health care. It also seeks to create a more inclusive and people-centred Health Service: that is easier to access and understand; that is more accountable for the actions it takes and the services it delivers; and a more democratically governed service (NAW, 2001a). As in the precursor 1998 White and Green Papers on Health, *'Putting Patients First'* and *'Better Health Better Wales'*, a central feature of the current approach to health care management is based around the development of new and dynamic partnerships within NHS Wales. Additionally, the future is likely to see further alliances across public-private boundaries with the private sector taking a greater role, as in England.

In July 2001, the National Assembly for Wales announced its plan for structural change of the NHS in *'Improving Health in Wales: Structural Change in the NHS in Wales'* (NAW, 2001e). This document outlined a number of significant organisational changes. At local level, local health groups are to be developed into local health boards and their role strengthened. They will take on new responsibilities for commissioning, securing, and delivering healthcare in their localities (NAW, 2001e). LHBs are to be directly accountable to their local population and more formally to the Director of the NHS Directorate (NHSD) and the Minister for Health and Social Services. The role of local government in health matters is to be enhanced by extending the membership of local health boards to include additional representatives from local authority members and the local population:

*"Local government will have a key role in developing and implementing a Strategy for Health and Well-being, working in consultation with a broadly based local Strategic Partnership"* (NAW, 2001e: 1).

In an attempt to elicit higher levels of accountability from the NHS, the National Assembly for Wales is seeking:

*'A new sense of leadership, direction and oversight to hold both local health boards and NHS Trusts fully accountable for their actions and the services they provide and commission'* (NAW, 2001f: 1).

This strategy involves a reasserting the Assembly's direct democratic control over the NHS and also includes a dimension of health economics for the implementation of nationally agreed strategic priorities. Across national and local levels, the Wales Government is seeking new ways of achieving health gain with increasing emphasis

on health measurement and health outputs. This goal has heightened the role of public health as a specialist service with NHS Wales. Public health is to form an integral part of the agenda for public protection, health promotion and preventative health. Table 5 lists the main role and accountabilities of future LHBs.

**Table 5 Key Accountabilities for Local Health Boards**

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- Assessing the health needs of their area and the effectiveness of their local health system through locally acquired information to support this process
  - Representing and meeting those needs by:
    - Securing and providing primary health care services
    - Securing community and intermediate care services (including locally organised mental Health Services)
    - Securing secondary care services (including mental health)
  - Holding the budget for primary, community, intermediate and secondary care services
  - Providing advice on the provision of tertiary services for their population
  - Developing local Health Services that are responsive to the health needs of the local population and which comply with the views of the user
  - Ensuring the delivery of primary care, community Health Services, intermediate care and community mental Health Services to their local area
  - Addressing inequalities in health in their communities
  - Achieving good quality health outcomes within an all Wales performance management framework
- 

Source: Extract from 'Improving Health in Wales: Structural Change in NHS Wales' (2001e: 5-6)

Local health boards are viewed as an attractive alternative to health authorities. The Assembly views the removal of the health authority system as “...*abolishing a tier in the current hierarchy between the Assembly and the patient*” (NAW, 2001e: 1-5). This example of change in managerial and administrative systems supports earlier argument from chapters 2 and 4, of a move away from hierarchy and bureaucracy to newer hybrid forms in the NHS. Recent policy and administrative developments in Wales are aimed at strengthening local and central organisations and are guided by three key objectives: making the NHS more accessible to patients; making the NHS more accountable for its actions and the services it delivers; making the NHS more democratic in the way it is governed (NAW, 2001a).

Since April 2003 onwards, local health groups are to be merged into larger local health boards (LHBs). It is proposed that local health boards become statutory bodies and take on a more corporate status (NAW, 2002b) with new powers, duties and obligations, consistent with their role as commissioners and providers of health services. LHBs are required to meet the requirements and standards of regularity and propriety established by the National Assembly for Wales. It is likely that LHBs will be asked to prepare and publish audited sets of accounts and annual reports on their financial status and on how budgets have been allocated. There appears to be increasing enforcement of financial accountabilities, a theme of centralised control highlighted by Klein (2001) in chapter 4. The proposals include two sets of objectives: shifting the emphasis from treating disease to improving health, and to increase the quality, effectiveness and efficiency of the health care system (NAW, 2001e: 5). Local health boards are tasked with a wide range of objectives, including:

- Improved access to patient centred primary health services
- Improved support for community health development
- Improved community health and intermediate care services
- Increased support for family-based care
- Stronger health protection programmes
- Increased support for informed community participation <sup>7</sup>

Each LHB is required to establish an executive committee comprising of a chair, a second GP (or two if the chair is not a GP), a HA and a LA representative, and a LHG general manager. There is no comparable requirement in England in PCTs. Whereas GPs form the majority of the boards of PCGs, in Wales, members of the LHGs and LHBs may select non-GPs, pharmacist, director of social services, or dentist, to act as chair or manager.

The distinct approach of Health Service reconfiguration in Wales has been founded on coterminosity between the remit of local authorities and local health groups, and future local health boards. This congruence of local government and local health agencies is perceived as an effective platform for the health and social agenda in

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<sup>7</sup> Source: *Improving Health in Wales: Structural Change in the NHS in Wales* (July, 2001: 5-6)

Wales. The recurrent discourse of health policy is of a more responsive Health Service, tailored to local needs. The National Assembly assert that the needs of local communities will be best served by the work of LHGs, and future LHBs, as a local solution to local problems. The future role of LHBs will be vast, having to recognise and respond to disparities of scale, health status, and inequalities in health and local working arrangements (NAW, 2001e). The new structure of the NHS has been designed to involve users and the public and to disseminate ideas and knowledge, in the two-directional learning and involvement loop, that encourages effective partnerships at the local and national levels. At the national level, the Health and Well Being Partnership Council, seeks to bring together different interest groups drawn from the NHS, from local government, the voluntary and independent sectors. The aim is to involve and communicate with NHS staff, professional interests and patient representatives, to ensure the overall direction and leadership of the new agenda for health and well-being (NAW, 2001e). At the local level, similar partnerships are planned, where the aim is to ensure that:

*“...service planning, commissioning and delivery contributes directly to the achievement of community strategies for the development of the whole area”* (‘Improving Health in Wales: Structural Change in the NHS in Wales’, 2001e: 8-10).

Another important area of strategic partnership building is the interface between health and social care services. The joining up of mainstream health and social service departments is one area in which new alliances are being formed. The National Assembly’s aim is to promote wider health and well being at the local level via integrated care and commissioning models that tackle health inequalities from multiple perspectives. This includes a wide range of local government, public health, housing, social care and community services, as well as voluntary and independent sector providers, working alongside the whole range of NHS services. According to the Assembly:

*“The Strategic Partnerships will require an extensive network of local players to ensure that the strategies are comprehensive, inclusive and responsive to local needs. The Health Alliance will provide the vehicle through which such wider referencing can take place”* (‘Improving Health in Wales: Structural Change in the NHS in Wales’, 2001e: 9).

A National Assembly Implementation Group has been given responsibility for implementation of a number of concepts and targets set out in *'Improving Health in Wales: a plan for the NHS with its partners'*. It has been proposed that there should be a new statutory duty on each local authority and local health board to work collaboratively to implement a strategy for health and well-being in each area. Local authorities and local health boards will also be required to cooperate with relevant NHS Trusts, and service providers in the independent and voluntary sectors, patient user and carer groups, the voluntary sector, and a wide range of related service interests including housing, education and community development. In addition, specialist public health will also play a role in this process. The Assembly intends that the establishment of strategic partnerships should be formalised in the new Health Bill. Each local strategy for health and well-being will have a direct relationship with the local community strategy required under the 2000 Local Government Act. The strategy for health and well-being will in turn provide a framework within which more detailed service delivery and operational plans may be taken forward by all partners. The strategy should therefore come to replace the strategic elements of health improvement plans (HIPs) and contribute to the health-related elements of the local community strategy.

The role of local authorities will be crucial in leading the development and implementation of strategic partnerships for health and well-being. This is in line with their responsibilities for leading the development and implementation of local community strategies, and other cross-cutting strategies such as that for crime reduction (Crime and Disorder Act, 1998), and to promote social, economic and environmental well-being (Local Government Act, 2000).

## **6.8 Summary**

This chapter reports findings following investigations of change and policy implementation at the regional level of the National Health Service of Wales. The chapter focused on the implementation and adaptation of health policy in primary health care in Wales. The National Assembly for Wales and NHS Directorate is responsible for overall policy and strategy for health and social care in Wales and is

accountable for the overall performance and management of NHS Wales. The devolution of power from Westminster to the Wales Assembly has provided the new Wales Government autonomy to adopt a regional approach to health and social care planning and provision. This has most often involved the modification of national health policy to fit with regional needs or objectives. The 1998 White Paper '*NHS Wales: Putting Patients First*' (Welsh Office, 1998a), set out the framework for the development of Health Services in Wales. In policy terms, the 1998 White Paper broadly follows the same themes of the 1997 White Paper for England. However, the modernisation agenda in Wales has led to some amendment of central health policy. The most noticeable development in NHS Wales over the past five years has been the creation of local health groups, rather than primary care groups, as in England. Introduced in April 1999, LHGs were established as the formalisation of the Welsh Assembly's plan to improve primary health care by promoting primary care-led commissioning and provision, as set out in the White Paper '*Putting Patients First*' (Welsh Office, 1998a). In their first year, LHGs acted as advisory sub-committees of health authorities. Over the subsequent four years (1999-2003), the remit of LHGs has increased to include the commissioning of local health services. Exactly 22 LHGs were established in Wales covering the same geographical boundaries as 22 local authorities. For each LHG in Wales, joint-working takes place across a number of levels, from the internal relationships between members, to the external relationships between LHGs themselves, and between LHGs and other agencies, such as social services or local government.

In July of 2001, the National Assembly for Wales published its strategy plan for the future development of the National Health Service in Wales titled, '*Improving Health in Wales: A Plan for the NHS with its partners*' (NAW, 2001a). The overall objectives of the 2001 Plan are to achieve wide scale improvements in patient services and to raise standards in quality of care. To achieve these aims the National Assembly for Wales has followed the model set by the NHS in England, however the main divergence from England has been the plan to abolish health authorities and move health authority responsibilities to new local health boards (LHBs), the equivalent of PCTs. The Wales Assembly decided to merge existing health authorities with local health groups to form new local health boards (LHBs) that hold increased control over

commissioning and delivering healthcare at various levels. The aim for the future is to further integrate these LHB organisations into 10 or 12 local partnerships, generally consisting of two LHBs, two local authorities, and one NHS Trust.

The Welsh Plan seeks to create a more inclusive and people-centred Wales National Health Service that is easier to access and understand, that is more accountable for the actions it takes and the services it delivers, and a more democratically governed service (NAW, 2001a). As in the precursor 1998 White and Green Papers on Health '*Putting Patients First*' and '*Better Health Better Wales*', a central feature of the Welsh Government's approach to health care management, has been based around the development of new and dynamic partnerships within NHS Wales. The National Assembly for Wales has designed primary health care services around local health groups, that are the central hub in a network of inter-professional and inter-agency relations. Additionally, the future is likely to see further alliances across public-private boundaries with the private sector taking a greater role in health care in Wales. Recent policy and administrative developments in Wales have been aimed at strengthening local and central organisations and have been guided by three key objectives: making the NHS more accessible to patients; making the NHS more accountable for its actions and the services it delivers; making the NHS more democratic in the way it is governed. Overall, recent developments in NHS Wales illustrate two fundamental movements, a move to more local-level collaborative arrangements in primary health commissioning and provision through the work of LHGs and future LHBs, but also, more emphasis on centralised control and accountability by the National Assembly for Wales and its NHS Directorate.



## 7.1 Introduction

This chapter presents findings drawn from data collected and analysed during field investigations of networking and collaborative activities within and across four Local Health Groups situated within a specified Health Authority area of the primary care sector of the Wales National Health Service. This represents a major stage in the research design and a significant part of the overall research strategy. The data presented by this chapter reflect how health policy, presented and discussed in earlier chapters, is implemented and enacted at the local community level, and how professionals and health care agencies have responded to changes in organisational structures and work processes. The purpose of such local level analysis is largely exploratory, seeking to generate informative insights into the collaborative practices of health care professionals and agencies working as part of a local health group. Another important aim of this research phase is to identify and map out network ties and relations between network actors and to assess the important and new links developing between health and social care agencies. In addition, this chapter examines and reports on the relational norms at work and the status of cooperative relations between the agencies and professionals involved. Importantly, the local health group strategically situated within this locality context is the focal point, or central node or coordination mechanism, for an examination of collaborative networking behaviours and relational processes. The chapter begins with a discussion concerning network specification and analysis, setting out the different levels of network investigation, as well as the analytical protocols used to collect and analyse data. The chapter moves on to present a description of the Health Authority and four Local Health Groups studied. Following this, the chapter presents and analyses data collected from across the four LHGs and discusses the range of network relations and ties between health care agencies, particularly the depth and breath of lateral and vertical networking. The chapter draws from insights from professionals' accounts of working within these organisations, and records professional attitudes towards collaborative working and recent changes in NHS Wales. The chapter goes on to discuss issues of management, accountability, change, stability, trust, and performance, across the different Local Health Groups.

## **7.2 Network Specification and Analysis**

According to Provan and Milward (2001: 414), networks in the public sector, particularly in health and other human services, require evaluation from a number of important levels of analysis, including: from the level of the community; from the level of the network; and from the level of the organisations and participants involved. Following on from network analysis at the national level, primary care level, and regional levels, this chapter moves the focus of the study downward to the level of the community. To maintain a local focus, this stage of empirical data collection reports on field investigations within a unitary community area, hereby referred to as Health Authority Zone-X. The Health Authority area chosen is one of the largest in Wales and covers four Local Health Group constituencies and four local authority zones. As outlined by chapter 3, the rationale for this local level analysis is to take account of micro-institutional level governance and practice within a local area of primary health care. The aim is to explore a wide range of participant perspectives and authority relationships, inter-organisational, inter-agency, and inter-professional, in the commissioning and delivery processes within this specified geographical area. Table 1 below describes the three main levels of network empirical interaction and analysis, in accordance with the recommendations of Provan and Milward (2001: 414). The first level specifies Health Authority Zone-X as an appropriate locality for examination. The size of the HA Zone-X makes it comparable with that of a large community. Network investigations in this area examine the patterning of ties between actors to ascertain the existence of distinct positions or roles within the network system and to describe the nature of relations among these positions. The second level of analysis is that of the individual network unit, in this case the four Local Health Groups. The Local Health Group acts as a central node of network activity in primary health care. Network analysis in this instance looks at the networking of health professionals and health agencies at the LHG level. The third level of analysis is that of individual level network actor, where individuals take on roles within networks. This level of analysis explores the role of individual actors within the higher-level network and community systems. The aim is to assess network actors' level of engagement within these systems and to track routes of engagement and network activities. These different analytical levels helped guide field data collection and the development of appropriate data retrieval methods and instruments.

**Table 1 Levels of Network Analysis during Field Investigations at the Local Level**

<p><b>Level 1. The Community</b></p>	<p><b><u>HA Zone-X Health Authority Area</u></b></p> <p>This study focuses on the geographical area of the HA Zone-X. The Health Authority area covers local authority and Local Health Groups boroughs. The size of the HA area makes it comparable with that of a large community. Network investigations in this area examine the patterning of ties between all actors to ascertain the existence of distinct positions or roles within the network system and to describe the nature of relations among these positions.</p>
<p><b>Level 2. The Network</b></p>	<p><b><u>The Local Health Group</u></b></p> <p>The Local Health Group acts as a central node of networking activity in primary health care. Network analysis in this instance looks at the networking of health professionals and health agencies at the LHG level. This level assumes a number of complex horizontal and vertical, dyadic, triadic and multiple networks.</p>
<p><b>Level 3. The Participant</b></p>	<p><b><u>The Individual Actor</u></b></p> <p>This level of analysis explores the role of individual actors with the higher-level network (LHG) and community systems. The aim is to assess network actors level of engagement within these systems and to track routes of engagement and network activity.</p>

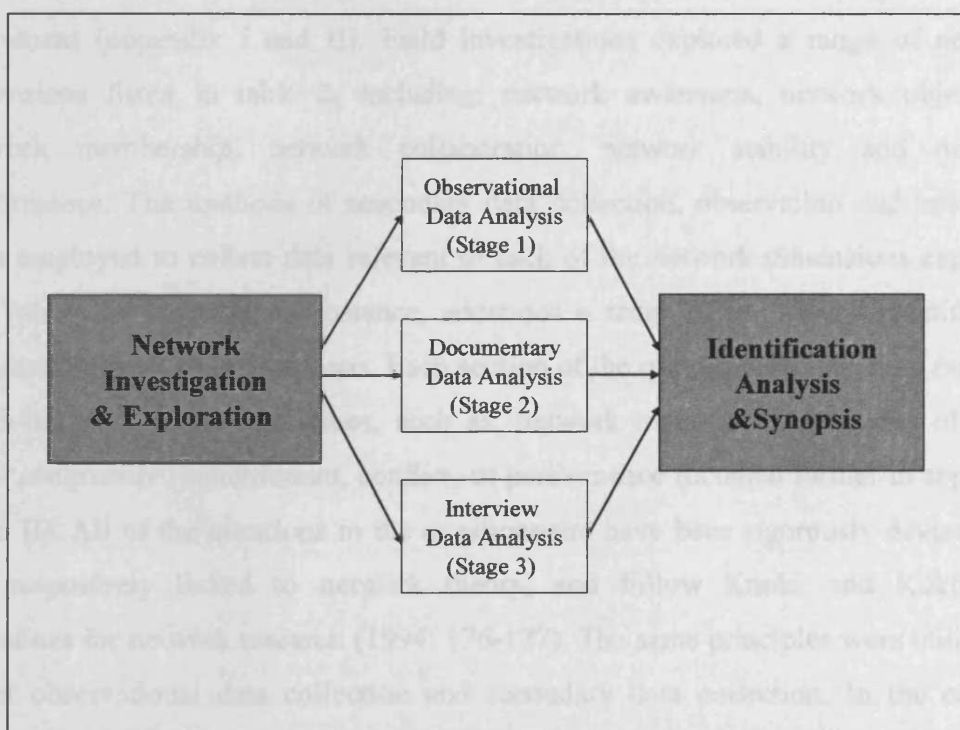
Source: Provan and Milward (2001: 414)

### 7.3 Phases of Fieldwork and Data Collection Protocols

Field investigations as part of this local level stage of the research design were divided into three main tasks, as specified in chapter 3. The first task involved observing the workings of the four Local Health Groups involved in Health Authority Zone-X, to draw inferences and conclusions about the level and type of collaboration among agencies and professionals in this real-life setting. This task involved the researcher attending a number of LHG executive board meetings across all four LHGs over a two to three year period, between 2000-2003. This stage was termed the

*'Observational Stage.'* The second key stage of primary data collection involved an extensive review of archival and internal documentary data relating to each Local Health Group, to document interactions with other agencies. A significant feature of this *'Documentary Stage'* involved a review of internal reports and minutes of meetings for each of the four LHGs studied. The third stage of field investigations involved interviewing key informants from across the four LHGs, and from representatives of affiliated agencies linked to these LHGs, to explore a range of research questions and relational issues (appendix I and II), as part of the *'Interview Stage'*. The process of interviewing principally involved face-to-face interviews with LHG members from across the four LHGs in the HA Zone-X, but also involved supplementary interviews with members from other LHGs in Wales. Face-to-face interviews were also supplemented by telephone interviews were contact with LHG members proved difficult due to the constraints of access, time, or geographical remoteness (interview process and outcomes are detailed in chapter 3). The three main methods of data collection are presented in graphical form in figure 1.

**Figure 1** Network Field Investigation Procedures and Stages



The collection and analysis of data generally followed the sequence described in chapter 3. An analytical framework guided empirical interactions and data collection-

analysis. Findings from primary level sector analysis and the regional sector analysis presented in chapters 4 and 5 provided a policy framework for LHG objectives, procedures, membership and funding, and helped target questioning and data collection. Secondary research on LHGs, and more generally on collaboration and inter-service joint working between health care agencies in Wales presented in chapter 6 provided initial insights into LHG activities. Of particular importance were the studies by the Audit Commission (2000), Lyne et al. (2000), Hayes et al. (2000), McClelland et al. (2001) and Link et al. (2001), reviewed and discussed in detail in chapter 6. Table 2 below illustrates the range of network attributes and network dimensions explored during this stage of empirical data retrieval and analysis. These network attributes and dimensions were identified during the literature review and conceptualisation of networks in chapter 1, and the subsequent exploration of network theory applied to the empirical setting of the UK NHS, conducted in chapter 2. Table 2 brings together the important dimensions of networking practices applicable to collaborative networking in primary health care between local health groups in NHS Wales that have been used to guide field investigations and the development of a framework for field investigations and a subsequent interview questionnaire instrument (appendix I and II). Field investigations explored a range of network dimensions listed in table 2, including: network awareness, network objectives, network membership, network collaboration, network stability and network performance. The methods of secondary data collection, observation and interview, were employed to collect data relevant to each of the network dimensions explored. The interview schedule for instance, addresses a range of key issues identified as important to network interactions. Each section of the questionnaire covers a range of relational dimensions and issues, such as, network members' perceptions of trust, goal congruence, commitment, conflict, or performance (detailed further in appendix I and II). All of the questions in the questionnaire have been rigorously devised and are purposively linked to network theory, and follow Knoke and Kuklinski's guidelines for network research (1994: 176-177). The same principles were utilised to target observational data collection and secondary data collection. In the case of observations, the same interview schedule acted as a guide for field observations of LHG meetings. In practice, observations were recorded and analysed against the list of network dimensions listed in table 2.

**Table 2 Network Attributes and Dimensions as Guides for Field Investigations**

Network Attributes	Network Dimensions	Research Approach
Transaction relations	<ul style="list-style-type: none"> <li>- Purpose</li> <li>- Objectives</li> <li>- Targets</li> <li>- Membership</li> </ul>	This involved gathering data on LHG objectives and membership from existing policy sources, NHS Wales resources and publications, and from individual LHG publications, to establish the framework of LHG operations and membership.
Communication relations	<ul style="list-style-type: none"> <li>- Upward</li> <li>- Downward</li> <li>- Lateral</li> </ul>	This involved mapping the vertical and lateral relationships between LHGs and other agencies, to identify and map-out authority relationships and lines of accountability.
Boundary penetration relations	<ul style="list-style-type: none"> <li>- Across Professions</li> <li>- Across Services</li> <li>- Across Agencies</li> <li>- Across Public and Private</li> </ul>	This involved using LHG publications and interviews to determine the directions, frequency and strength of relationships among professionals, agencies and interest groups, interacting within and across LHGs.
Instrumental relations	<ul style="list-style-type: none"> <li>- Teamwork</li> <li>- Collaboration</li> </ul>	This involved direct questioning of LHG members and direct observation of LHG meetings, to explore issues of team working and to gauge professionals' feelings and attitudes towards collaborative working practices.
Sentiment relations	<ul style="list-style-type: none"> <li>- Trust</li> <li>- Commitment</li> <li>- Conflict Resolution</li> </ul>	This involved interviewing LHG members about their level of trust among members, their level of commitment to their LHG and new working practices; and to identify any instances of conflict.
System relations	<ul style="list-style-type: none"> <li>- Stability</li> <li>- Longevity</li> </ul>	This involved asking LHG members whether or not they viewed the LHG as a short or long term phenomenon, and also sought to gauge perceptions of stability.
Authority / power relations	<ul style="list-style-type: none"> <li>- Power</li> <li>- Control</li> <li>- Accountability</li> </ul>	This involved seeking to explore issues of power and control in LHGs. Observations of LHG meetings were employed to view member interactions as 'external observer', and interviews were used to further explore issues of power, control and accountability.
Performance	<ul style="list-style-type: none"> <li>- Performance Appraisal</li> <li>- Performance Monitoring</li> </ul>	This involved examining performance goals and performance outcomes in LHGs, using internal and external sources, such as LHG reports and CHI reports, to determine how LHGs report performance and to identify successes or failures in the goals attained by LHGs.

Access to the four Local Health Groups studied involved making contact with each of the LHGs to inform them of the study and to request access to LHG members for interview. First contact was made via letter to each of the LHGs, detailing the project. Following this, contact was made via telephone with either the chairperson, manager, or general secretary, of each LHG. One of the key strategies of data collection and access negotiation involved attendance at LHG board meetings. Each of the four

LHGs held regular executive board meetings that were open to members of the general public. This provided an opportunity to access individual LHG board members and to obtain valuable observational data. In total, two to three meetings per site were attended over a two-year period between 2000-2003. The procedure for gaining access to LHG members for interview involved sending letters to each of the LHG members inviting them to be interviewed, or speaking with individual professionals at LHG events. Respondents were given the option to choose either a face-to-face interview, a telephone interview, or to decline interview. Overall, the initial response rate to invitations was poor, approximately 20% of potential interviewees responded and many declined to be interviewed. In an effort to raise the number of actual interviews conducted, direct contact was made with 'non-responsive' members via telephone to verify reasons for non-participation and possible alternatives to interview. Many professionals cited time pressures and heavy workloads as the primary reason for non-participation; others reported a feeling of being over-interviewed:

*“...professionals on the ground do not have time to spend filling in questionnaires and taking part in interviews, we are constantly asked to take part in all those things, and if you work on the LHG you already have a busy workload”* (GP LHG, Int. 42).

In some instances, LHG members refused to take part. In response, a process of seeking referrals and recommendations was followed. This increased the overall number of interviewees, however, the final figure remained lower than anticipated at the beginning of the study. This difficulty in accessing health professionals echoed problems elaborated during interviews and dialogue with other leading researchers in primary health care in Wales. For example, a senior researcher at the University of Wales College of Medicine reported:

*“We have encountered severe difficulties in getting access to primary care practitioners....they are often stretched for time or are unwilling to talk to us”* (Health Specialist, Int. 1).

Similarly, the reviewed studies by Lyne et al., (2000) and Linck et al., (2001), also reported problems accessing LHG staff. This study experienced similar difficulties in gaining access to health professionals working in LHGs (detailed in chapter 3).

In order to obtain permission to conduct interviews with members of the primary care teams involved, or community patient groups and others, it was necessary to offer contributors the maximum level of anonymity and confidentiality. Consequently, the names of the organisations or individuals that have taken part have been codified to protect the identity of those involved. The central organisations involved were given the following pseudonyms: the Health Authority (HA Zone-X), Local Health Group in Area 1 (LHG-1), Local Health Group in Area 2 (LHG-2), Local Health Group in Area 3 (LHG-3), Local Health Group in Area 4 (LHG-4). In addition, all networked organisations connected with these LHGs were coded, for example, the Community Health Council in HA Zone-X working with LHG-1 is coded as CHC-1 LHG-1, if there are two the second becomes CHC2-LHG-1, providing it is in the same LHG. In the same way, the local authority in LHG-3 is coded as LA-LHG-3. The names and identities of the individual respondents involved were also coded and numbered on a specified grid that shows the profession of the respondent and the group or organisation they belong to (appendix V). While this grid represents the bulk of respondents, it is not complete; as discussed above, some members refused interview or withdrew at a late stage. In addition, many more supplemental interviews were conducted with other primary care professionals within and outside the Health Authority area covered. The views of these contributors have been inserted where possible and are reflected in the overall findings of the study. The identities of individual contributors are further protected by combining recurrent views and consistent professional commentary, for example 'the views of GPs in LHG-1 that suggest cooperation is high'. Rather than presenting individual extracts from interviews attached to a specific LHG, data are presented in combination whereby common themes or unusual events are recorded and reported.

As fieldwork proceeded, a database was constructed to store and analyse outputs from the different methods employed. The database consisted of observational field notes, internal documents collected from each of the research sites, and transcripts or notes of interviews undertaken. The collective groupings of data were synthesised into summary reports on each of the research sites and into findings sheets under each of the sub-topics explored by this study. The data was systematically analysed for recurrent trends, prominent occurrences, present or absent network relations,



sentiment relations, relational norms, once-off events, conflicts, failures, successes, and all the range of network activities targeted by the interview schedule. Data analysis involved a degree of subjective interpretation but attempted to maintain a true and accurate account of the social phenomenon under investigation, as espoused by qualitative researchers that support and advocate the use of such methods (Morgan and Smircich, 1980; Miles and Huberman, 1984, 1994; and Eisenhardt, 1989; Yin, 1994).

#### **7.4 Profile of Health Authority Zone-X**

Health Authority Zone-X, created in 1996, covers the local authority areas of Area 1, Area 2, Area 3, and Area 4. The authority is responsible for assessing the health needs of the people in the Health Authority Zone-X area and for commissioning the majority of hospital and community Health Services for them. The Authority is also responsible for managing the primary health care services provided by family doctors, dentists, community pharmacists and optometrists (ophthalmic opticians) across the four local authority areas. Health Authority Zone-X is responsible for implementing national health policy and has overall responsibility for identifying and assessing the health care needs of residents and for arranging that those needs to be met, either through access to primary care services such as GPs, dentists, or pharmacists, or via access to secondary care, primarily services provided in a hospital setting. The core functions of the HA are: to work to improve health and reduce inequalities in health; to support high quality primary care services; to develop and support partnerships to improve health; to promote higher standards of service and extend choice; to ensure Government and National Assembly for Wales priorities are met; to manage the inspection and registration of nursing homes; to monitor and protect the health of the public; to prevent and control the spread of communicable disease; and to exercise effective stewardship of resources (HA Zone-X web-site 1999-2003).

These functions are fulfilled as part of the development and implementation of a comprehensive health improvement plan (HIP), covering all aspects of the development of health and health services, from population health promotion, to tertiary specialist services. The Health Authority population age and sex structure is

broadly similar to that of England and Wales however, there are differences between the local authorities within the Health Authority zone. Area-1 has the highest proportion aged 20-39 years, and a high proportion aged 20 years or under. Area-2 has a high proportion aged 20-39 years. Area-3 has a high proportion aged under 20 and 60 years and over, while Area-3 the has the highest proportions aged 40-59 years, and 60 years and over.

**Table 3 Key Statistics for Health Authority Zone-X**

Population:	736.4000
Budget:	£532.1million (1999/2000)
Number of family doctors (GPs):	422
Number of GP practices:	135
Number of dentists:	258
Number of dental practices:	128
Number of pharmacy practices	183

Source: <http://www.ha-zone-x.wales.nhs.uk>

In 1997, the population of HA Zone-X was estimated to be 736.4 thousand. Since HA Zone-X came into existence in April 1996 it has served a quarter of the Welsh population who live within the local authority areas of:

**Table 4 Population Coverage for Health Authority Zone-X**

Area-1	318.3 thousand
Area-2	241.3 thousand
Area-3	57.3 thousand
Area-4	119.5 thousand

Source: <http://www.ha-zone-x.wales.nhs.uk>

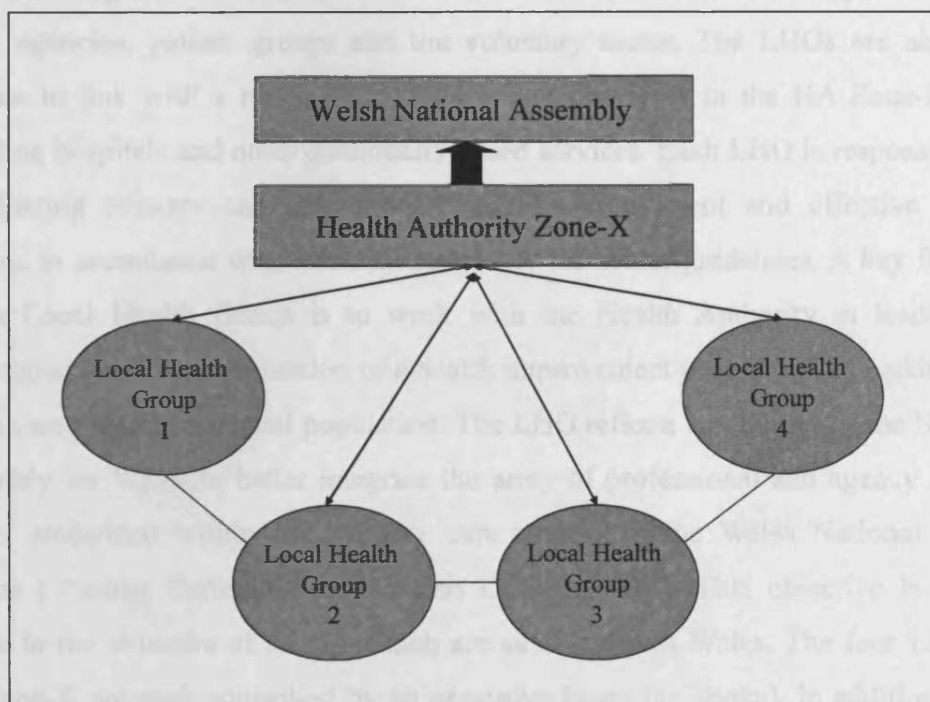
HA Zone-X is directly accountable to the Welsh Assembly Government. Overall, the executive board of the Health Authority are all accountable, however the chief executive of the HA has individual responsibility as the accountable officer. The HA has a health improvement programme (HIP) steering group with representatives from all partner organisations, to act as the project board for the development of the HIP. A HIP project team, with representatives of local NHS Trusts, LHGs, local authorities and voluntary organisations, lead the day-to-day work developing the HIP. HA Zone-

X also has a number of clinical governance committees and groups in place. The clinical governance team is the operational arm of the clinical governance function, which relates to LHGs and other HA departments, and brings together the following functions: quality, clinical effectiveness, audit, risk analysis, risk management, and standards of care.

### 7.5 Local Health Groups of Health Authority Zone-X

The White Paper, *'Putting Patients First'* (Welsh Office, 1998a), has been the principal policy document responsible for the development of local health groups in Wales. HA Zone-X encompasses four Local Health Groups that each cover the local authority areas within the HA boundary, namely: LHG-1, LHG-2, LHG-3, and LHG-4, covering Area-1, Area-2, Area-3, and Area-4 respectively (figure 2). The four Local Health Groups within HA Zone-X began operations as a shadow bodies of the HA up until 1998, but were formally enacted as fully operational committees of the HA Zone-X on the 1st of April 1999.

Figure 2 Overview of Health Authority Zone-X and Local Health Groups



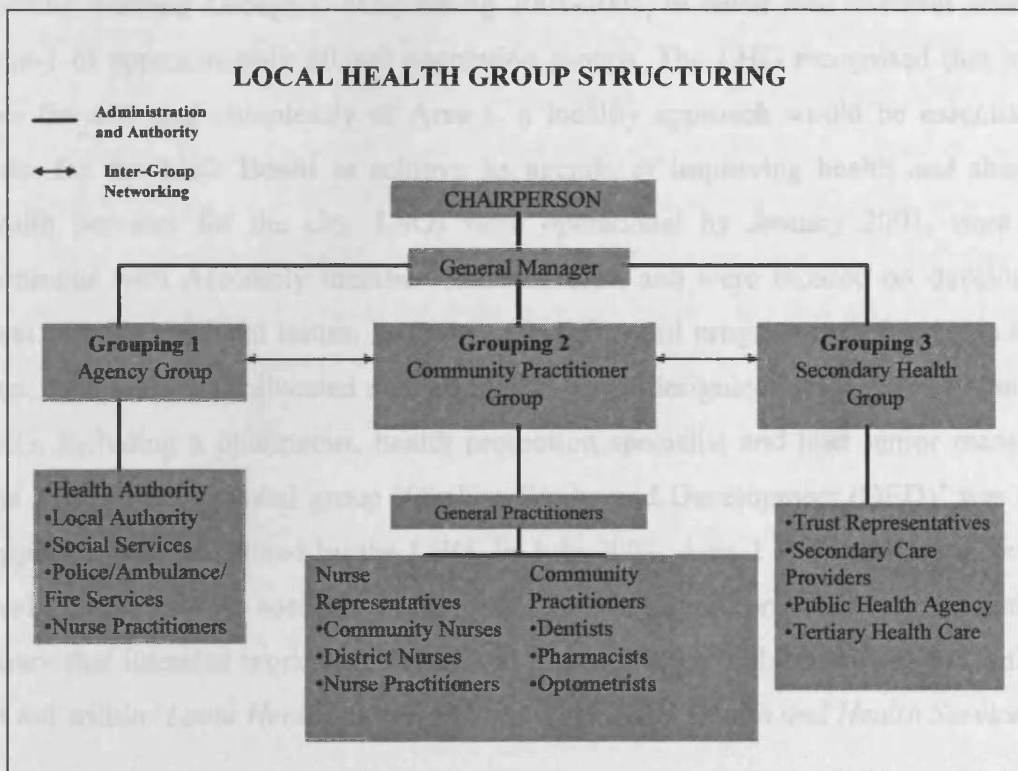
At first, the four LHGs operated in an advisory capacity, but have since taken on greater responsibilities for planning and commissioning health services over the period 1999-2003. Their responsibilities entail the planning, provision, and development, of primary health care services, and the commissioning of community and secondary health services. They also play a part in shaping and delivering NHS contributions to improvements in the health and care of the communities they serve, and provide data to help tackle health inequalities. The role of each LHG is to utilise their grasp of local issues to inform the strategic overview provided by the Health Authority and its partners, to develop primary care services at the community level.

The four LHGs operating in HA Zone-X since 1999, are multi-professional organisations, encompassing one general manager, six general practitioners, two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member, and one lay member. As well as involving GPs, nurses, local government and community groups, each LHG is responsible for ensuring that other health professionals, including professions allied to medicine and secondary care clinicians, are engaged in decision making, service commissioning and delivery. The four LHGs also work collaboratively with public health agencies, patient groups and the voluntary sector. The LHGs are also in a position to link with a range of secondary care providers in the HA Zone-X area, including hospitals and other community based services. Each LHG is responsible for coordinating primary care services to provide an efficient and effective Health Service, in accordance with National Assembly for Wales guidelines. A key function of the Local Health Group is to work with the Health Authority in leading the development and implementation of a health improvement programmes to address the health care needs of the local population. The LHG reflects an attempt by the National Assembly for Wales to better integrate the array of professional and agency interest groups embedded within the primary care system of the Wales National Health Service (*'Putting Patients First'*, Welsh Office: 1998a). This objective is clearly visible in the structure of LHGs, which are similar across Wales. The four LHGs of HA Zone-X are each controlled by an executive board (as above). In addition, some LHGs have opted to include additional co-opted members to advise them on specific issues, as in the case of LHG-1 (detailed below). One of the most remarkable features

of these LHGs is the inclusiveness of professional membership, particularly if compared with PCGs in England. LHGs involve a larger board of executive members, representing a wider coalition of primary care professionals, particularly the inclusion of community pharmacists, dentists, and optometrists, to the executive board. It is possible to demarcate a number of groupings within the LHG.

Figure 3 below illustrates some of the important professional and agency groupings across the LHGs studied: an agency grouping, including members of the Health Authority, local authority, and emergency services; a practitioner grouping, including GPs, community nurses and dentists, pharmacists, and optometrists; and a secondary care grouping, with representatives from upstream organisations, hospitals, NHS Trusts, and public health. While social services is positioned within the agency grouping, social services may represent an additional group, as it lays outside the traditional boundaries of the NHS, which explains why the inclusion of social service representatives on LHG boards is viewed as a means of bridging the gap between the NHS and the Department of Social Services.

**Figure 3 Local Health Group Membership and Professional Grouping**



## 7.6 Local Health Group Area-1

Area-1 Local Health Group serves a population of approximately 330,000 people. The LHG involves 56 general medical practices, with approximately 199 GPs, 66 dental practices, 74 pharmacy practices and 47 optometry practices (2001, LHG-1 Report). These primary care service providers link with a range of secondary care providers in Area-1 and HA Zone-X, including hospitals and other community based services. The Local Health Group is responsible for coordinating these services to provide an efficient and effective Health Service. The goals and objectives of Area-1 LHG are prescribed within the overall 'local health action plan', which sets out the generic objectives of all LHGs in Wales, such as 'improving health and health services in the community'. In addition, a primary care plan outlines a number of more specific targets for improving primary care services:

*"Our main challenge is to ensure that you get the chance to influence these plans for the future. It will also reflect your needs and those of the community in which you live. We are answerable to you, and we need your views"* (Area-1 LHG Mission Statement).<sup>1</sup>

LHG-1 covers the city of Area-1 and surrounding areas. LHG-1 developed four Locality Steering Groups (LSGs) during 2001-2003, to cover four different areas of Area-1 of approximately 80,000 population groups. The LHG recognised that in an area the size and complexity of Area-1, a locality approach would be essential in order for the LHG Board to achieve its agenda of improving health and shaping Health Services for the city. LSGs were operational by January 2001, were co-terminous with Assembly member constituencies, and were focused on developing local solutions to local issues. In order to take forward programmes of work in their area, each LSG was allocated a small budget and a designated team from within the LHG, including a pharmacist, health promotion specialist and lead senior manager. The existing GP oriented group 'Quality, Equity and Development (QED)' was also supported and maintained by the LHG. In July 2002, Area-1 LHG ratified a service level agreement with each LSG and QED. This document provided a framework to ensure that intended work was undertaken in accordance with objectives and actions set out within '*Local Health Action Plan for Improving Health and Health Services in*

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<sup>1</sup> Internet Source: Area-1 LHG web-site: <http://www.wales.nhs.uk/LHG-1> (2000-2002 data retrieval)

*Area-1* and the *'Primary Care Development Plan: A Contextual Document'* (LHG-1 Internal Publications). It was intended that LSGs would influence the development of health and social service issues in respect of these plans. The steering groups address local issues in each of the four areas they cover and are headed and operated by LHG professionals working within the designated areas. Members from Area-1 LHG, including the medical adviser, health promotion specialist, prescribing adviser, and primary care development manager, and others, support each Local Steering Group.

LHG-1 has focused much of its resources on tackling a range of health issues, such as rehabilitation and intermediate care, and health promotion (LHG-1 publications, internal reports, Health Authority and CHI reports). A new local hospital has provided help with the provision of services and a limited number of intermediate beds however, the limited number of nursing home beds in the Area-1 has put pressure on secondary care hospitals in the city to improve bed management and outpatient services. LHG-1 has worked in partnership with other LHGs in the HA Zone-X to pioneer and fund the development of better outpatient services and primary care services designed to relieve pressure on secondary care hospitals. LHG-1 has helped establish a back pain management scheme for non-surgical cases; physiotherapy in the community; a domiciliary hip assessment service; elderly care assessment service (ECAS); a rapid response team; and an emergency admissions local action teams (EMA LAT). LHG-1 has also been instrumental in developing a range of mental Health Services in Area-1, such as counselling projects and assessment teams. The LHG has also been working on establishing out-of-hours services and novel initiatives to cater for the large student population in Area-1. The LHG has also been heavily involved in health promotion initiatives, tackling poverty and related health problems and in improving access to secondary care and specialist care services.

LHG-1 has also been working on an agenda to improve the health and healthcare of the people of the community it serves. The LHG has set about developing a range of relationships with primary care providers, representatives and the community. Board members of the LHG represent GPs, nurses, allied health care professionals, local authorities and local people. The LHG has been particularly proactive in organising and coordinating Health Services in Area-1. The collaborative approach taken by

LHG-1 is clearly visible in its aims to: make a positive difference to local Health Services; improve people's health and tackle inequalities; work in partnership with the public as key stakeholders to improve services.<sup>2</sup> The LHG has sought to meet its objectives by developing and strengthening relationships with other partners, including Area-1 county council, local NHS Trusts, the voluntary sector, South Wales Police and the Probation Service. LHG-1 has been actively engaged in data gathering and consultation exercises. Field notes from one LHG-1 Board meeting showed that:

*“The LHG seems to be placing a lot of emphasis on wider health and social well-being, rather than stricter health issues. At today's Board meeting, a representative from the local council gave a presentation on sectors of social deprivation in different localities in LHG-1. It was clear from the presentation that there are two areas of mass unemployment, poor housing, mortality and morbidity; while there are three areas of relative affluence. The LHG is targeting resources in the poorest areas where need is greatest”* (Field notes from LHG Board meeting, March 2002).

LHG-1 has also played a key role in establishing a framework for partnership working and alliances in the HA Zone-X area that LHG-2, LHG-3, and LHG-4 have followed to some degree. The LHG-1 is the largest in Zone-X and one of the largest in Wales, thus within the locality area of Zone-X, LHG-1 has operated as the most powerful and influential LHG.

## **7.7 Local Health Group Area-2**

Area-2 Local Health Group covers an area to the north of HA Zone-X and covers a mixture of urban and rural communities. The area has very high levels of social and economic deprivation (*Health in Wales: Chief Medical Officer's Report*, 2001-2002). Historically, local employment has been heavily reliant on coal mining and associated industries, however such industries no longer exist and the level of unemployment in the area is high compared with the national average for Wales. The Local Health Group covers approximately 45 General Medical Practices, a smaller number of Dental Practices, Pharmacy Practices and Optometry Practices. These primary care service providers link with a range of secondary care providers in the HA Zone-X, including hospitals and other community based services. LHG-2 has

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<sup>2</sup> Source: Area-1 LHG web-site: <http://www.wales.nhs.uk/lhg-1>



been working on addressing a range of local Health Service challenges since its creation in 1999. Unlike Area-1, Area-2 LHG covers a relatively small population with a high percentage of elderly patients and rural patients. The LHG has attempted to focus attention on improving the breadth of primary care services provided in the area, such as access and referral systems, health promotion, staff and service development (LHG-2 Report, 2002: 1-5). Area-2 LHG has been addressing a number of issues concerning emergency services and access to secondary care. The LHG has held a number of management seminars on this issue during 2000-2002 and has been actively engaged in building a range of partnerships with secondary care providers like the HA Zone-X, the local NHS Trust and organisations in the voluntary sector, such as Age Concern. As part of an emergency planning and improvement process, Area-2 LHG, in conjunction with Health Authority Zone-X, has developed an action plan to address deficiencies in ambulatory services (LHG-2 Action Plan on Ambulatory Services, 2002). The LHG has subsequently developed strong links with the local ambulance service and the County and Borough Council, and the HA Zone-X emergency planning team. The ambulance service has already achieved a number of successes, including the use of new rapid response vehicles, better non-emergency and high-dependency transport systems, and a fast track system to the critical care unit at two of the local hospitals (CHI Report, 2002: 57). In addition to access to emergency care, access to standard and specialist secondary care services has been a prime focus of the LHG-2. Over a two-year period, the LHG monitored GP referrals to hospital/specialist services, such as x-rays and imaging, orthopaedic assessment, and cancer care. As in Area-1 and Area-4, LHG-2 has funded a liaison manager to study referral patterns and waiting times. As a result, a set of guidelines concerning referrals has been developed and distributed to GPs in the area, in an attempt to improve the referral system.

LHG-2 has also been involved in establishing and promoting a number of additional health care services, in response to health needs at the local community level, identified during the LHGs initial phase of operation between 1999-2001. The LHG has worked with neighbouring NHS Trusts to deliver improved cancer services for residents at the community level. The LHG has also established a lower back pain clinic to provide more timely access to alternative treatments for patients. The LHG

helped establish a primary care support unit (PCSU) in the area, that is open for patients to access a number of clinics including coronary heart disease, asthma, diabetes and women's and children's health. The chairperson of the LHG-2 Executive is a strong advocate of the LHG system and has been instrumental in championing local service improvements via the LHG:

*“I describe it [the LHG] as a collection of people whose responsibility is to promote health and well-being, and as part of that it recognises primary care as being an essential part of that...LHGs were established as a first step in a journey...in a journey where we move from, in Wales; the fundamental issues in Wales are health inequalities, health deprivation, inequalities of care provision, both health and social care...They have been fundamental in starting the process of bringing these issues to the front of the agenda” (Chairperson LHG-2: Int. 31).*

The above statement reflects the broader approach taken by LHGs to health and social care at the community level. LHG-2 has also been successful in attracting new staff to positions that were vacant for many years. The LHG introduced a new salary and training scheme for new GPs. As a result, two new female salaried GPs have been recruited to the PCSU, to supplement the four already in general practice (LHG-2 Internal Report and Interviews). Area-2 Local Health Group has been working on the development of an integrated strategy for primary care premises. The first stage of the process took place during 2000-2001 and involved an audit of all GP owned and occupied premises within the LHG area. Stage two (2001-2002) involved an evaluation of options and a public consultation, and led to the production of a strategy document for development and modernisation of LHG-2's estate. A more detailed outline of the activities of LHG-2 is presented in section 7.14.1.

## **7.8 Local Health Group Area-3**

Local Health Group Area-3 serves an area to the north of LHG-1. LHG-3 spans one of the smallest unitary authority areas in NHS Wales and is the smallest LHG within HA Zone-X. Despite its size, the area has some of the highest levels of social and economic deprivation in Wales, with comparatively high levels of unemployment and long-term chronic illness<sup>3</sup>. The work of the LHG since its creation in 1999 has been primarily

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<sup>3</sup> Internet Source: LHG web-site: <http://www.wales.nhs.uk/LHG-3>

concerned with assessing local needs, improving access to secondary care, the development of local auxiliary services and targeted health promotion. The LHG has drawn up an orthopaedic action plan with the local NHS Trust to address the waiting lists for hip and knee operations. The LHG also developed a glaucoma screening project, that allows optometrists to screen for glaucoma at local practices, thus reducing the number of GP referrals and outpatient admissions. The LHG has also responded to the need for better sexual health screening, treatment and education. Area-3 has a high rate of teenage pregnancies and LHG-3 has attempted to provide better access to pregnancy and contraception information and advice, by taking part in the creation of a new youth drop in centre. The LHG has also communicated with local pharmacists to offer advice and emergency contraception to young people in the area. LHG-3 has also targeted its efforts at developing dental care services in the area, improving drug prescribing, and modernising estates and staffing arrangements.

LHG-3 has formed a number of key partnerships to help develop local services and meet objectives. LHG-3 has formed links with the Area-3 County Borough Council, social services and neighbouring NHS Trusts. The LHG working in partnership with other agencies has been able to submit bids to the Welsh Assembly Government for special grants and funding to develop services. The LHG placed one bid for a scheme targeting stroke victims, to provide rehabilitation for patients suffering the effects of a stroke. The aim was to achieve early discharge of patients from hospital who were medically stable. It resulted in the use of a residential home to accommodate suitable patients for time-limited rehabilitation. The LHG, in conjunction with LHG-2 and the local NHS Trust, have also submitted bids to the Welsh Assembly Government to improve the current diabetic services provided in Area-3. The LHG successfully secured funding that has subsequently been used to fund: a diabetes nurse facilitator; allied health professional support; a peer support programme; a diabetes care pathways project; and from January 2002, a primary care physiotherapist. (LHG Internal Report, 2002).

LHG-3 has been instrumental in the development of services for diabetes in the County Borough. LHG-3 has worked closely with the neighbouring LHG-2 and local NHS Trust, to establish a diabetes strategy group to oversee service developments in

Area-3 and Area-2. The chairman of the local community health council heads the diabetes strategy group. A number of projects aimed at improving the diabetes service are currently underway. The 'Diabetes Peer Support Programme' (DPSP) emerged from the diabetes project. The programme is led and managed by diabetic members of the public that work to help diabetics in the local community. The programme aims to provide participants with non-medical advice and support, enabling them to build confidence in their ability to manage their health and maintain active and fulfilling lives. Another initiative, the 'Diabetes Care Pathway Project' commenced in May 2002 and is concerned with mapping the services available locally for diabetes and identifying where improvements might be made:

*“Our goal is to produce a patient centred model of care, which aligns diabetic services across primary, community, and secondary care”* (LHG-3 Chairman. Int. 41).

The LHG has also improved access to dental services within the area with the aid of the HA Zone-X dental adviser. The most recent surgery opened in February 2002, supported via the primary care development fund. In partnership with HA Zone-X, LHG-3 has also helped develop a managed clinical network for ear, nose and throat services, which commenced in November 2001, followed by a formal launch in January 2002. LHG-3 also established a primary care resource team (PCRT). The team currently consists of a diabetes nurse facilitator, two coronary heart disease nurses, a practice manager support officer, and an administrative assistant. A steering group oversees the development of the PCRT. To date, ten practices have nominated a general medical practitioner to sit on the group. One area in which the PCRT have been active is in the area of coronary heart disease (CHD). An example of the work currently undertaken in CHD is the 'risk factor intervention project'. The project commenced in January 2002 and is funded by the 'inequalities in health fund' from the Welsh Assembly. The project aims to reduce the incidence of coronary heart disease across the Borough of Area-3. There are two specialist nurses in post, a CHD facilitator and a CHD nurse. Their role is to identify the service provision across GMPs across the Area-3 Borough, and where required, assist in enhancing existing care of the patient with CHD. The aim is to improve patients' quality of life by better provision of services or regular intervention and monitoring. In addition, for patients who have existing coronary heart problems, such as heart surgery cares or have heart

attack victims, a voluntary peer support group called 'HEARTBEAT 95' was established, providing a telephone helpline for patients providing information and advice on a range of coronary issues. This reflects the level of interaction between LHG-3 and voluntary groups and the new emphasis placed on public health, health planning and health prevention: a central aim of National Assembly for Wales Policy.

## **7.9 Local Health Group Area-4**

The Area-4 Local Health Group covers a mostly rural area to the west of Area-1, with a population of approximately 122,947. There are 68 GPs working in 19 practices within the LHG boundary. A large proportion of the residents requiring secondary care access services within Area-4 are referred to specialists in Area-1 and the Area-4 NHS Trust, some residents located to the west of Area-4 are referred to a neighbouring NHS Trusts. LHG-4 has focused on tackling a core range of local health issues, such as access to continuing care, drug prescribing, and developing better links between primary and secondary care services. LHG-4 has attempted to develop a multi-disciplinary primary care team to provide appropriate support to nursing and residential homes and to other vulnerable patients in the local community. This has been partly achieved by the introduction of a number of new schemes like the emergency admissions local action team (EMA LAT), that ensures social care input for vulnerable patients on discharge from hospital. The LHG has sought to improve the secondary care referral system by working in partnership with health, social services and the voluntary sector, to modernise local admissions procedures and relieve pressure on hospitals by offering alternative services to patients. LHG-4 has worked closely with the local NHS Trust and LHG-1. This partnership has led to the joint funding of a demand management post. Service improvements include: a higher number of available intermediate care beds at a local hospital; taking part in an intermediate care review undertaken by Area-1 and a local NHS Trust; a short-term intervention scheme to provide therapy and social care input in patients' homes; and the introduction of an acute response team in the community served by Area-1 and the local NHS Trust (LHG Publications and CHI Report, 2002).

The LHG has also produced and agreed a prescribing policy that provides a

framework with the overall aim to improve quality and cost effectiveness of prescribing. The objectives of the scheme are to support prescribing, train and support doctors, promote evidence based prescribing, and encourage cost effectiveness. Additionally, the LHG was the first to establish a primary eye care acute referral scheme (PEARS), which has improved performance and efficiency by ensuring appropriate assessment of patients by optometrists and allowing for direct referral to secondary care specialists. This has reduced pressure on GPs and reduced the number of inappropriate referrals to hospital specialists.

LHG-4 established a clinical governance team, whose overall aim is to maximise the quality of Health Services available to residents. The team is represented by LHG Board members and includes the clinical governance lead, nurse representative, an optometrist, a pharmacist, GP, local community representative, dentist, LHG manager and office support personnel. In 2001/2002 the clinical governance team completed a report which looked at important aspects of healthcare; such as how long patients have to wait for an appointment, access for disabled patients, and how the public are informed about how to make a complaint. Other important issues that come under the umbrella of clinical governance include patient confidentiality and involving the public in planning services. The LHG has sought to tackle the issue of patient involvement. LHG-4 has worked closely with GPs in the community to start up GP-patient liaison groups. Patient liaison groups provide the opportunity for people to play a more active role with their GP practice. Such groups provide a forum to improve communication between GPs and patients, provide ideas for improving services, and help to define local health needs. Groups have for example, produced information booklets and newsletters for patients, have helped set up patient self-help groups, and have organised health education talks and discussions. Other groups have organised voluntary driver schemes to enable people to attend surgeries and have set up patient libraries.

### **7.10 Networking Across Local Health Groups**

Across the four Local Health Groups investigated during this phase of the study, a range of cooperative issues and relations emerged. Since the creation of LHGs in

1999, all four LHGs have been involved in a process of learning and development, overseen by HA Zone-X. While all four LHGs began life as advisory sub-committees of the Health Authority, each LHG has become a fully operational primary care institution; being involved in decision making around service provision and commissioning. While many members of the different LHG Executive Boards started with only limited experience of NHS management or strategic governance, over the past three years, constituent members have been working on creating cohesive primary care teams and collaborative relations across the services, agencies, and professional groups involved. This process of development, improvisation and adjustment, has been particularly evident in the four LHGs examined here. Despite the demands placed on the managers and professionals involved, many of the LHG Executive Board members interviewed reported that their LHG had made strides towards meeting the objectives set by the relevant Boards, although it was noted that there was a significant amount of work still left to undertake. The chairman of LHG-1 commented that:

*“All the members of our board have worked hard to build on the work of our LHG...we have been actively engaged in working with the professionals on the ground and the health authority to improve services in our area”* (LHG-1, Int. 21).

Interview and observational data revealed a high level of motivation among LHG members, corroborated by the high numbers of attendees at board meetings<sup>4</sup>. While the attendance of board members at board meetings is not a proxy of motivation, the consistent high attendance rate at monthly meetings across the four LHGs, illustrates one aspect of the commitment of health professionals to the work of individual LHGs. In addition, observations made during LHG board meetings revealed a significant degree of inter-professional discussion and decision-making around a wide range of health issues.

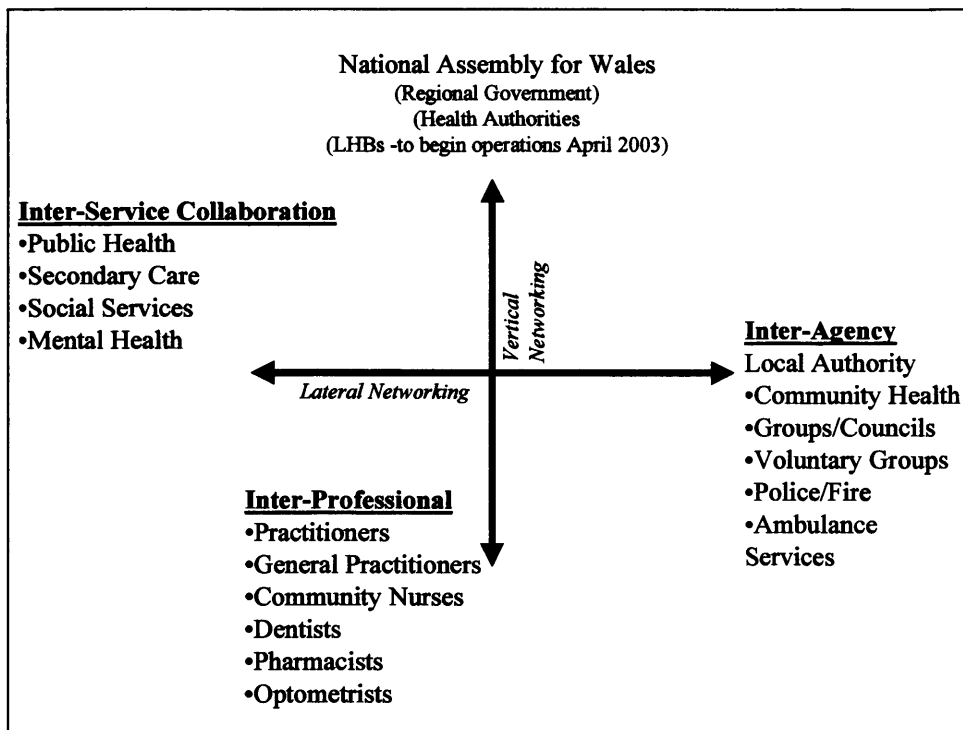
One of the central aims of all the Local Health Groups, in terms of service development, has been the development of purposeful links between health care agencies and professional groups at the community level. All four LHGs have been actively engaged in a wide range of relationship maintenance and building. The

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<sup>4</sup> Points made in reference to observational and interview data across the four LHGs

diagram in figure 4 illustrates a range of collaborative activity positioned along two axes, *vertical* and *lateral*. The vertical axis points upward to executive-level authority relations, principally between Local Health Groups and Government-health authorities; while the lower end of the vertical axis points downward towards ground-level constituents and the lower limits of the NHS hierarchy. The lower end of the vertical axis points to community/locality inter-professional cooperation. Across the two extremes of the lateral axis lie relations between services beyond the boundaries of Local Health Groups, including, the Department of Public Health, Social Services, Secondary Care Providers, and Mental Health Services. At the other side of the lateral axis lie the range of cross-boundary and inter-agency relations, specifically with Local Authorities, Community Health Groups and Patient Interest Groups, Voluntary Organisations and services such as Accident and Emergency Services, including Fire, Ambulance and the Police.

**Figure 4 Vertical-Lateral Dimensions of LHG Networking Activities**



Chapter 1 showed how the term network is a rather abstract notion relating to ‘a set of nodes and relations that link incumbents’ (Fombrun, 1982). This loose definition is perhaps the best all-inclusive definition of a network, as it is universal to all networks, whether simple or complex. However, as Nohria and Eccles (1992) point out, the term



network has become synonymous with a vast array of relational forms, from strategic alliances to organisational sets (see page 11). There is some requirement to differentiate network forms and relational processes. Many writers in the public domain cite the terms 'inter-professional', 'inter-agency', and 'network', without any specification of the organisational unit of analysis. In addition, despite strong interest in the study of inter-organisational networks, very little attention has been devoted to assessing the effectiveness of multi-organisational networks (Provan, 1998). In this study, the Local Health Groups investigated were viewed as the central node for coordinating and developing a range of vertical and lateral relations, as described in figure 4 above, for a range of inter-professional, inter-agency and inter-service relations (discussed in more detail below). As such, this study's analysis of networking in Local Health Groups in NHS Wales is akin to a 'complete network analysis', as outlined by Knoke and Kuklinshi (1991: 173): taking into account, inter-personal, inter-agency, and wider trans-organisational relations, between the NHS and stakeholders, such as patient representative groups and the voluntary sector. Few studies account for such relationships, or tend to focus on single elements of dyadic relations between a small number of specified network actors.

### **7.11 Vertical Authority Networking**

LHG-1, LHG-2, LHG-3, and LHG-4, have all operated as subordinate organisations to a large centralised Health Authority, since established in 1999. HA Zone-X has played an important role in the establishment of the four LHGs, providing each LHG and individual members with guidance and support since 1999. Despite some minor difficulties in appointing staff in two of the LHGs, particularly finance positions, the Health Authority has worked to establish and develop the role of the four LHGs within the Authority's domain. This rapid transition from an advisory role to a more managerial role is exemplified by the expeditious move each of the LHGs have made in taking over responsibilities for the management of the general medical service (GMS) and prescribing budgets in April 2000. Since then there has been a gradual shift of power and responsibility away from the Health Authority to Local Health Groups, in line with the Welsh Assembly's plans for LHGs to be the principal instruments for primary care planning and delivery in the coming years.

A key function of the Local Health Group is to work with the Health Authority in leading the development and implementation of a Health Improvement Programme to address the health care needs of the local population. In the case of LHG-1, LHG-2, LHG-3, and LHG-4, all four LHGs showed signs of cooperative working with HA Zone-X (evidenced by number of meetings, joint-working initiatives, and interactions). LHG-1 and LHG-2 were particularly involved in joint working initiatives with HA Zone-X, which is a likely result of the closer geographical proximity of these LHGs to the HA and the larger size and scope of these LHGs. The Health Authority has worked closely with each LHG to develop primary care services, tackle local needs, and address pending service shortages or failures. In addition, the Health Authority, in conjunction with LHGs, has attempted to tackle a number of local health concerns, particularly improving links between primary and secondary care, improving the referral system, drug prescribing, and creating new primary care programmes for a range of health issues. One such programme has been the development of community mental health teams (CMHT). These teams are available to patients requiring mental status evaluation or mental health advice or support at times outside normal GP practice times. The Health Authority has also established a network of clinical advisers that are located at the Health Authority to assist individual LHGs in areas of specialist care, such as pharmaceuticals, optometry and dentistry. Partnership working between individual LHGs and the Health Authority has led to improved access to specialist secondary care services, such as the development of an ophthalmology advisory position that leads a primary eye care acute referral scheme (PEARS), originally in partnership with LHG-3, that allows for more patients to be treated within primary care and for patients to get faster access to specialist care for conditions such as cataracts or glaucoma (Health Authority X Report, 2003). There are many other examples of integrated working between Health Authority Zone-X and the four LHGs.

The 1997 White Paper on health, *'The new NHS, modern, dependable'* (DoH, 1997) set out a vision for the development of primary care groups in England. The 1998 White Paper *'NHS Wales: Putting Patients First'* (Welsh Office, 1998a), set out a similar framework for the development of local health groups in Wales. Table 5 below sets out the four potential levels that local health groups were to ascend to during the

first years following implementation. The four LHGs started as shadow organisations of HA Zone-X in 1998, and between 1998 and 2000 functioned at level 1, as advisory organisations. Since 2000, the role of the four LHGs expanded rapidly as each gained experience and the Health Authority devolved some responsibilities down to LHG-1, LHG-2, LHG-3 and LHG-4. This moved the LHGs on to level 2 or 3 of the development pathway.

**Table 5 Levels of Development within LHGs**

<b>Level 1</b>	At a minimum, support the health authority in commissioning care for its population, acting in an advisory capacity.
<b>Level 2</b>	Take devolved responsibility for managing the budget for healthcare in their area formally as part of the health authority.
<b>Level 3</b>	Become established as free-standing bodies accountable to the health authority for commissioning care.
<b>Level 4</b>	Becoming established as free-standing bodies accountable to the health authority for commissioning care with added responsibility for the provision of community Health Services in the community, including running community hospitals.

Source: Adapted from NHS White Paper (1997)

While, LHG-1, LHG-2, LHG-3, and LHG-4 showed signs of upward movement towards level 4, HA Zone-X retained significant powers during the period 2000-2003, whereby no LHG reached full independent status. Although the relationship between the Health Authority and the four LHGs appeared productive and amicable, some Health Authority officials (Int. 30, Int. 40) raised concerns about the speed of change and the ‘readiness of LHGs to become full commissioning bodies.’ Conversely, some health practitioners raised concerns about the Health Authority’s ‘decision-making

procedures and criteria'. One prominent GP summarised the relationship between his LHG and HA Zone-X as follows:

*"...in many of our views, especially among the GPs and some of the other clinicians, the evolution actually went backwards. We did go forward and try to break species but the species pulled us back..., I mean you can almost describe the Health Authority as a cancer. It sent out cells to these new sprightly organisations and took them over, and again that's the view expressed in a few places, certainly my view, they...pulled it back to what they wanted it to be" (GP LHG-1, Int. 22).*

The dominance of managerialist health authorities (Hudson, 1999) may have impacted on the Wales National Assembly's decision in 2001 to abolish health authorities ('*Improving Health in Wales: Structural Change in the NHS in Wales*', NAW, 2001e), such as HA Zone-X, and move their responsibilities over to new local health boards: a new institution made up from an amalgamation of local health groups. This follows a similar trend to that of PCTs in England, however while England retains health authorities, the Wales Government has been free to develop regional policies for health improvement within the scope of the NHS Plan 2000. The abolition of health authorities in Wales exemplifies regional policy orientation. From April 2003, LHG-1, LHG-2, LHG-3 and LHG-4, are expected to take over the lead role for commissioning, planning, and management, of primary and community services from HA Zone-X and become one large Local Health Board. The Health Authority established a dissolution project board in May 2001 and worked throughout 2001-2003 with the four LHGs towards the transfer of power and responsibilities by April 2003. During the life-time of this project the role of the HA continued to be the commissioning of specialist services with the LHGs monitoring these contracts. The Welsh Assembly Government announced in 2002-2003 that the future system would be a consortia of LHGs commissioning health care.

## **7.12 Inter-Agency Networking**

One of the most interesting and dynamic aspects of the work of the four LHGs in HA Zone-X is that of inter-agency networking. LHG-1, LHG-2, LHG-3, and LHG-4, have all formed links with a range of agency partners since 1999. In this case, an agency is an organisation with some involvement with health or social care in the community,

that lies outside the boundaries of the National Health Service of Wales, perhaps in a different area of local government or beyond, but that is linked to the Health Service in some way. LHGs in Wales have been encouraged to form new inter-agency partnerships and to work with all relevant agencies in developing primary care services (Welsh Office, 1998a; *Improving Health Care in Wales*, NAW, 2001). In response, the four LHGs of HA Zone-X have been involved in forming a range of formal and informal relationships with agencies such as local authorities, community health councils, voluntary sector groups, police, fire and ambulance services.

One of the most interesting inter-agency partnerships for LHGs, is the partnership between health care provider-commissioning organisations and local authorities. Local authorities reside outside the NHS and are democratic bodies accountable to the wider electorate; that manage local government activities. In this regard, local authorities have a special role in being able to bring democratic legitimacy to a public and patient involvement strategy. Local authorities are charged with responsibility for the social, economic and environmental, well-being of their communities. There are clear benefits of integrating local authorities and health care agencies. Local authorities already have well developed networks of contacts in local communities and health professionals working in community development and support roles, as well as established relationships with the voluntary sector and community groups. These are valued resources for NHS organisations to tap into, particularly as local authorities have experience of community development projects initiatives. Local authorities are not just useful for building links and relationships, they are a valuable source of expertise and intelligence about local communities and local issues, and provide an additional avenue for public and patient involvement.

Across the four Local Health Groups studied in Health Authority Zone-X, the relevant Local Authorities have been actively engaged with LHG-1, LHG-2, LHG-3, and LHG-4, not just via representative membership on the LHGs' Executive Committees, but also via an array of less formal partnerships and links. In working within and across the Local Health Groups studied, LAs have brought the wider health and social well-being agenda to the attention of health professionals, for example, by raising issues such as housing, the environment and public health. This dialogue and

consultation processes is two-directional in that LA decision making might be influenced by participation on LHGs, thus helping local authorities make better decisions about coordinating services in particular areas, or ensuring their work covers issues such as prevention, intermediate care, after care and home care. In addition, the Local Authorities of HA Zone-X have been able to inform the LHGs on a range of wider health and well-being issues. In particular, the LAs are in a position to identify socially excluded groups and promote partnership working to target such groups: something NHS organisations have found difficult to achieve working alone (Hudson, 1999). Partnership working between the four LHGs and Local Authorities has also raised the profile of wider socio-economic issues at the community level, for example, by making sure that housing and environmental issues are considered when allocating LHG and Health Authority resources. The LHG acts as a forum for the coordination of health and local government service development and ensures that the work covers often ignored subjects such as prevention, intermediate care, after care and home care, particularly for socially excluded groups, like the homeless, prostitutes and drug users. As demonstrated by the comments of one Local Authority representative in LHG-2:

*“We have identified that drug users in our authority area have no access to alternative drug therapies, apart from whats available from local GPs, we have contacted the community nurse to discuss ways forward to develop a drop-in centre and offer drug users the opportunity to have treatment...we have also been in contact with police about this problem”* (LA Representative at LHG-2 Board Meeting, April 2002).

LHGs in Health Authority Zone-X have developed a good working relationship with their respective Local Authorities, and have begun to jointly-plan service development at the community level. In the future, post-2003 and the introduction of local health boards, the link between link between NHS agencies and local authorities is likely to be become deeply embedded. The Welsh Assembly Government has identified the involvement of local authorities as central to the development of primary health care services. Guidance issued by the Welsh Assembly Government has proposed a statutory duty for local health boards and local authorities to jointly formulate and implement a ‘Health, Social Care and Well-being Strategy’ for their area. Local authorities in conjunction with local health boards will be required to draft a Local Health Action Plan (LHAP) annually, detailing the LHBs and LAs plans for

improving health and well-being in their local area. The health, social care and well-being strategy, is a partnership strategy and is unique in that, the local authority and the local health board will be jointly responsible in law for the planning of NHS services and health-related local authority services. Underpinning the strategy development will be the need for local health boards and local authorities to adopt an inclusive approach. They will be required to cooperate with a range of bodies and individuals including NHS Trusts, Health Commission Wales (specialist services), community health councils, county voluntary council, voluntary sector, and private sector organisations in the area. Wider stakeholder and community involvement will also be required. The first health social care and well-being plan will be implemented during 2005 in the LHG-1 Area and is a three-year strategy to address a wide range of issues affecting health and well-being. The plan aims to improve health and reduce health inequalities and will provide This cooperative approach highlights the nature of service development in primary care, where a network approach is being adopted, and forms the basis of a joint-commissioning strategy and template for NHS and local authority health related services.

The four LHGs of HA Zone-X have also been involved in working with community health councils to develop more patient focused services: a major objective of the 2000 NHS Plan. Community health councils are agencies that provide information about the NHS and its organisations, or free help or advice for the public. Community health councils are statutory lay organisations with rights to information about, access to NHS organisations. Community health councils are non-governmental organisations (NGOs), enacted to represent the views and interests of patients and users of the National Health Service in Wales. The Association of Welsh Community Health Councils (AWCHC) is the body that supports the twenty CHCs across Wales. The Association collects information about patients' concerns and communicates on behalf of patients with the Health and Social Services Committee in the National Assembly of Wales. In addition, AWCHC also represents patients to the Department of Health in Westminster. CHCs in Wales are engaged in a number of consultation exercises with the National Assembly for Wales, covering a wide range of issues, including:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>▪ Public involvement in the NHS</li> <li>▪ Policy developments in Wales</li> <li>▪ National health policy</li> <li>▪ New Health and Social Services</li> <li>▪ Charter NHS complaints procedures</li> </ul> | <ul style="list-style-type: none"> <li>▪ The role of Welsh CHCs in the NHS</li> <li>▪ Clinical Governance</li> <li>▪ Voluntary sector groups/organisations</li> <li>▪ Police/fire/ambulance<sup>5</sup></li> </ul> |
|--|--|

In LHG-1, LHG-2, LHG-3 and LHG-4, a representative from the Community Health Group works as part of the LHG Board or with each individual LHG to represent the views of patients and take part in all LHG activities, particularly the development of public and patient involvement initiatives. In addition to the direct involvement of the Community Health Council representatives, each LHG in Health Authority Zone-X has engaged with a number of voluntary sector groups to work in partnership, to develop and provide services to patients in the community, particularly helping to meet the needs of vulnerable groups in society. A prominent CHC leader in Wales expressed the view that:

*“Our concern is that the Health Service has too many boundaries, for example the boundary from primary care to secondary care, the boundaries from health and social care; whilst it is recognised that there are efforts to bring these closer together, the fundamentals of a free NHS and other services that are means tested, is a big hurdle for a totally integrated service”* (Community Health Council Representative, Int. 61).

In addition, within each LHG area, a Health Alliance has been established to implement the health and well-being agenda set by the Wales Assembly and to promote partnership working with voluntary groups. A Health Alliance Manager coordinates with a range of health care agencies, such as local health groups, to establish joint-working arrangements, tackle health inequalities, identify the determinants of health and promote partnership working. Health Alliances are very small bodies with only a small number of staff (less than 5) that work within a limited budget provided by the National Assembly for Wales (£100,000 over 5 years in Area-1). An interview with the manager of the Health Alliance in Area-1 revealed an enthusiasm for recent changes in health policy in Wales and for the work of LHGs in tackling wider health and well-being issues at the community level:

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<sup>5</sup> Community Health Council web-site: <http://www.wales.nhs.uk/chc/home>



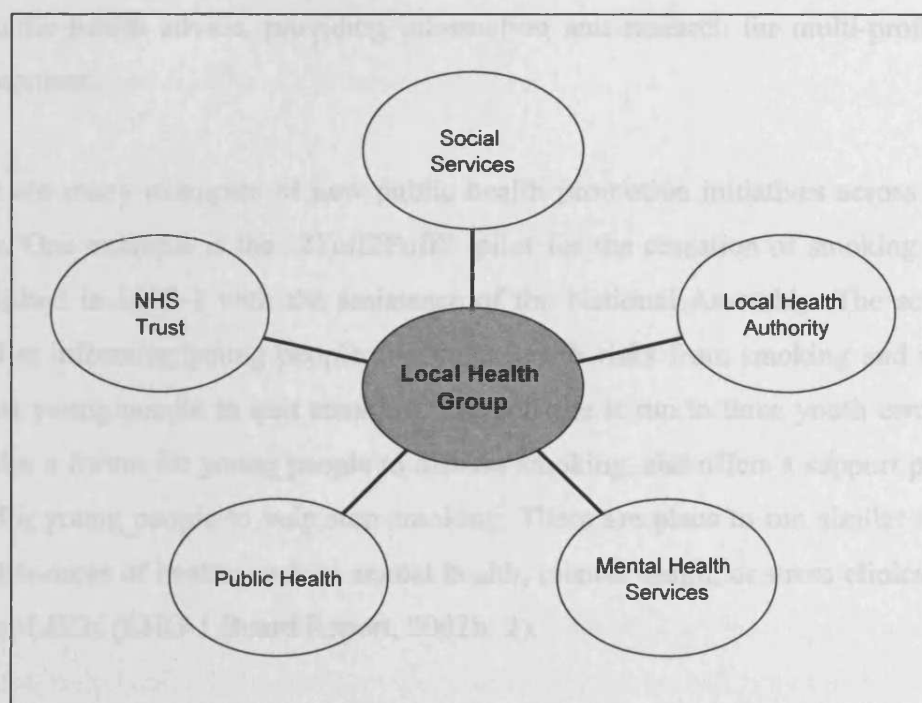
*“In the two years I’ve been doing this, the working relationships between the agencies involved, I feel has improved...there is quite a good commitment [from agencies]...[in relation to the Health and Well-being strategy]...the Local Authority is the lead and chair it and the corporate manager is very much a leader, and has the vision to push it, with the Local Health Group a close second,...others are slow to contribute” (Health Alliance Officer, Area-1; Int. 63).*

Local Health Groups have also made tentative links with the police, fire, and ambulatory services, in Health Authority Zone-X, although during 1999-2003 HA Zone-X carried out the bulk of partnership working between such services. LHG-2 and LHG-4 identified the need for improved ambulance services in Area-2 and Area-4 and have worked with the HA and the Ambulance Service Trust to record and improve on problems in achieving appropriate and equitable ‘response times’ in emergency ambulance services (Health Authority Zone-X and LHG Publications, 2001-2003).

### 7.13 Inter-Service Networking

Figure 5 highlights some of the central services being networked, in differing degrees, with the Local Health Groups of HA Zone-X.

**Figure 5 Inter-Service Networking Via LHGs**



Public health has emerged as a major element of the reform agenda in Wales since 1999. Traditionally public health as a function of health care has remained on the margins of the National Health Service, but recent restructuring in NHS Wales, has brought public health to the forefront of health policy and planning and has generated a new role for public health closer to the centre of health reform programmes. In May 1998, the Welsh Office published the consultation document '*Better Health Better Wales*' (Welsh Office, 1998c). This document set out a vision for better health in Wales and the basic approaches to tackling the underlying causes of ill health. Following this, in October 1998, '*Better Health Better Wales: a Strategic Framework*' (Welsh Office, 1998e), was published, setting out aims and priorities for improving health and reducing health inequalities. These documents prioritised public health promotion and paved the way for new links between local health groups and public health care, thus bridging a long-standing divide between public health and local health care agencies. Across the four LHGs studied, public health issues have received increasing attention. In 2003, two new public health organisations were established in Wales, the National Public Health Service (NPHS) and the Wales Centre for Health, to oversee and improve on the majority of public health functions that have been normally managed by Health Authorities. The new Public Health Service in Wales aims to provide public health advice and expertise, predominantly to local health boards, while the new Wales Centre for Health is an independent centre for public health advice, providing information and research for multi-professional development.

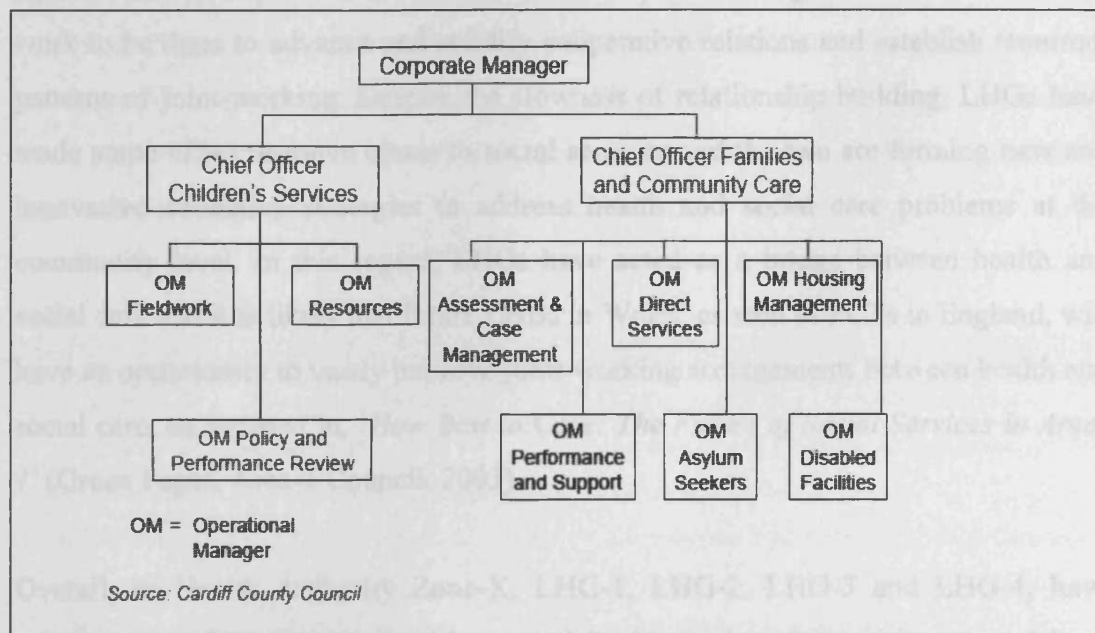
There are many examples of new public health promotion initiatives across all four LHGs. One example is the '2Tuff2Puff' pilot for the cessation of smoking scheme established in LHG-1 with the assistance of the National Assembly. The scheme is aimed at informing young people about the health risks from smoking and seeks to support young people to quit smoking. The scheme is run in three youth centres and provides a forum for young people to discuss smoking, and offers a support pack and tutor for young people to help stop smoking. There are plans to run similar schemes for other areas of health, such as sexual health, mental health, or stress clinics, across all four LHGs (LHG-1 Board Report, 2002b: 2).

Another area in which LHGs have been able to respond to local need, is the area of mental health. The four LHGs studied each identified mental health as an area for investment and improvement, following directions from the National Assembly to address clear deficiencies in the provision and assessment of mental health. LHG-1 for example, undertook a substantial review of mental Health Services during 2001-2003, that led directly to the drafting of a new service model to tackle the local need for mental Health Services in area LHG-1, and across the three other LHGs within HA Zone-X. Local health groups have followed the recommendations of the national service framework on mental health, '*Modern Standards and Service Models: Mental Health*' (DoH, 1999), which calls for a long-term approach to strategic change and development, and is specifically aimed at ensuring that people receive the right sort of treatment, in the right place, at the right time, according to their needs. LHG-1 has sought to develop a mental health programme, supported by inpatient beds and integrated with primary care services. More detailed components of the plan are: establishing five community mental health teams in Area-1 to provide a more community focused service; providing specialised community mental Health Services on an integrated basis for Area-1 and in central and eastern Area-4; establishing a new day hospital for Area-1; providing new inpatient facilities to replace the current old and dilapidated buildings. Initial costs of the proposals are identified as being £38.3 million capital and £12.3 million revenue. A three-month public consultation on the above proposals as set out in, '*A New Mental Health Service for Area-1*' was undertaken from July 2002 to October 2002.

One of the underlying aims of the NHS Plan 2000 (DoH, 2000) has been to further integrate primary health care with social services. Critics of the long-standing separation of health and social care have argued that large cost savings and service improvements might be made by combining the vast bureaucratic Department of Social Services, with primary health care health authorities and NHS Trusts. The Health Act 1999 (DoH, 1999) enables local councils and the NHS to: pooled budgets, allowing local health and social services to create a single dedicated budget to fund a wide range of care services; lead commissioning, either the local authority or the health authority/primary care group to take the lead in commissioning services on behalf of both bodies; integrate providers, local authorities and health authorities may

merge their services to deliver a one-stop package of care (NHS Plan, chapter 7: DoH, 2000). Since 1999, the four Local Health Groups of Health Authority Zone-X have sought to develop better links with social service departments. Across the four LHGs investigated, LHGs have forged tentative links with a range of agencies involved in social care. In most instances networking with social services has occurred as part of wider cooperative working schemes, such as that in LHG-1, where the LHG has worked as part of a health alliance comprising of the Health Authority, the Local Authority, the Trust, Community Health Council, voluntary organisations, and Social Services. Figure 6 below shows the relative managerial structure of social services in Area-1.

**Figure 6 Structure and Organisation of Social Services in Area-1**



Source: Joint Review Report by the Audit Commission and Social Services Inspectorate for Wales (SSIW) in Area-1, 2002: 20

A Joint Review Report by the Audit Commission and Social Services Inspectorate for Wales (SSIW) in Area-1 of HA Zone-X found that social and health care agencies had failed to jointly deliver patient-centred programmes of work. The review found that:

*“The Joint Review Team judges that the Authority is not serving the people of Area-1 well and that, without a significant change in approach, it has poor prospects of improving its performance...The Authority is still recovering from many years of organisational and management change. As a consequence, the development of a more strategic and cost-effective use of resources has been delayed...although many staff are committed to providing high quality care, they*

*are constrained by a below average level of funding, recruitment difficulties and a limited range of largely uncoordinated services”* ('Overall Conclusions', Audit Commission and SSIW Joint Review, 2002: 4).

The report also outlined the need for better joint working arrangements in Area-1, stating that:

*“The Authority has the benefit of being coterminous with the Area-1 Local Health Group, on which it is represented at both member and officer level, but joint strategic planning is still at an early embryonic stage. Nevertheless, some effective partnership working has been initiated through the local Health Alliance”* (Audit Commission and SSIW Joint Review, 2002: 20).

Observations made by this study, substantiated by reports such as the Audit Commission and SSIW review, show that links between primary care health care agencies and social services remain in a developmental stage. There is much more work to be done to advance and solidify cooperative relations and establish recurrent patterns of joint-working. Despite the slowness of relationship building, LHGs have made some effort to move closer to social services and the two are forming new and innovative collective strategies to address health and social care problems at the community level. In this regard, LHGs have acted as a bridge between health and social care and it is likely that future LHBs in Wales, as well as PCTs in England, will have an opportunity to vastly improve joint-working arrangements between health and social care, as outlined in, *‘How Best to Care: The Future of Social Services in Area-1’* (Green Paper, Area-1 Council, 2003).

Overall, in Health Authority Zone-X, LHG-1, LHG-2, LHG-3 and LHG-4, have raised the profile of public health, mental health, and social care issues and have brought such issues closer to the centre of decision-making. For the first time decisions about the allocation of resources and the targeting of such resources are being made by professionals that are working at the community level and understand local needs. Each Local Health Group has been able to raise the profile of public health, mental health and social care, and has been able to forge new links across public health, mental health, and social care agencies. The important aspect of this cooperative form of working is the emphasis placed on ‘local need’ and ‘local problems’. The LHG brings together a range of professionals with individual insights into the health and well-being issues within the locality context. Importantly, the LHG

identifies need from the bottom up, or responds to strategic policies, that are formulated at the national or regional levels, such as the emphasis placed on public health promotion.

#### 7.14 Networking across Local Health Groups: The Work of LHG-2

Health Authority-X reports and external studies of Area-2 have consistently shown that Area-2 suffers from high levels of social and economic deprivation, and poor health (*Health in Wales: Chief Medical Officer's Report*, 2001-2002). In addition, the provision of health services in Area-2 have remained underdeveloped (LHG-2 Report, 2002: 4). In 1999, Area-2 LHG-2 set about tackling a wide range of health and health-related problems. The LHG spent much of its time appraising the 'health needs' of the local population during 1999-2000. LHG-2 subsequently devised and implemented a 'Health Action Plan' (LHG-2, 2000-2003) to tackle the areas identified as needing immediate attention. Table 7 shows the outcome of the assessment of health needs in Area-2.

**Table 6 Area-2 Health Status and Causes**

Health Problems Identified	Socio-Economic Reasons for Poor Health
<ul style="list-style-type: none"> <li>▪ High levels of ill health: heart disease, respiratory problems, diabetes</li> <li>▪ High levels of hospital admissions (higher than Welsh average)</li> <li>▪ High levels of teenage pregnancies</li> <li>▪ High levels of mental health problems</li> <li>▪ High levels of substance abuse</li> </ul>	<ul style="list-style-type: none"> <li>▪ Many people have unhealthy lifestyles</li> <li>▪ Low uptake of preventative healthcare, such as screening and immunisation</li> <li>▪ Low income households, with high numbers of people on social care benefits</li> <li>▪ High number of lone parents</li> <li>▪ High number of residents over 65 living alone</li> <li>▪ Poor quality housing and local leisure facilities</li> </ul>

Source: 'LHG-2 A New Beginning: Consultation Document on Developing Health Services in the LHG-2 Valley', Report, March, 2002.

In March 2000, LHG-2 began to respond to the areas of need identified above by commissioning a project with Health Authority Zone-X to develop a model of integrated primary, community, intermediate and hospital based services. The model aimed to improve the services provided in Area-2 by devising new collaborative ways of working and service delivery that would involve primary care, the NHS Trust, the

local authority, user groups and the voluntary sector. The plan expressly sought to:

*“Develop and provide a network of modern services which are clinically effective, appropriate, locally accessible and responsive to the needs of the local population” (LHG-2 Report, 2002: 9)”*.

The plan involved working with a wide array of partners to deliver on the health needs and service developments outlined. A Task and Finish Group in Area-2 worked on forming collaborations with the following groups: clinical staff: doctors, nurses, and therapists; local GPs and allied health professionals, Health Authority Zone-X, Area-2 NHS Trust, Area-2 community health council, Area-2 borough council, Area-2 LHG, voluntary sector groups and the public. In essence, LHG-2 conducted a consultation exercise over the years 1999-2001, to identify needs, establish new institutional relations, form bonds, link-up staff and services, and to put in place new procedures and secure funding for service developments. In 2001, a primary care support team (PCST) was established by LHG-2 to provide general practices with training and support. The PCST also provides services to patients, if such services are unavailable within existing practices, thus providing additional expert and specialist care that single GP practices may not be able to provide. The team have been involving in scheduling new training opportunities for primary care doctors and nurses, and in the recruitment of new staff to the area, something that has been identified as a problem over the past ten 10 year. The introduction of the PCST has been welcomed by the general practitioners working in Area-2 (Interviews 31-33), and the majority of professionals interviewed expressed admiration for the work of the PCST and suggested that it was a ‘new innovation in health care delivery’ (Interviews 31-40). The chairperson of LHG-2 commented that:

*“...what is expected in Wales is a much more holistic approach. I think it’s the chair’s responsibility to make sure that all members of the board know what they’re there for, that they have to have an understanding of what is appropriate, that they have a realisation of what governance is...the chair’s job is to make sure that every single member can participate to the best of their capability, and that means them understanding governance” (LHG-2 Chairperson, Int. 31).*

Following further consultation with health professionals and interest groups in Area-2, LHG-2 proposed the development of two Primary Care Resource Centres (PCRC) in 2002. The Primary Care Resource Centre is designed to support the development of primary care in Area-2. The PCRC provides physical space to house additional

facilities, that are either lacking or underdeveloped in Area-2. GPs are able to use the PCRC to consult with their own list patients, to run additional specialises tests for example, or to simply act as a capacity buffer for over-subscribed general practices. One of the main functions of the PCRC is to run specialist clinics, for areas such as heart disease, diabetes, orthopaedics, gynaecology and urinary medicine, or sexual health. In this way, the PCRC extends beyond the capabilities of single general practices, and pools expertise from across Area-2. In addition, the PCRC links with specialist treatment centres situated in the secondary care setting of the NHS Trust, which allows the PCRC to access specialist staff and equipment, as well as expertise. The PCRC also provides training opportunities and support for health practitioners, doctors, nurses and allied health professionals. It is also proposed the PCRC might be used to co-train health and social care staff. Additionally, the PCRC will be the focal organising unit for local authority involvement and the work of voluntary groups. The PCRC represents a novel approach to health service planning and provision. Since 2002, LHG-2 has been working on the development of two Primary Care Resource Centres, a stand-alone PCRC that sits within the community, and an integrated PCRC that transcends primary, intermediate, and secondary care (table 7, 8, respectively).

**Table 7 Stand-Alone Primary Care Resource Centre Area-2**

<p><b><u>Primary Care:</u></b></p> <ul style="list-style-type: none"> <li>▪ Minor Surgery</li> <li>▪ Consulting rooms</li> <li>▪ Counselling service</li> <li>▪ Health promotion advice</li> <li>▪ Chronic disease management</li> <li>▪ Primary care clinics</li> </ul>	<p><b><u>Trust Services:</u></b></p> <ul style="list-style-type: none"> <li>▪ Base for community staff</li> <li>▪ Community dentistry</li> <li>▪ Therapists</li> </ul>
<p><b><u>Local Authority:</u></b></p> <ul style="list-style-type: none"> <li>▪ Access to employment advice</li> <li>▪ Housing and benefits advice</li> <li>▪ Links to nursing and residential homes</li> <li>▪ Links to education</li> </ul>	<p><b><u>Voluntary Sector:</u></b></p> <ul style="list-style-type: none"> <li>▪ User and carer support groups</li> <li>▪ Advocacy services</li> <li>▪ Links to community groups</li> </ul>

Source: 'LHG-2 A New Beginning: Consultation Document on Developing Health Services in the LHG-2 Valley', Report, March, 2002: 16.



**Table 8 Integrated Primary Care Resource Centre Area-2**

<p><b><u>Primary Care:</u></b></p> <ul style="list-style-type: none"> <li>▪ GP out-of-hours service</li> <li>▪ Consulting rooms</li> <li>▪ Counselling service</li> <li>▪ Health promotion advice</li> <li>▪ Chronic disease management</li> <li>▪ Primary care clinics</li> </ul>	<p><b><u>Trust Services:</u></b></p> <ul style="list-style-type: none"> <li>▪ Rehabilitation clinics</li> <li>▪ Base for community staff</li> <li>▪ Therapists</li> <li>▪ Diagnostics</li> </ul>
<p><b><u>Local Authority:</u></b></p> <ul style="list-style-type: none"> <li>▪ Access to employment advice</li> <li>▪ Housing and benefits advice</li> <li>▪ Links to nursing and residential homes</li> <li>▪ Links to education</li> </ul>	<p><b><u>Voluntary Sector:</u></b></p> <ul style="list-style-type: none"> <li>▪ User and carer support groups</li> <li>▪ Advocacy services</li> <li>▪ Links to community groups</li> </ul>

Source: LHG-2 A New Beginning: Consultation Document on Developing Health Services in the LHG-2 Valley, Report, March, 2002: 15.

The PCRC goes far beyond the historical limits of single GPs working as gatekeepers to the larger hospital sector, whereby nurses and other health professionals worked in an isolate fashion out in the community. The development of the PCRC in Area-2, by LHG-2, illustrates the enhanced integration of primary care professionals and agencies, and the new closeness of the planning and commissioning of services. It is doubtful whether such cooperation and closeness would have been achieved by maintaining the health authority system, or under the internal-market system. The micro example of the joint-working in LHG-2 is significant for a number of important reasons. Firstly, it is clear that LHG-2 has been able to access the community, and community services, arguably in a way that Health Authority Zone-X has found difficult to achieve. LHG-2 is situated in Area-2 and is operated by professionals that have many years experience of the problems and services required for the area. The LHG has brought a more local focus, that is far more inclusive than that of the health authority system; whereby health authorities have historically adopted a strategic-perspective and resource-allocation approach (Smith and Shapiro's, 1997). In addition, service change is now being championed by the health professionals that work within the community setting, rather than by Health Authority managers that reside in offices in a geographical area outside Area-2. To this end, there is a new level of closeness to the problems of the community, whereby the professionals on the ground are involved in devising appropriate and novel solutions that directly tackle

the needs of the community. These professionals have many years experience of the needs of the community. The suggestion here is that by being part of the LHG, health professionals feel more empowered to influence the decision making process in health care planning and commissioning, particularly the allocation of resources, whereby they feel more involved and committed to change. This might feed into the New Public Management thesis of the '*managerialisation of health professionals*' (Ferlie et al., 1996), however it does illustrate an empowering of health professionals in primary care and the devolution of centralised power away from bureaucratic bodies like health authorities, to health care professionals working on the front line of the NHS. The supposition is that the increased involvement of primary care professionals, and the increased networking of health care agencies and stakeholders, will lead to more targeted services that better formulate and respond to the needs of patients and users.

### **7.15 Inter-Professional Networking**

One of the main themes to emerge from interviews with professionals working across LHG-1, LHG-2, LHG-3 and LHG-4, was the high level of support for the work of LHGs and the high level of commitment expressed by individual LHG members towards this new form of collective decision-making and professional collaboration in primary health care. The structure of LHG boards held widespread support among the four LHGs. In comparison to primary care groups in England, local health groups in Wales are more inclusive, with a wider spectrum of health managers, health professionals and co-opted members (described in chapter 6). Table 6 illustrates the breadth of membership across the four LHGs studied in Health Authority Zone-X and the inclusive composition of LHGs including: general practitioners, a community pharmacist, a dentist and an optometrist, two local authority representatives, two health authority officers (one from social services and one from another department such as environmental health, environmental safety, housing or strategic planning), a representative of a local voluntary organisation, and a lay member, specifically appointed to represent the local community.

**Table 9 LHG Board Membership Across LHGs in Health Authority Zone-X**

<b>LHG – 1</b>	<b>LHG – 2</b>
<b>Profile of Executive Board</b>	<b>Profile of Executive Board</b>
<ul style="list-style-type: none"> <li>▪ Chair Person (GP)</li> <li>▪ General Manager</li> <li>▪ General Practitioner Members x 6</li> <li>▪ Nurse Representatives (health visitors) x 2</li> <li>▪ Optometrist x 1</li> <li>▪ Dentist x 1</li> <li>▪ Health Authority Representative x 2</li> <li>▪ Local Authority Representative x 2</li> <li>▪ Pharmacist x 1</li> <li>▪ Lay Member x 1</li> <li>▪ Voluntary Sector Representative x 1</li> </ul>	<ul style="list-style-type: none"> <li>▪ Chair Person (GP)</li> <li>▪ General Manager</li> <li>▪ General Practitioner Members x 6</li> <li>▪ Nurse Representatives (health visitors) x 2</li> <li>▪ Optometrist x 1</li> <li>▪ Dentist x 1</li> <li>▪ Health Authority Representative x 2</li> <li>▪ Local Authority Representative x 2</li> <li>▪ Pharmacist x 1</li> <li>▪ Lay Member x 1</li> <li>▪ Voluntary Sector Representative x 1</li> </ul>
<b>LHG – 3</b>	<b>LHG – 4</b>
<b>Profile of Executive Board</b>	<b>Profile of Executive Board</b>
<ul style="list-style-type: none"> <li>▪ Chair Person (GP)</li> <li>▪ General Manager</li> <li>▪ Clinical Governance Lead (GP)</li> <li>▪ General Practitioner Members x 4</li> <li>▪ Nurse Representatives x 2</li> <li>▪ Optometrist x 1</li> <li>▪ Dentist x 1</li> <li>▪ Health Authority Representative x 2</li> <li>▪ Local Authority Representative x 2</li> <li>▪ Pharmacist x 1</li> <li>▪ Lay Member x 1</li> <li>▪ Voluntary Sector Representative x 1</li> </ul>	<ul style="list-style-type: none"> <li>▪ Chair Person (GP)</li> <li>▪ General Manager</li> <li>▪ General Practitioner Members x 6</li> <li>▪ Nurse Representatives (health visitors) x 2</li> <li>▪ Optometrist x 1</li> <li>▪ Dentist x 1</li> <li>▪ Health Authority Representative x 2</li> <li>▪ Local Authority Representative x 2</li> <li>▪ Pharmacist x 1</li> <li>▪ Lay Member x 1</li> <li>▪ Voluntary Sector Representative x 1</li> </ul>

Note: LHG Board Membership as-at 01/12/2002

In addition to the fixed membership of the different LHGs in HA Zone-X, all four LHGs had co-opted representatives from a range of external services or agencies, from secondary care with inclusion of NHS Trust representatives, and from community groups, particularly community health councils (CHCs), to either the main board or one or more subcommittees. Examples 1 and 2 below show the type of co-opted members involved across two Local Health Groups, (LHG-2 and LHG-3). This co-opting of additional professional members, health specialists, or interest parties, from outside the prescribed list of LHG professional board members, illustrates one of

the best examples of how LHG are being used to network with upstream secondary care providers and downstream health users, as well inter-agency collaboration and inter-professional joint-working. The LHG reflects a more flexible and fluid structure than the traditional health authority. Where a LHG requires specialist assistance or input, it can co-opt members to the board. One of the key areas for development is cooperation between the LHGs and the NHS Trust. This link remained under-developed up until 2001, however it is expected that as LHGs take on more responsibilities for service commissioning and delivery, particularly when they become local health boards (in April 2003), links between primary care LHGs/LHBs and secondary care providers, NHS Trusts, will strengthen.

**Example 1: Local Health Board Meeting**  
**LHG-1 March 2002**

Co-opted members and additional attendees:

- Community Health Council Representative
- Head of Primary Care and Clinical Governance – NHS Trust
- Corporate Support Manager – Health Authority
- Finance Manager – Health Authority
- Partnership Manager<sup>6</sup>

**Example 2: Local Health Board Meeting**  
**LHG-3 September 2002**

Co-opted members and additional attendees:

- Health Development Manager – Health Authority
- Lead Primary Care Pharmacist
- Nurse Consultant – NHS Trust
- Finance Manager – Health Authority
- Primary Care Audit – Health Authority

As mentioned earlier, the diverse and inclusive structure of LHG boards has elicited considerable support among LHG members and health professionals within HA Zone-X. Interviews with LHG Board members drawn from community-level services, dentists, pharmacists and optometrists, revealed a high level of satisfaction among these professionals and predominantly positive comments relating to members' experiences. Only limited negative accounts were recorded and these mostly all related to professionals feeling isolated from LHG activities, particularly were LHG managers failed to inform professionals of developments within their LHG. Informal interviews with the pharmacist and dentist members of LHG-1 showed how these

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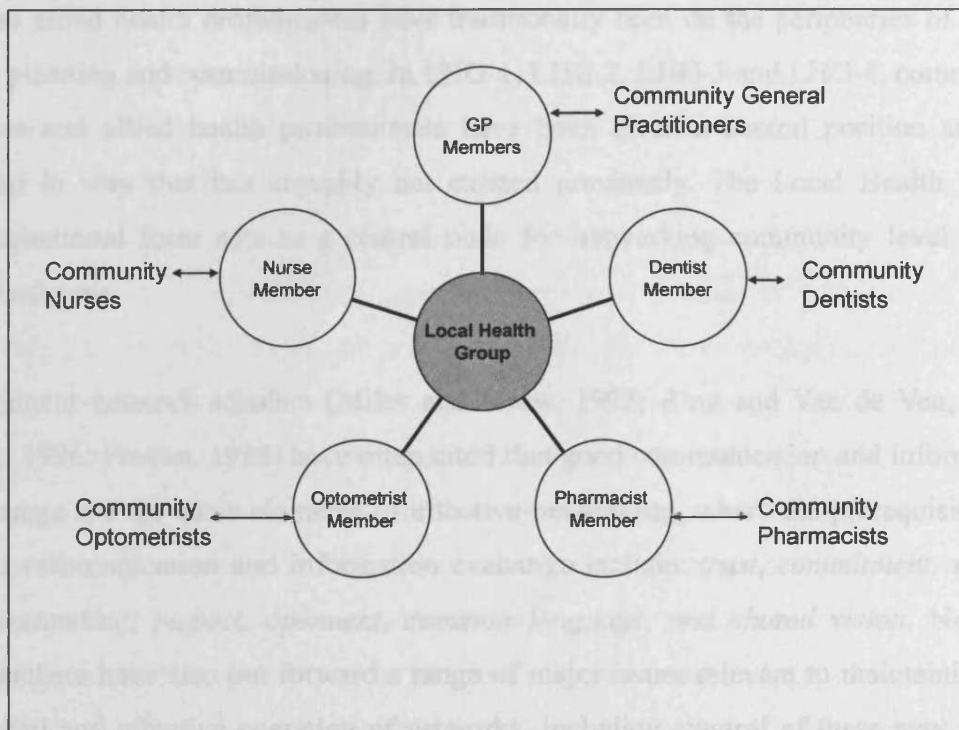
<sup>6</sup> Source: Participant observation; minutes of meeting LHG-1 March 2002 and LHG-3 September 2002  
246

professionals sometimes felt on the periphery of LHG decision making:

*“Generally the LHG works well however, there are times when I’m not sent the details of all the decisions made via the general manager and the financial officer...my position is to act as a committee member that has special knowledge of community pharmacy practices and requirements...I feel fully involved in the work of Area-1 LHG”* (Pharmacy Officer, LHG-1 Board Meeting, Int. 25).

The majority of accounts recorded in the field and from dialogue with a wide range of professionals working within LHG-1, LHG-2, LHG-3, and LHG-4, reflect that there has been a positive response to the introduction of LHGs from health care practitioners and allied representatives working in primary care at the community level. Each LHG brings together a wide grouping of health professionals to jointly plan and manage primary care services; previously service planning and commissioning occurred within the health authority. Professionals such as community pharmacists, dentists, optometrists and nurses have been given a platform to relay their experiences and knowledge of patient need and service development. In essence, each LHG reflects a microcosm of inter-professional networks, whereby each professional representative of the LHG Board represents a body of professionals working at the community level (figure 7).

**Figure 7 Inter-Professional Networking Via LHGs**



The LHG reflects a two directional form of networking activity. Across LHGs 1, 2, 3 and 4, health professionals such as general practitioners, community nurses, community pharmacists, community optometrists, and community dentists, make up the Executive Committees of the different LHG Boards. These professionals help shape the policy of the LHG, implement the LHG's strategies, but also influence the LHG's approach and priorities. While community health professionals act as committee members with the capacity to remain neutral in decision making, committee members bring with them their professional expertise and experience. They also indirectly represent the body of health professionals working within a given locality area. For instance, in LHG-1 area covers the remit of 56 general medical practices, with approximately 199 GPs, 66 dental practices, 74 pharmacy practices and 47 optometry practices. The presence of the LHG allows these professionals to engage with Health Service planning and development, not only through direct contact with the LHG, but also via individual professional representatives, such as the GP members of LHG-1 communicating with the 199 GPs of Area-1. While GP representation has traditionally been strong at the national level via the British Medical Association (BMA) and at the regional level via professional bodies such as the Royal College of General Practitioners, representation for allied health professional such as dentists, pharmacists and optometrists, has been arguably weaker. These allied health professionals have traditionally been on the peripheries of health care planning and commissioning. In LHG-1, LHG-2, LHG-3 and LHG-4, community nurses and allied health professionals have been given a central position and are linked in way that has arguably not existed previously. The Local Health Group organisational form acts as a central node for networking community level health professionals.

Prominent network scholars (Miles and Snow, 1992; Ring and Van de Ven, 1994; Park, 1996; Provan, 1998) have often cited that good communication and information exchange are the basic elements of effective networking, where the prerequisites for good communication and information exchange include: *trust, commitment, mutual understanding, respect, openness, common language, and shared vision*. Network researchers have also put forward a range of major issues relevant to maintaining the survival and effective operation of networks, including, control of these new forms;

stability and longevity over the short and long terms; the need to maintain a high trust and high commitment environment; aligning goals and congruence; and evaluating performance (detailed in chapter 1 and 2).

Across the four Local Health Groups investigated in Health Authority Zone-X, a number of observations and findings emerged concerning the nature of relationship building and maintenance within these organisations. Interviews were conducted with representatives from LHG-1, LHG-2, LHG-3, and LHG-4, as well as with representatives from allied agencies or stakeholder groups. These interviews explored a range of important relational factors and contextual factors previously identified in chapters 1, 2 (appendix I and appendix II). Interviews explored a range of issues and factors, including: the role of individuals within the LHG, their level of commitment; the objectives of the LHG; the range of agencies and professionals involved; levels of trust and goal congruence; stability and longevity; conflict and rivalries; accountability and performance. In practice, this structured style required constant adjustment, as many professionals offered between less than 30 minutes for interview, while others opted for short telephone interviews and a significant proportion of potential interviewees declined interview requests. In such instances, a more limited number of topics were covered.

One of the most striking aspects of interactions with health and social care professionals working within and across the four Local Health Groups of Health Authority Zone-X was the enthusiasm for work of the respective LHGs and the positive response towards structural and procedural changes in NHS Wales post-1999. Across the four LHGs studied, members expressed a clear enthusiasm for joint-working and the new role of LHGs in formulating and implementing health policies. LHG representatives often commented on feeling more involved than ever before in the decision making process. The majority of interviewees expressed feelings of commitment towards the work of their LHG and new collaborative working arrangements. However, some expressed concerns over heavy workloads and the dual commitment of professional work as well and working as a representative of the LHG. The majority of health professionals interviewed expressed feelings of harmony and trust towards other members of the primary care team. However, some professionals,

particularly community nurses, felt GPs dominated LHG meetings and agendas. This view was supported by observations that revealed that GPs tended to dominate discussions at LHG Board Meetings:

*“After attending a number of executive board meetings across the four LHGs a pattern of working is clearly visible. The chairperson opens meetings by setting out the agenda for the meeting. During meetings, points of service development are discussed among the professionals present. The general practitioner members talk more often than any other professional group and are the main group for protest against any plan or policy they may oppose. The other professionals, nurses, pharmacists, optometrists, and dentists, only really speak when the discussion is directly related to their field of expertise. The most common conflict or disagreements appear to occur between GPs and Health Authority officials. However, all groups appeared to work amicably and all parties are involved”* (Field notes LHG-1, 2, 3, 4 site visits 2001-2003).

In follow-up interviews, GPs often emphasised their position as specialist, and as patient advocate, in relation to their role as a representative on LHG boards. The issue of the dominance of GPs on LHG Boards raises the important issues of power and goal congruence (Appendix I and II). The majority of interviewees were clear about the overall objectives of the LHG, most had knowledge of the National Assembly's Plans for reform as well as Department of Health policy. Goals only ever appeared in conflict with regard to professional goals versus managerial goals, for example GPs versus health authority managers. This study found only minimal instances of conflict between LHG partners. In one instance, conflict arose between a general manager and GPs within the LHG-1 board, whereby GPs felt that the general manager had not consulted them on changes made by the LHG. There appeared to be some level of tension between health professionals and health managers. General practitioners in LHG-1 reported feeling dissatisfied with Health Authority Zone-X. One GP recounted how:

*“...we (GPs) got together at one stage and threatened to boycott the LHG...we were just fed-up with one particular manager from the health authority and we wanted to take action...about the coupes, there have been two separate occasions when the Board members have met without the chairman and General Manager being there to decide ways forward, if you see what I mean...and that would be where we have had meetings and summoned them to the meeting to be very clear that the Board sets the policy, it doesn't rubber stamp policy coming the other way”* (GP LHG-1, Int. 22).

In other instances GPs and community nurses in LHG-3, argued over decisions made



at the allocation of resources for specific projects in the locality. Overall, there were very few identifiable instances of significant disagreement among LHG members, or between LHGs and other agencies.

In relation to goal congruence, some instances of goal incongruence were recorded. One of the most interesting areas of dispute over goals emerged in LHG-1 concerning the need for an out-of-hours service, akin to a 24-hour drop-in centre, to cater for the large student population residing in Area-1. Members of the wider primary care team and LHG board forwarded proposals for the creation of an out-of-hours service in Area-1. Importantly, the District Audit Office and the local Community Health Council were instrumental in bringing proposals forward for a 24-hour health centre however, the proposal was blocked by GPs on the LHG board and GPs within Area-1. Interviews with the District Audit found that the DA had written to the Students Union of the main university in Area-1, offering them the opportunity to take part in a health forum on 'the need for out-of-hours health care', that would link up with the Locality Steering Group of LHG-1, to formalise the proposal. However, GPs at the LSG level and in the wider primary care area blocked the proposal, on the grounds that it went beyond the remit of the current GP Contract. The District Audit officer blamed the contractual status of GPs as a barrier to development:

*"I've said in meetings, the whole of the Welsh nation use general practice, but nobody, or a small percentage of the people actually know how primary care works, how GPs are funded...people believe that GPs are in the NHS, whereas pharmacists they know are not. I think there is total patient ignorance about how primary care services are organised, delivered and paid for in this country...and if you made people aware, there would be hell at high noon, because they wouldn't be happy with it...its cartelish, it's a monopoly"* (District Audit Officer, Int. 7).

Importantly, the District Audit Office felt that the introduction of Local Health Groups in Wales and more specifically within Health Authority Zone-X, provided a platform to challenge professional power and dominance within primary care:

*"...with so many people in independent contractor status, too many people have too much invested, they don't want to go along with what's obviously good...until we had LHGs, GPs wouldn't really talk to each other at all...we come back to the setting up of these Local Health Groups, were you can over a period of time...actually start to ask some challenging questions"* (District Audit Officer, Int. 7).

The example from LHG-1 relating to the out-of-hours service, demonstrates the continuing blocking power of the medical profession in primary care and their dominance of new institutional arrangements such as local health groups. However, as noted by the District Audit Office, the introduction of LHGs has also provided a platform to challenge GP power and to articulate the need for service developments, such as services that go beyond the remit of traditional general practices. While this example appears to implicate GPs as a restrictive force, this view needs to be counterbalanced by the positive work of GPs in service improvements, such as those articulated in LHG-2 and LHG-3 above, where GP members have been champions for service development and innovation at the local level. Importantly, the LHG has been the platform for such innovations.

Another recurrent theme in interviews and interactions with health professionals working in primary health care across all four LHGs, is the perception of instability that has arisen in the NHS in recent years. As one practitioner commented:

*“I think basically its (LHG partnership working) likely this is going to continue for the next few years, one of the problems is that we set up a structure, it doesn't work because it doesn't have the funds to work and therefore we then change the structure again. We don't leave them long enough to see if they will have good outcomes because what you have is politicians whose life spans are five years trying to decide how an organisation with a life span of say, 20 or 25 years, is going to function. They want quick-fixers...headlines, so they're re-elected and then they go, whereas the NHS you know, it needs more...., for example diabetes, I wont see the result of my diabetic work today for 15 or 20 years, so if you're going judge me on my outcomes today, you actually have to judge me when I was still...doing A-levels” (GP LHG-3, Int. 43).*

Some interviewees expressed concerns about the pace of change in the NHS and in primary health care. Respondents reported feeling insecure that any future change in government might bring about a change in policy direction in health. Health professionals, particularly GPs, reported a number of contradictions in health policy, such as the emphasis on cooperation and the introduction of foundation hospitals.

In addition to the above relational factors, the important issue of the training of health care managers and practitioners to work collaboratively appears to be wholly absent, or neglected by health care policy makers. However, it is well know, particularly in the fields of social psychology, that training schemes between agencies and people

can aid the development of teamwork and collaboration between different sub-groups or professions. Interviews with LHG members across Health Authority Zone-X revealed that the majority of members had no formal training or advice on how to manage, collaborate, or resolve conflicts. One GP commented that:

*“The Board almost spends the vast majority of its time receiving reports of work that’s ongoing. Eighty percent of what we do is to review reports of work ongoing now. Very few of us are trained sufficiently to ask the sort of critical questions that need to be asked about things, and there is some discomfort among the managerial team when we do that....we spent some time developing our team working and looking at various things, links...but of course, everyone came from a slightly different viewpoint”* (GP Lead LHG-1, Int. 22).

The above statement provides an insight into the workings of LHGs and the role of individual professionals that have been asked to step outside their day-to-day roles as health practitioners and become effective partners making decisions about the allocation of large amounts of public funds, without any prior training or support for such cooperative working. As such, cooperation between partners in LHGs appears ad-hoc and founded on inter-personal relations, particularly among allied professional groups, particularly doctors. Across all four LHGs, GPs recounted being in contact with other GPs to communicate and cross-reference ideas or points of disagreement. This view is echoed in evidence from secondary sources (Audit Commission, 2000; Lyne et al., 2000; Hayes et al., 2000; McClelland et al., 2001; and Link et al., 2001). In addition, many LHG members complained that there were limited funds to develop innovative projects. One practitioner recounted how the LHG ‘*shelved new ideas and focused on budgets and general practice*’ (GP LHG-1, Int. 23). An Audit Commission report (2000) on local health groups in Wales highlighted the lack of time, physical and financial resources, as problems effecting LHGs. Time pressures are particularly salient in relation to LHG member involvement. In the majority of cases, professional members of LHGs, doctors, nurses, and NHS managers, cited a lack of available time as a major inhibiting factor for involvement in joint-working.

## **7.16 Involving the Public: the Role of Local Health Groups**

Involving the general public in health care and social care decision-making has been a major theme for the National Assembly for Wales since 1998, and is well articulated

in a number of strategic documents: *'Putting Patients First'* (Welsh Office, 1998a) and *'Improving Health in Wales'* (NAW, 2001c). More recently, the issue has gained considerable prominence following the publication of the Kennedy Report on the Bristol Royal Infirmary, whereby over 30 recommendations emerged relating to public involvement issues. In Wales, the issue has also gained increasing momentum, *'Improving Health in Wales'* pronounced that patients and the public are to be fully involved in decisions about their health, both at a strategic level, and on an individual basis. The benefits of involvement include: increased patient satisfaction, more responsive and cost effective health care services, and a general strengthening of public confidence in the NHS (NAW, 2001c). In November of 2000, the National Assembly for Wales commissioned the Office for Public Management (OPM, NAW) to carry out a review of all public and patient involvement initiatives in Wales, and to identify existing best practice from across Wales. The OPM subsequently produced a guidance document for LHGs and Trusts to carry out baseline assessments of public involvement and annual strategy plans for improving involvement. *'Signposts: A practical guide to public and patient involvement in Wales'* (OPM, 2001), clearly marks the way forward for this agenda, with guidance for all local health groups to produce baseline assessments and action plans for ensuring public and patient involvement in local planning of services. In future, these operating influences will continue to play a key part in maximising the 'lay voice' in influencing health and social care decision making.

Despite the clear rhetoric of increased public involvement, all four LHGs investigated by this study reported relatively moderate levels of direct public engagement. Despite members of the public being allowed to attend executive LHG board meetings, LHG managers and board members reported that it was rare for members of the public to attend meetings. One LHG chairperson commented that:

*"Executive Board meetings are probably not the best way for the public to be involved with what's happening in the LHG...meetings might be intimidating to members of the public, although they are more than welcome and we certainly encourage people to come and see what we are doing here...however we do try and engage with the public in the work we do, particularly in the GP practices and with the Local Authority"* (LHG-2 Chairman, Int. 31).

This lack of public involvement was also evident during attendance at LHG board

meetings over period of the study. Observational notes taken during visits to all four LHGs during 2000-2003 revealed a pattern of poor public involvement:

*“There appears to be very few members of the public at this meeting and the community health council representative and layperson members of the board do not seem to be involved in discussions...it seems that GPs dominate the discussion and talk about a range of specialised medical problems that lay members may not have expertise to understand or challenge”* (Observational Notes, LHG-2 Meeting May, 2002).

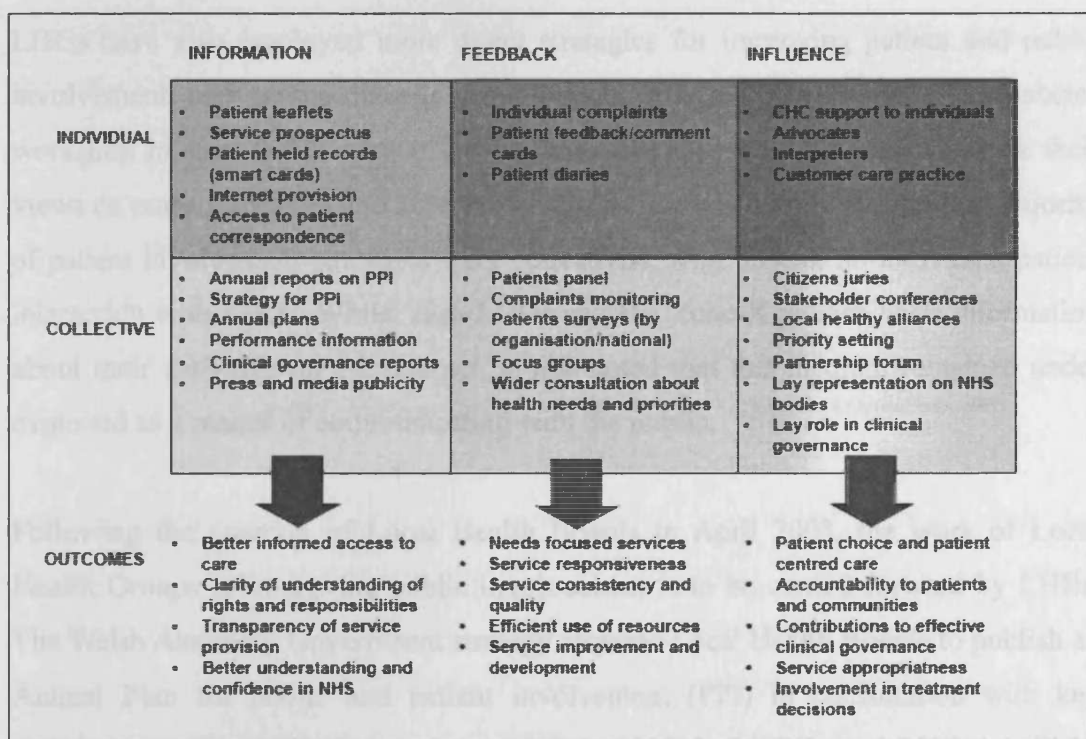
The relevance of such observations is that LHG board meetings may not be the best way of improving public access. The majority of LHGs suggested that they have made improvements in engaging with the public, but that this has been via collaboration with community health councils or as part of local projects, such as the diabetes project in LHG-2. All four LHGs stated that they were involved in community-based networks and were keen to expand the profile of the work they do in the community. Each of the four LHGs reported working with local patient groups around a range of specific health related issues, for example health awareness in LHG-3, drug abuse in LHG-2 and LHG-4, and economic poverty in LHG-1. LHG-1, LHG-2, LHG-3 and LHG-4, have each attempted to implement public involvement policies but have also developed innovative and localised forums for public participation. LHG-1 was the first of the four LHGs to establish a Public Participation and Partnership Sub-Group, to promote public involvement, and acted as a pilot site for the Baseline Assessment Exercise as part of the implementation of a guidance document *‘Signposts: A Practical Guide to Public and Patient Involvement in Wales’* (OPM, 2001). The baseline assessment showed Area-1 LHG to have established a broad range of involvement strategies, including:

- A well developed communication mechanisms for providing information and receiving feedback
- Strong partnerships with other organisations who have a wealth of experience and expertise in the area of public and patient involvement, the Community Health Council, the Voluntary Sector and the Local Authority
- Active involvement in partnerships that engage the public in a variety of ways
- A history of commissioned research projects designed to capture the public’s needs and views

- Excellent examples of involvement with communities who are traditionally difficult to reach, such as minority ethnic communities and socially disadvantaged groups<sup>7</sup>

The National Assembly for Wales Office of Public Management guidance document for LHGs and Trusts to improve public involvement, '*Signposts: A practical guide to public and patient involvement in Wales*' (OPM, 2001), suggests that LHGs need to focus on collective and individual strategies to improve public involvement. Figure 7 shows the individualistic and collectivist strategies that LHGs and NHS Trust should adopt to improve patient and public involvement.

**Figure 8 Dimensions of Public and Patient Involvement for LHGs**



Source: '*Signposts: A practical guide to public and patient involvement in Wales*' (OPM, 2001: 10)

Each of the four LHGs studied, LHG-1, LHG-2, LHG-3 and LHG-4, attempted to improve on public involvement by developing new communication and participation strategies. However, all four LHGs found it difficult to engage with the public and to increase public involvement. One of the ways in which the public are represented in

<sup>7</sup> Source: Area-1 Local Health Group (2002) *Pathways to Progress: Area-1 LHG's Legacy Statement*, December, 2002: 48-52.

LHGs is via the Community Health Council representative. CHC members are unique to LHGs in Wales and do not exist in PCGs in England. One prominent CHC member articulated the role of CHCs in shaping health policy and developing patient centred services:

*“If services are to be delivered locally for local people, you have to determine what is local and what is local enough to be deliverable, the model they have gone for in Area-1 is four Locality Steering Groups...our vision is for a core local forum in each of these areas that would challenge the professional view on the health issues that are needed in that area. For too long local people have had professionals saying this is what is good for you, and this is what we want to do...thinking its always in the patients best interest...sometimes it is in the patients best interest...sometimes its in the consultants' interest that wants more beds, or the consultant that wants to develop this;...its not really what the patient wants”* (Community Health Council Representative LHG-1, Int. 61).

LHGs have also employed more direct strategies for improving patient and public involvement, such as the diabetic group project in LHG-3. LHG-3 set up a diabetes workshop in June 2002, open to people with diabetes and their carers to seek their views on current services and how they might be improved in the future. The majority of patient involvement strategies were collectivist, with little or no individual patient interaction with LHGs. While, each LHGs and HA Zone-X publish basic information about their activities on the internet, it was noted that this medium remained under exploited as a means of communicating with the public.

Following the creation of Local Health Boards in April 2003, the work of Local Health Groups in improving public involvement, is to be carried forward by LHBs. The Welsh Assembly Government strategy requires Local Health Boards to publish an Annual Plan for public and patient involvement (PPI) in consultation with key stakeholders. The LHB that replaces LHG-1, LHG-2, LHG-3, and LHG-4, will be required to produce such an annual plan, detailing PPI activities. The Local Health Board will need to develop its own PPI Strategy, which will inform Annual Plans in future years. The Welsh Assembly Government has set out its vision of patient and public involvement in *‘The Future of Primary Care: An Action Plan for Primary Care in Wales’* (NAW, 2002). Local Health Boards will be responsible for implementing this PPI Strategy.

## **7.17 The Accountability of Local Health Groups**

The accountability of LHGs, to both central authorities and the public they serve, has been a central issue in debates concerning recent developments in primary health care. There has been some disquiet among commentators that the devolution of control and responsibilities away from health authorities to local health groups might hold adverse consequences for stakeholders and the general public (Hudson, 1999). In particular, as LHGs assume greater responsibilities, will their decisions be sufficiently 'transparent' or open to public scrutiny? The Audit Commission (2000: 10) found that only one-third of LHG boards meet in public at least once a month, compared to 82% of PCG boards in England. The National Assembly for Wales has suggested that accountability is a key priority and task of all LHGs in Wales. NAW policy dictates that accountability arrangements for all health bodies should be underpinned by new performance management targets for the NHS in Wales (NAW, 2000). During 2000-2001, local health groups and health authorities from across Wales agreed to develop a wider set of guidelines and targets for accountability, particularly in relation to involving the public and on clinical governance issues. There appears to be little in the way of clear guidelines for dealing with the important issue of accountability. All four LHGs expressed the need to develop greater emphasis on accountability matters, particularly how to involve the public and develop more transparency of service.

Clinical governance by LHGs is something of a complex concept given the independent contractor status of clinicians. LHG baseline assessments cover all the range of primary care professions. However, there continues to be some need to establish a more integrated system of clinical governance, one that includes all primary care professionals, such as practice nurses and attached staff. The majority of LHGs began by appointing a general practitioner as sole clinical governance lead in comparison to PCGs, with a majority of medical and nursing leads (Audit Commission, 2000: 10). The four Local Health Groups studied have all placed considerable emphasis on building collaborative relationships between practitioners, however many LHG members felt that more time was needed to evaluate if this higher level of inter-professional working would provide a more robust basis for clinical governance activities. A range of priorities emerged from discussions with the four LHGs: establishing leadership, structures, and accountabilities for clinical



governance; establishing multidisciplinary consortia to promote good working practices and developing performance feedback systems; developing innovative systems and technologies, such as e-mail, intranet access, and clinical information systems; advancing prescribing and referral protocols; tackling morbidity criteria, such as diabetes, cardiovascular diseases and cancer.

### **7.18 The Performance of Local Health Groups**

As mentioned earlier, the diverse and inclusive structure of LHG boards has elicited considerable support among LHG members and health professionals within HA Zone-X. The wider and more inclusive nature of LHGs has arguably improved outcomes across a number of important areas of primary health care, including: contributions to clinical governance; developing referral protocols and clinical pathways; tackling prescribing protocols and costs; oral health issues; research on determinants of health; establishing new alliances across boundaries between health and other agencies, as well as user groups and the voluntary sector. The Commission for Health Improvement (CHI) conducted a clinical governance review of HA Zone-X between November 2001 and July 2002. The Commission recorded a number of areas of successful service improvement and areas for further development and action (CHI, 2002: XI-XV). CHI found a number of examples of notable practice that are worthy of sharing within the health authority and, more widely, across the NHS. CHI also identified a number of areas for action of strategic importance to improve clinical governance in the Health Authority.

All four LHGs in Health Authority Zone-X have produced documents recording their achievements up until 2003, as part of the process of transfer of power from the four LHGs to the new Local Health Board of Zone-X. Table 8 below shows an extract from the 'Legacy Statement' of LHG-4, detailing the LHGs main achievements before handing over to the new LHB. LHG-4 is the smallest LHG in HA Zone-X, yet has been involved in a wide range of activities and programmes, and exemplifies some of the achievements made by LHGs, as illustrated below:

**Table 10 Clinical Governance Performance for LHG-4**

<b>Patients' / Public Experience</b>
<ul style="list-style-type: none"><li>▪ Successful implementation of the LHG Patient and Public Involvement Strategy</li><li>▪ Successful implementation and evaluation of the General Practice Assessment Survey (GPAS)</li><li>▪ Development of Healthwatch project across LHG Area-4</li><li>▪ General practice based patient participation groups established</li><li>▪ Community Improvement Project (CIP) established</li></ul>
<b>Use of Information</b>
<ul style="list-style-type: none"><li>▪ Caldicott Audit completed in all general practices across LHG-4, with a comprehensive report on audit results disseminated to each individual practice to inform further developments</li><li>▪ IM&amp;T manager appointed to support the practices and IT systems upgrade plans for each practice developed</li><li>▪ Medical records project supported helping practice to achieve a minimum standard, working with HA Zone-X Primary Care Audit Group through the ICE project and support the i3PC project</li><li>▪ In collaboration with HA Zone-X, a successful complaints procedure was enacted and information on trends analysed in order to ensure an improvement in the quality of service provided</li><li>▪ A whistle blowing policy was implemented in all primary care practices and also in the LHG team</li></ul>
<b>Process for Quality Improvement</b>
<ul style="list-style-type: none"><li>▪ A process of significant incident reporting was established</li><li>▪ 2 GPs part funded to complete the Diploma in Therapeutics</li><li>▪ Purchased SWEEP program for all community pharmacists, provided a tutor and workshops</li><li>▪ Advice on the implementation of NICE guidelines and guidance provided on prescribing visits and prescribing newsletters</li><li>▪ Successful implementation of the Prescribing Strategy</li><li>▪ Successful implementation of a pilot looking at the implementation of the atrial fibrillation pathway for the CHD NSF</li><li>▪ Successfully worked actively with the Area Child Protection Committee to ensure the development and implementation of a framework for the assessment of vulnerable children</li><li>▪ Commencement of working with the Area-4 Mental Health Locality Steering group to ensure implementation of key actions found in the Mental Health NSF</li><li>▪ The LHG supported the work of the Primary Care Audit Group</li></ul>
<b>Staff Focus</b>
<ul style="list-style-type: none"><li>▪ All LHG staff completed the appraisal and PDP process</li><li>▪ LHG supported dental nurses to under a NHQ</li><li>▪ Supported 3 GPs to complete the Certificate in Substance Misuse Management</li></ul>
<b>Leadership, Strategy and Planning</b>

- Role of General Practice Clinical Governance Lead established in each practice across Area-4
- Clinical Governance action plan delivered

Source: LHG-4 'Clinical Governance Annual Report' 2002-2003 (2003: 3-4)

Chapter 1 showed how performance in networks is something of an illusive research subject. While this study did not set out to assess the performance of the four LHGs in HA Zone-X, the accounts of LHG activities discussed above, demonstrates some of the achievements of LHG-1, LHG-2, LHG-3 and LHG-4, over the period 1999-2003. One of the speculative points this study raises, is whether or not such achievements would have been made prior to 1999, under the more hierarchical health authority dominated system, based on competition between purchasers and providers. This central question might be rephrased to: is collaboration more effective a governance form, than either hierarchical or market systems? This chapter has detailed some of the many achievements of LHGs in primary care, particularly the integration of primary care services using a cooperative approach with LHGs at the centre. However, these assertions are merely tentative conclusions drawn from this study, a full cost-benefit study of a quantitative nature would need to be conducted using time-series analysis to draw firm conclusions about the performance of primary health care institutions such as LHGs or PCGs, in delivering better services for patients and users.

### **7.19 Summary**

This chapter presented findings drawn from data collected and analysed during field investigations of networking and collaborative activities within and across the four Local Health Groups of Health Authority Zone-X between 1999-2003. This local level insight into the networking practices of four newly formed Local Health Groups represents an important element of the overall research design of this study. The community level focus explores and depicts how national and regional level health policy is implemented at the local level, and accounts for how health care agencies and professionals have responded to changes in working practices, particularly the more cooperative approach being developed between health care professionals and agencies within and across primary care services. The approach taken to collect data at the community level has been largely exploratory and descriptive, seeking to

explore the range of issues relevant to networking and seeking to map out and describe network ties and relations between network actors. The other main objective has been to report on the relational norms at work and the status of cooperative relations between agencies and professionals, by recording professionals' and network actors' attitudes towards new cooperative forms of working, across professions, agencies and services. Importantly, LHG-1, LHG-2, LHG-3 and LHG-4, being strategically situated as the central node or coordination mechanism, for an array of collaborative networking behaviours and relational processes, provided a platform for network analysis.

This chapter has detailed how the four LHGs of Health Authority Zone-X have engaging themselves in the process of relationship building across agency and professional boundaries. Each LHG is a multi-professional body responsible for integrating primary care organisations and professionals at the community level. Since their establishment in 1999, the four LHGs have moved from simple advisory bodies of the Health Authority to more proactive health care commissioning and provisory bodies. Each LHG has been involved in an array of vertical and lateral relationships that span between health and social care, health and public health, and between health and local government. This level of cross-linking of health care reflects an innovation that goes beyond the traditional remit of health authorities. This chapter showed how the health professionals involved with the different LHGs welcomed this new form of working. Professionals reported being highly committed to the work of LHGs. Inter-professional relations appeared cordial and functional, however there were signs that general practitioners dominated specific areas of the health development agenda. The introduction of LHGs has provided a platform for the inclusion of previously marginalised health professionals, such as community nurses, pharmacists, optometrists. Interviews and dialogue with these professionals revealed their enthusiasm for being involved in health planning. One of the key features of the LHG, is the way it is able to connect at the community level. Each LHG in HA Zone-X has been able to react to the micro-community needs of patients. Before the introduction of LHG-1, LHG-2, LHG-3, and LHG-4, Health Authority Zone-X was responsible for the commissioning and provision of all primary care services. Following the introduction of LHGs in the four sub-community localities of the Health Authority,

each LHG has responded to the established needs of the different communities served by the different Local Health Groups. Significantly, each LHG has been established by members of the primary care team that work within that specific locality areas. For instance, LHG-2 is headed by a local GP, that incorporates an LHG committee of doctors, nurses, social workers, local authority officers, health authority officers, and lay members from the voluntary sector. Since 2000, LHG-2 identified a lack of provision around key areas of health need, in coronary care, mental health, diabetic care, and family planning/sexual health. In response, LHG-2 devised and implemented a 'Health Action Plan' (LHG-2, 2000-2003), that brought together a range of agencies and professionals, such as doctors, nurses, therapists, health authority officers, the NHS Trust, the community health council, local authority, and user groups, to establish a Primary Care Support Team (PCST) and two Primary Care Resource Centres (PCRC). From 1999-2003, LHG-2 was able to establish a coronary care assessment programme, a diabetic care centre, a mental health assessment team and intervention protocols and a young persons drop in centre for sexual health advice and family planning. Similar activities have occurred across LHG-1, LHG-2, LHG-3, and LHG-4, whereby each LHG has been in a position to address very specific local health needs.

This chapter has outlined the many complex relations at work in primary health care. The remit of the Local Health Group goes far beyond that of early initiatives in primary health care, such as total purchasing pilots. This chapter has shown how LHGs have developed collaborative links between professions, medicine, nursing, optometry, dentistry, between health professionals, health managers and policy makers, and between health and social care agencies. As mentioned earlier, the diverse and inclusive structure of LHG boards has elicited considerable support among LHG members and health professionals within HA Zone-X. The wider and more inclusive nature of LHGs has arguably improved outcomes across a number of important areas of primary health care, including: contributions to clinical governance; developing referral protocols and clinical pathways; tackling prescribing protocols and costs; oral health issues; research on determinants of health; establishing new alliances across boundaries and between health and other agencies, such as the voluntary sector. The nurturing of partnerships between primary health

care providers and agencies responsible for health commissioning, has gone some way towards creating a more integrated and networked system of health care. The inference drawn from the accounts illustrated in chapter 7 is that (1) there has been an overall positive response to the introduction of LHGs from health care practitioners and allied representatives working in primary care at the community level, (2) for the first time a wide grouping of health professionals have been brought together to jointly plan and manage primary care services; as previously service planning and commissioning was conducted by the health authority, (3) professionals such as community pharmacists, dentists, optometrists and nurses have been given a platform to relay their experiences and knowledge of patient need and service development, (4) there is a higher degree of networking and integration via the LHG system than via previous fundholding or total purchasing pilots, (5) this cooperative system of working is in an early stage, and while it is possible to identify some improvements in service delivery and planning, the overall success of LHGs will not be known for some years to come.

While the initial enthusiasm for joint-working between the different professionals and agencies involved in the Local Health Groups of Health Authority Zone-X undoubtedly helped the initial development of these new institutions over the short term. The question now arises as how well these organisations can succeed to deliver health benefits through collaborative working over the long term. From April 2003, the four Local Health Groups of Health Authority Zone-X will cease to exist. Their responsibilities will pass over to one new large local health board. The LHB will combine the responsibilities of the Health Authority with those of the four Local Health Groups of Area-1, Area-2, Area-3, and Area-4. The concern is that by moving to one large health commissioning and provision body, the local focus and high level of professional involvement generated via the work of the LHGs, might be lost, where the LHB becomes a health authority under a different name.

## 8.1 Introduction

This chapter draws together the significant outcomes to emerge from the different stages of the study and seeks to relate outputs to the institutional and managerial contexts in which the study takes place. The chapter begins by restating the guiding aims and objectives of the study. Findings from the extensive literature review presented in chapters 1 and 2 are used to appraise the status of network research and to reaffirm the rationale for this study: as a response to the lack of research on networking and collaborative governance in health care. The chapter also presents the methodology crafted and utilised to address the main objectives of the study. The chapter goes on to present the important outcomes from the multi-level analysis of network activities across the national sector level, primary care level, regional level, and the local level contexts of the Health Service.

## 8.2 The Status of Network Theory

This study began with an extensive review of the literature on the theory and conceptual basis of inter-organisational networking. Chapter 1 began by presenting two views of networks: the institutional economic view of the network as an intermediary hybrid or short-term phenomena; and the organisational theory view of the network as a complex social arrangement that is distinct from markets or hierarchies. Chapter 1 also presented a summary or index of the main approaches and perspectives taken in the study of networks. The principal approaches outlined included: economic, organisational, negotiation analysis, resource dependency, neo-institutionalism, organisational sociology, radical Marxist, social psychology, business policy, industrial marketing, and population ecology. These different approaches have, in an iterative way, added to our understanding of organisational networking. Economic and strategy-based studies are notable as major contributors to network theory. Coase (1937) and Williamson (1975, 1985) have been instrumental in the development of a robust theory of exchange between firms. To emerge from economics and transaction cost theory are the important concepts of opportunism,

certainty, risk, asset specificity, and the problems of contingency contracting. Such concepts are extensively investigated and cited across many disciplines. Williamson's (1975, 1985) transaction cost theory is particularly dominant. Among managerial perspectives, industrial marketing studies of long-term buyer-seller relationships (Hakansson, 1982; Ford, 1980; Ford, Hakansson and Johanson, 1986; Forsgren and Johanson, 1992) that analyse the social-exchange aspects of inter-firm networks have been particularly influential in adding the social dimension to inter-firm exchange, as has social network theory (Burt 1979; 1990). The importance of the scarce resources theory has resulted in Pfeffer and Salancik's (1978) resource dependency perspective, another significant contributory approach. These antecedent contributions to contemporary network theory, while varied, have clear overlaps between approaches. Many organisational and strategic studies have been founded on economic principles of micro-economic firm behaviour. Despite the inter-twining of perspectives, distinctions may be drawn from the methods and approaches employed by different studies. Chapter 1 classified the major motivating factors influencing organisations to network under two main headings, namely 'economic' and 'strategic'. Chapter 1 found that firms commonly seek partnerships or network relations to achieve economic synergy (Luke et al., 1989). Networking facilitates resource sharing including production capabilities, or less tangible assets such as knowledge or know-how. The network represents a unique form of potential operational flexibility. The concept of the 'strategic network' has been used to define the inter-organisational network as a purposeful and conscious arrangement among related profit-seeking firms, to gain or sustain competitive advantage *vis-à-vis* their competitors outside the network (Miles and Snow, 1986; Jarillo, 1988). Teece (1992) illustrates how networks are used as connecting and transferring mechanisms for complementary and inter-dependent competencies between firms. Powell (1987) adds that the network facilitates the transfer of codified knowledge and technology, which are commonly difficult to trade in a market, or communicate through the hierarchy. Reve (1990) highlights the importance of inter-firm relationships to sustain competitive advantage.

Following on from discussions concerning the rationale for entering into networks, chapter 1 presented arguments concerning '*theories of the firm*', and consequently '*theories of the network*'. The argument that firms emerge from the imperfections of



markets holds some relevance to the assertion that networks emerge from the imperfections of markets and hierarchies. This market-firm-network continuum raised the problem of network classification, and raised questions about the distance between conceptualisations of network and the empirical manifestation of network. Table 1 of chapter 1, provided a summary of the different forms of network identified in the literature. Significantly, there are many factors influencing the type of network, from the number of partners, to the level of interaction, to objectives, expectations, and so on. Chapter 1 also highlighted that while the range of approaches taken in the study of inter-organisational networking are broad and multi-disciplined (*breath of understanding*), there appears to be a lack of understanding concerning the processes of networking (*depth of understanding*). Network theory is somewhat limited in explaining the factors that influence the success or failure of network arrangements (Grandori and Soda, 1995; Park, 1996; Ring and Van de Ven, 1992: 90; Jenson and Meckling, 1970; Mintzberg et al., 1996:60). In addition, the literature provides little in the way of guidance on how to manage network relationships post-formation. In a related vein, the benchmark against which to assess network outcomes, network effectiveness and network performance, remain ambiguous and poorly defined. Even in the general organisational-based network literature, which places a heavy emphasis on network-level properties (Aldrich and Whetten, 1981; Marsden, 1990; Scott, 1991), issues of network outcomes and effectiveness are commonly omitted from study findings. This study found that the network literature is weak in explicitly linking process factors, or inputs and contextual factors, to network outcomes. These conceptual and theoretical limitations are compounded when the network is viewed in the non-profit public sector setting, where the formalisation of the network organisation is less clear and where the inputs and outcomes are particularly salient (Provan and Milward, 1995).

In response to the growing significance and prominence of networks, organisational theorists argue for an increased emphasis on network research (Rogers and Whetten, 1982; Thorelli, 1986; Nohria, 1992; Ring and Van de Ven, 1994). The increased importance of the 'network paradigm' has refocused organisational theory away from traditional issues of strategy and structure, to broader societal, economic and political issues, such as the social relationships of social network theory, notions of transaction

costs, ideas of dependency and legitimacy, formal and informal relationships, such as Granovetter's 'loose ties' (1973). An important contribution of network theory is how exchange processes are conceptualised in relational and sociological terms (Ring and Van de Ven, 1994). Concepts of trust, reciprocity and partnership take on greater importance. As such, network theory presents a powerful perspective and discourse as a meta-analytical approach to the study of organisations, or more appropriately, to the study of the behaviour of organisations. This study has sought to adopt the network paradigm and the tenets of network research to explore cooperation in the UK National Health Service. As such, this study provides a new and novel insight into different aspects of organising and managing the NHS.

### **8.3 Public Sector Networks: An Emerging Research Field**

The integration and coordination of organisational actors in the delivery of publicly funded health and social services has remained an important issue since the creation of public welfare systems like the UK National Health Service in 1948. There has been considerable debate within economics, management and organisational fields, as to how best to deliver and coordinate such services. Until recently, two models of governance, that of markets and hierarchies, dominated theories of public sector administration. Whilst the development and utilisation of cooperative relations between organisations has been the focus of management and organisational scholars since the 1960s (Levine and White, 1961: 583), much of this early work concentrated on dyadic lateral relationships and the impact of cooperative relations on organisational structure and behaviour. More recently, the focus of coordination research has moved upward to an examination of multiple interactions or more complete network systems (Alter and Hage, 1993; Ring and Van de Ven, 1994; Salancik, 1995; Provan, 1995, 1998). As a result, the network organisation has emerged as a new and alternative conceptualisation of organisational life. Over the past ten years, an increasing body of literature on networks and inter-organisational collaboration has emerged, challenging traditional competition-based theories of exchange. Network scholars suggest that organisations are more appropriately viewed as fluid and interconnected forms of social and economic interaction that involve a complex array of relational norms and strategic objectives, from seeking to reduce

uncertainty, increase legitimacy, innovate, and elicit a range of resources from knowledge and know-how, to capital and markets, from a range of loose and dense organisational ties with competitors and allies (Granovetter, 1990; Ring and Van de Ven, 1992; Pfeffer and Salancik, 1992). This study adopts such a 'complete network system' approach.

In the public non-profit domain, there has been considerable support for the development of collaborative network-based relationships within and between organisations, particularly within and across health and social service institutions (Powell, 1991). There is some argument that governance mechanisms have moved away from more traditional bureaucratic and hierarchical modes, towards more decentralised and autonomous structures, more characteristic of the 'network organisation' (Newman, 2001). Following the election of the Labour Government in 1997, UK public policy appears to have followed the collaborative trend. This has been most clearly visible in the move away from the competition ideology of internal-markets during the 1980s and 1990s. In health care, the emphasis has shifted to new governance strategies designed to achieve partnership, collaboration, joint-working and joined-up services. The 1997 White Paper on Health '*the new NHS: modern, dependable*' (DoH, 1997) has been the blueprint document for an array of recent structural and procedural reforms in health, aimed at creating effective high-performing service-delivery systems. The Government's 'modernisation agenda' in health has been largely based on a new collaborative ideology that manifests itself in new hybrid forms of multi-professional and multi-agency working. This policy agenda has been widely implemented in primary health care. Of particular importance has been the creation of new primary care groups in England (PCGs) and local health groups in Wales (LHGs), introduced in April 1999 to redress the imbalances of quasi-markets and the purchaser-provider split.

This study has shown that despite the increasing interest in the subject of networks and cooperative working arrangements, there has been relatively little empirical research on organisational networks in health care or across the public sector. There have so far, been few studies which have taken the public sector as a context for an empirical examination of the network phenomena, or that have sought to link network

theory to practice (Nohria and Eccles, 1992). Network theory remains predicated on studies of inter-firm exchange that focus on the structural and strategic dimensions of network-ties in industrial markets. In addition, studies of networks in the public management field, are commonly based on localised case studies of unitary organisations, rather than on more complete network systems, where networks are often treated as a metaphor, a conceptual scheme, or a managerial technique (Milward and Provan, 1998: 387). In addition, there are many unanswered questions concerning the viability and efficacy of the network as a stable, high-performance, effective organisational governance mechanism. In particular, there has been scant examination of the factors affecting the longevity and performance of these new organisational structures. Chapter 1 showed a clear lack of understanding of the processes of relationship building and network failure (Ring and Van de Ven, 1992; Park, 1996). Chapter 2 showed how this lack of detail concerning the procedural and functional aspects of networks is exacerbated in the public non-profit setting, a sector comparatively ignored by organisational and management theorists. The public sector in the UK is the largest single employer, encompassing a wide range of organisations including defence, education, social services, and much more. As Newman (2001: 1) states, it is surprising that much of organisational and management research continues to focus most attention on issues relevant to the private sector.

This study marks a response to the limited exploration of networks and networking processes within this non-profit public context. There has been some debate in public management fields concerning the network organisation as an alternative philosophy or mode of governance for the commissioning and delivery of public services such as health care (Harrison, 1997: 27; Kirkpatrick, 1999; Hudson, 1999; Ferlie and Mcgovern, 2003). Chapter 2 focused on the current rhetoric surrounding recent moves away from internal-markets and bureaucracy to new collaborative governance and network forms in the National Health Service. The chapter brought together important findings from a variety of literature sources to examine emerging structural and procedural developments in health care, and addressed speculation that the NHS is becoming more characteristic of the network archetype. Chapter 2 showed how the internal-market has been heavily criticised. The suggestion is that the internal-market raised monitoring costs, increased opportunistic behaviour, adversely effected service

coordination, and increased levels of uncertainty and instability across public services (Flynn et al., 1995; Wistow et al., 1996; Boyne, 2001). Critics of market-based approaches advocate a move away from adversarial arms-length relationships towards more partnership-based practices, where services are integrated, rather than fragmented. Ferlie and Pettigrew (1996: 81) ask:

*“The question arises as to whether there is now a deep-seated shift underway from organisation forms based on markets and hierarchies and towards more network-based forms of organisation?”*

In response, this study tracked the development and implementation of new network strategies in the UK National Health Service over the period from 1999-2003. The overall aim of the study has been to address current deficiencies in network research on the role and impact of networks as alternative governance mechanisms for the commissioning and delivery of public services like health care. This study provides an insight into the development and implementation of new network arrangements in health care, particularly in primary health care. The study also provides original theoretic and empirical exploration of the environmental and contextual issues driving public sector reform, and the salient factors impacting upon network relations within the unique and complex setting of health care, particularly the important issues to be considered when entering into, operating, and maintaining multi-agency organisational networks in a non-profit public health sector context. Three central research questions guided the study’s design and implementation: what evidence is there of a move away from market and hierarchy, to new network forms in the National Health Service; what are the important factors and processes involved in networking agencies and professional groups in health care and how might these factors be linked with performance and quality improvements; what are the potential implications of networks for the organisation and management of the NHS?

#### **8.4 Application of Methodology**

In response to the broad questions posed by this study, chapter 3 outlined the methodology and research design that has underpinned this research project. The overall objective of the research design has been to explore the networking phenomenon in the UK health care sector. The chapter discussed the philosophical

biases underlying the choice of research design, strategy, and methods, particularly the implications of these assumptions with respect to an interpretation and evaluation of findings. This study mainly follows a realist tradition, that scientific knowledge is personal, value-bound, multi-causal, plausible, indeterminate and specific. All data that is observable or retrievable is important (Wass and Wells, 1994: 9). Additionally, philosophical or methodological pluralism vindicated the use of multiple methods. This study is multi-paradigmatic, incorporating for example, elements of functionalist causality and fundamental laws, realist impartiality and interpretivist subjectivity (Burrell and Morgan, 1979; Easterby-Smith et al., 1991; Hassard, 1993). This study partly adopts a research framework that is problem-orientated, seeking to understand the network phenomenon and effective network management. A significant proportion of the study has been directed towards the recovery of facts, for instance retrieving data on Government health policy or data on the Local Health Groups studied. This study also incorporated key elements of research that is subjective or naturalist, *'that meaning is derived from the inter-subjective experience that social actors apply to it'* (Hassard, 1993). As such, this study has sought to explore and understand the networking phenomenon by engaging with research subjects, health care professionals and network members, in a form that allowed for more qualitative data gathering and interpretation. The study focused on participants' feelings, emotions, attitudes, meanings and experiences, of being involved in multi-organisational networks, whereby theory has been induced from holistic data gathering, in depth and over time, from mainly small population samples (Easterby-Smith et al., 1991).

This study favoured a mixed exploratory-descriptive research design. In exploratory terms, the emphasis of the study has been on developing new and original insights into network organisational arrangements and into network governance and practice in health care. Additionally, the study aimed to better formulate the 'network phenomenon' and to produce high quality research outputs that help develop more rigorous propositions and analytical constructs, that lead to clearer research priorities or aid in policy formation or management practice. In descriptive terms, the study has been concerned with changes in governance and the recent move away from markets and hierarchy to new collaborative forms in health care. The study has sought to describe how new collaborative governance is reshaping health care organisations and

accounts for the impact on relations between health care agencies and staff in primary health care. Consequently, a mixed deductive-inductive approach has been used that adheres to the recommendations espoused by methodological writers such as Eisenhardt (1989) and Glaser and Strauss (1967). A significant feature of this study is the multi-levelled approach taken to explore networking across a range of levels within the National Health Service. Following other network researchers (Gittel, 2000), the research design involved a number of levels of analysis including: a national level analysis of change in the UK health care sector; an analysis of change at the primary care sector level; an analysis of developments at the regional level in the National Health Service in Wales, and an analysis of networking and collaborative practices at the local community level across four Local Health Groups within a large Health Authority area. Within this research design, a range of research instruments were utilised to collect a broad set of data. This involved an analysis of Governmental policy publications and employing interview methods and observational methods of data collection. Chapter 3 set out the research protocols used to guide data collection and data analysis, and detailed the application of the research strategy, accounting for how the methodological approach required adjustment, refinement, and evaluation at different stages.

The study has also addresses issues arising from the conceptualisation of the network phenomenon and set out an analytical framework to guide network analysis and theoretic-empirical interaction. One of the most important methodological considerations for this study concerned the need to specify the 'network'. As discussed in chapter 1, the term network is widely used and holds multiple meanings (Nohria and Eccles, 1992). The network is best described as a conceptual metaphor, '*an abstract notion referring to a set of nodes and relationships that connect them*' (Fombrun, 1982), or a set of social ties "*a specific type of relation that links a specified set of persons, objects, or events*" (Michell (1969: 2-4)). In this way, the type of relationship defines the type of network. As outlined in table 1, chapter 1, there exists a wide classification of different types of network forms. The structure of these different networks is often demarcated according to the degree, frequency, and depth of interaction, ranging from the isolated or fragmented structure in which no actors are connected, to more dense or embedded structures in which all actors are strongly

linked. Easton (1992) proposes three broad definitional groups: one describes the network as the total pattern of relationships within a group of organisations working to achieve a common goal; the second focuses on the social relationships that link connected organisations; while the third looks at the exchange dimensions, where the components of exchange can include products, services, information, or knowledge. Utilising Easton's (1992) definitional groupings, it is clear that this study has remained within the first and second groupings, by seeking to explore the changing patterns of governance, organisational structure, and relational norms in health care, rather than the exchange dimensions of networks.

While critics might argue that this study is highly subjective and qualitative in nature, the uniqueness and insightfulness of the study lies in its depth and breadth. Not only is the study wide in terms of the different levels of analysis, including national level, primary care sector, regional level, and local level, the study is also deep in terms of the use of multiple methods, policy analysis, literature review, documentary inquiry, observation and interview. It is the combined outputs from these methodologies that give this study credibility and originality. This study is not a case-analysis of networking in local health groups, but rather a multi-level review and analysis of networking governance and practices in the primary care sector of the United Kingdom National Health Service between 1999-2003. As such, this study presents a narrative on the changes that have occurred in health administration during this time and a perspective on the impact these changes have had on the cooperative behaviours of actors and agencies, namely health care professionals, during this period. The study captures an important first phase of network activities, of collaborative policy formulation and implementation in health care. In longitudinal terms, this study has captured many of the changes that have taken place in health during this period, the introduction of the NHS Plan 2000 being a significant event. The study also includes a broad range of historic and contextual data used to trace and identify developments within the present case. As such, policy review and analysis (hermeneutics) has constituted a major part of this study, most notably presented in chapters 4, 5, and 6. The reliability and credibility of the study have been established via an explicit description of the research design, methods and data analysis used, an 'audit-trail' (Yin, 1994), that might be followed or contested by other researchers.



## **8.5 Networking at the National Sector Level**

Since the creation of the NHS in 1948, the interim half-century has witnessed transformations in the social, economic, and political context, of the Health Service. This study has explored the most recent era of change in the UK NHS, between 1999-2003. This study concurs with Klein's view (2001), that the original commitment to collectivism and belief in central planning, that epitomised the first years of the Health Service, has most recently given way to a new philosophy of public management, characterised in modern times by pragmatism and individualism. An analysis of change in health care conducted in chapter 4, showed that the modern era of the NHS is one dominated by discussions of performance, value-for-money, innovation and service quality. However, Britain's NHS continues to exist as a unique form of public provision, a publicly funded health system, administered by government officials and paid for through central taxation.

In 1997, the administration of the National Health Service passed to the incoming Labour Government. In policy terms, 'new Labour' positioned itself as something new and different from previous Labour Governments or Conservative Governments. New Labour marked a move away from more traditional socialist values to a new set of goals and ideas on how to provide public services. The new philosophy, ideologically positioned somewhere between the 'old-left' and the 'new-right', came to be known as the 'third-way'. The language of the third-way, embodied in new Labour policy statements and publications, emphasised the importance of community, partnership, collaboration, cooperation, responsibilities and opportunities. Another feature of the third-way, something that may well distinguish new Labour from old Labour, has been the relationship between public and private, where the market-place is a phenomenon to be embraced and encouraged (Prime Minister, 1997 Labour Party Manifesto). The first years of Labour in power (1997-2001) revealed a number of social and economic policy objectives. Over the first three years in power the Government demonstrated a reserved and pragmatic approach to public sector reform, a philosophy of '*What Counts is What Works*' (Prime Ministers Forward, Election Manifesto, 1997). One of the main policies to emerge over this period was that of low public expenditure. The Chancellor of the Exchequer attempted to control spending on Government services in an effort to address public debt. In addition, the Labour

administration sought to honour manifesto pledges to stabilise or reduce taxation, particularly income tax. This emphasis on fiscal and monetary discipline characterised new Labour's approach to public investment, under the slogan of, 'investment in public services conditional on achieving results via reform'. Spending on health care from 1997-2000 fell far below other leading OECD nations (table 1, chapter 4). Later, in response to increasing criticisms relating to under-funding in public services, the Government introduced a new spending plan for the National Health Service in 2000. Following the March 2000 Budget, the NHS received a major boost in funding, a rise in real terms by 7.4 per cent for 2000-01, and by 5.6 per cent in each of the following three financial years (table 2, chapter 4). The extra resources under the NHS Spending Review 2000-01 allocated funds to finance NHS wages, recruit additional staff and to rehabilitate capital stock, and to finance some reorganisation costs (OECD, 2000: 18). One of main priorities behind the extra spending involved the lowering of NHS waiting lists, which became a major political issue around 2000. A major part of the extra funding post-2000 was directed towards modernising services, tackling health inequalities, reducing bureaucracy and contracting costs, and tackling local health needs (NHS Plan, 2000).

The Government's focus for reforming public services has been on goals and on monitoring performance rather than prescribing practices. For services like the NHS, the emphasis has moved away from control and central planning to themes of partnership, collaboration and innovation. The 1997 White Paper on health care, '*The new NHS: Modern, Dependable*' (DoH, 1997) has been the blue-print document for an array of administrative reforms in health care. Firstly, more emphasis has been placed on improving health across the population, encapsulated in new health improvement programmes (HIPs). Secondly, there has been an attempt to innovate in the delivery mechanisms used to provide health care, both around hospitals (secondary care centres) and GPs (primary care centres). Thirdly, greater emphasis has been given over to raising standards, particularly the speed and coverage of treatments and the quality of the care provided. New and challenging targets were set for reducing deaths from cancer, coronary heart disease, accidents and suicides (Secretary of State for Health, 1999). As such, the NHS is now required to engage with all other agencies to address wider social problems. A statutory duty has been

imposed on health authorities to work with local government in promoting the economic, social, and environmental, well-being of communities and the people living within these areas. The focus has been on integrating health and social care services with other governmental agencies, into 'joined-up government'. An example is that of health action zones (HAZs), a scheme introduced in 2000 to bring together many organisations previously outside the traditional boundaries of the Health Service. Lastly, the Government has sought to improve efficiency through improved performance measurement, backed-up by the threat of centralised intervention where performance falls below the targets set.

Chapter 4 illustrated how since 1997, the Labour Government set about the termination of the quasi-market in health care. The 1999 Health Act detailed the Government's vision of the 'new NHS' as a more responsive and efficient Health Service. The thrust of this reform agenda has been targeted towards primary health care. While the independent contractor status of GPs remained, GPs and other health care professionals were asked to form and operate new primary care organisations (PCGs). The introduction of primary care groups in England, with equivalents in Wales, Scotland and Northern Ireland, marked the departure point away from the competition model in primary care, to a new and more cooperative governance strategy based on '*collaboration*' rather than '*competition*'. Health professionals and agencies in primary care are being brought together to jointly plan and commission services in a more combined and inclusive system. The task of raising quality standards in the NHS has been given increasing emphasis under the heading of 'clinical governance', introduced in 1998. Clinical governance represents the formalisation of a micro-institutional strategy to improve performance and illicit further accountability. NHS Trusts are now required to establish and monitor quality standards, and are responsible for implementing new clinical standards originating from new monitoring agencies, such as the Commission for Health Improvement (CHI) and the National Institute for Clinical Excellence (NICE) (chapter 4: 4.5). The Commission for Health Improvement currently monitors the implementation of clinical governance and monitors the delivery and quality of care provided by NHS Trusts. The issue of performance and control play a significant part in characterising administrative reforms in health post-1997. In an effort to increase control and enforce

accountability, there has been some tension between the needs of the centre to raise efficiency and the needs of the periphery to achieve autonomy. A prominent feature of the Government's strategy to improve performance has been the writing and dissemination of national service frameworks (NSFs). NSFs specify national standards of care, to ensure greater consistency and reduce unacceptable variations in care using the best evidence of clinical and cost-effectiveness. CHI, in partnership with the Audit Commission, has a statutory responsibility to review the progress of implementation of NSFs in England and Wales. CHI carries out national studies in partnership with the Audit Commission. Accordingly, NSFs have taken on priority status and act as a 'model of best practice', used as a template for the organisation and management of services (Secretary of State for Health, 1998).

In July of 2000, the Government published its major policy document for reforming the National Health Service, *'The NHS Plan, a Plan for Investment, a Plan for Reform'* (DoH, 2000). The Plan announced a 10-year modernisation strategy for the NHS. A major part of the plan involved an increase in funding in exchange for continuing reform. In announcing the increase in funding for the NHS, the Prime Minister set five challenges that needed to be addressed: partnership, performance, professions and the wider NHS workforce, patient care, and prevention. In seeking to meet these objectives, the 2000 NHS Plan set out ten core principles that are to underpin the new NHS (table 3, chapter 4). These principles are to guide the modernising and rebuilding of the Health Service, including: free access, a more needs-led service, improved performance and quality standards, and more choice and patient involvement. Accordingly, the NHS Plan pushed forward the Governments reform agenda in health care:

*"We are on a journey – begun with the NHS Plan – which represents nothing less than the replacement of an outdated system. We believe it is time to move beyond the 1940s monolithic top-down centralised NHS towards a devolved Health Service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values"* (Chapter 1, NHS Plan).

The NHS Plan focuses attention on the supply-side dynamics of provision of Health Services and care. The central theme of the document is about increasing funding and resources for the NHS to create greater capacity. Increases in budgets and direct funding, staff numbers, principally nurses and doctors, hospitals, and hospital beds,

are aimed at reducing waiting times for surgery, access to specialist care and hospital appointments, and improving the quality of care provided. The plan also outlines details of new public-private-partnership schemes to increase capacity. The NHS Plan sets out a number of ambitious targets to be reached within the specified period of the plan, 2000-2010. A major part of the overall Plan is that PCTs should control over 75% of the growing NHS budget. The NHS Plan places primary care at the centre of the change agenda. Overall, the role of primary care has been enhanced. While the general practice remains the basic unit of primary care, new methods of multi-disciplinary working are being pioneered to diversify and deliver services within a more flexible system that offers a wider range of more accessible services.

The myriad of policies and initiatives introduced by the Labour Government post-1997, arguably have a strong connection with the past. Despite the constant invocation of the word 'new', there is in fact a large element of continuity with old market policies of the Conservatives. The Labour Government came to power in 1997 with a manifesto pledge to retain the NHS within the public realm and to dismantle all elements of the internal-market created under the previous Conservative Government. The Labour Administration requested that health authorities restrict contractual relations with the private sector and set about abolishing fundholding in the initial wave of demarketisation. However, despite the anti-market discourse, the Government has retained some essential elements of the internal-market, such as the purchaser-provider split and the concept of GP commissioning, although within the new infrastructure of primary care groups or trusts. The first three years under Labour witnessed little evidence of radical change. While the 1997 White Paper on health and the NHS Plan 2000 set out some clear guidelines for developing primary care, secondary care has remained relatively untouched, apart from the host of new external monitoring agencies. More recent policy directives during Labour's second term in office, '*Delivering the NHS Plan: next steps on investment, next steps on reform*' (Department of Health, 2002a) and '*Growing Capacity: a new role for external healthcare providers in England*' (Department of Health, 2002b), have marked the return of the mixed economy in health care. The retention of the purchaser-provider split has meant that the concept of market-buyer and market-seller has remained intact. The role of the PCT as buyer organisation is an attempt at keeping the notion of

incentives and choice alive. In future, PCTs are to procure services from the best suppliers, thus forcing providers to raise standards to attract resources. This system is a variant on the old fundholding concept. Chapter 5 showed how a historical view of developments in primary health care reveals that the concept and practice of cooperative working, and the development of multi-disciplinary groups, has its routes in early experiments with differing institutional formats in the primary care sector over the past twenty years, such as: district health authority locality-commissioning; general practice fundholding; general practice commissioning groups; total purchasing projects; and primary care groups (chapter 5, 5:4). In addition, the view of the public user as a stakeholder and investor for instance, clearly has some link with the notion of the consumer publicised as part of the internal-market. Accordingly, patients are now to be allowed to choose their service provider. In the new NHS, patients are to be viewed as customers and are to be given choice about where and when they are treated. The previous Conservative slogan of '*the money followed the patient*' has resurfaced under new Labour in the form of '*resources will follow the choices patients make*'. New Labour pragmatism, demonstrated by the avocation of public-private partnerships (PPPs), shows a recycling of previous market-based ideas on building closer relationships between the private and public sectors.

A central feature of NHS reforms since 1997 is the increasing move to new forms of provision. One of the Government's key targets has been the reduction in patient waiting times. In an effort to reduce waiting lists the Government is now considering alternative ways to provide extra capacity in the NHS. The NHS Plan (DoH, 2000) suggests that capacity might be increased via recruitment of more staff. However, since 2000 the Government has outlined new plans to involve the private sector, commission private hospitals, and more radically, to offer patients treatments in European Union hospitals (DoH, 2002b). These Health Service innovations in health delivery reflect a new plurality in provision and a new type of Health Service, one that maintains a state-funded universal system, free at the point of delivery, but where provision will take either public or private forms. These policy themes suggest a very new conceptualisation of the NHS. New Labour health policy goes further in terms of the restructuring and refocusing of the NHS. This study suggests that the new NHS is to be a mix of new flexible and autonomous organisations, like PCGs, or foundation

hospitals; that are strictly controlled and monitored by centralised and bureaucratic targets; where centralised targets and standards are enforced by external monitoring agencies; with an inter-twining of new forms of public-private provision arrangements; where the patient has choice and is viewed more as a consumer than a user.

## **8.6 Networking at the Primary Care Level**

Chapter 5 took the research agenda forward by exploring issues of networking and organisational integration in primary health care. Primary health care has undergone considerable change and restructuring following the implementation of the 1997 White Paper on health '*The New NHS, modern, dependable*' (DoH, 1997), and has been a central focus of health policy over the period. The reorganisation of the primary health care sector has been a central feature of the Labour Government's reform and modernisation agenda, whereby the NHS has sought to become a more primary care focused organisation. Under previous Conservative Governments (1991-1997), the locus for the planning, commissioning and provision, of primary health care, centred on GP fundholding at the level of the general practice. Following the election of a Labour Government in 1997, the focus has shifted upwards to localities run by primary care level institutions. New primary care groups (PCGs) were introduced in April 1997 for England, and local health groups in Wales, with equivalent organisations in Scotland and Northern Ireland. The role of these primary care organisations has been to bring together all community-based services and community-based professionals to plan and provide services in primary care. Figures 1 and 2 of chapter 5, illustrate the changing structural form of the NHS with the emphasis shifting away from the purchaser provider split to a new vision of health care provision, where the emphasis is on increasing cooperation between providers and planners. Since the publication of '*Local Voices*' (NHS Management Executive, 1992), a strategy of reducing the number of agencies and then joining large agencies together, has emerged in health care, with a '*think big but act local*' logic. Primary care organisations are a key weapon in helping to keep a community or local focus at a time of large-scale integration. The development of a primary care-led NHS has become one the Government's main policies for modernising the National Health

Service. This goal is intended to ensure a localised focus, where general practitioners are well placed to identify and prioritise service development need across the whole of the healthcare spectrum, to revitalise the primary care sector, and to relieve pressure on secondary care hospitals (DoH, 1997; 2000). The Government has sought to address many of the problems of the NHS by focusing on developing the primary care health care sector. All general practices have been required to become part of a local PCG. Importantly, PCGs are more than commissioning agencies, “...*the purchaser-provider split will be conflated, since the key participants – GPs and community nurses – are also providers*” (Hudson, 1999: 162-163). The 1997 White Paper sets out plans for PCGs to evolve over time, from simple advisory agencies of health authorities to full and independent commission bodies (table 1, chapter 5). In addition, smaller primary care groups would in future join together to form primary care trusts (PCTs). In 2000, the Government announced the ‘*NHS Plan*’ (DoH, 2000), detailing the increasing role of PCGs and the future introduction of PCTs in 2003. Subsequently, from April 2002, England’s 95 health authorities were abolished, whereby the functions of health authorities moved to 28 new strategic health authorities and PCTs. The Government stated that by 2008, 75% of the NHS’s budget will be controlled by PCTs (NHS Plan, July 2000). Over three hundred PCTs were formed in April 2003 in England, and LHGs became local health boards in Wales.

Since being introduced in 1999, the role of the PCGs has been diverse including: health promotion; the commissioning of health services; implementing the health authority’s health improvement programme; monitoring trust performance against service agreements; and the development of primary care in the community. However, chapter 5 showed how there has been little empirical data on the functions and operations of PCGs or LHGs. This is partly due to the newness of these agencies. Consequently, a number of important questions emerged concerning the management, organisation and representation of these new primary care organisations, that has given credence to this study. The 1997 White Paper and 2000 NHS Plan have tended to be prescriptive concerning the development of PCGs. The Department of Health have provided little in the way of management and administration guidelines for practitioners and executive members of PCGs, particularly in relation to dispute resolution, unfair power distribution between groups and professional bias.



As discussed in chapter 2, the inter-linkage of organisational units in primary care, professionals and agencies, is part of the wider adoption of the network paradigm in public services. Rummery (1998: 432) states that recent moves to join-up services at the primary care level marks a move towards collaborative-commissioning and networks. The proposed benefits of collaborative-networking in health care include a wide range of issues, such as improving information exchange, task duplication minimisation, improving commitment and involvement, and shared decision making. Under recent reforms in primary care, the primary care team is now responsible for eliciting the proposed benefits of cooperative working. *'The New NHS: Modern, Dependable'* (DoH, 1997) asserts that, *'decisions about how best to use resources for patient care are best made by those who treat patients'*. The commissioning of services role, previously in the domain of health authority managers, has moved to members of primary health care teams (PHCTs). These groups involve all GPs, unlike fundholding which only included those GP practices which choose to opt-in, and for the first time, other members of the health professions, for example social workers and community nurses. Government policy has moved the emphasis away from the purchasing of services to the joint-commissioning of services. The importance of this move is that, whereas purchasing emphasises budgetary control and the effective utilisation of scarce resources, commissioning implies having a strategic impact on the development and delivery without necessarily purchasing them (DoH, 1995; 1997). PCGs, and to a lesser extent LHGs, are being modelled on a blueprint of locality-commissioning groups (Rummery, 1998: 431).

One important area of integration for PCGs is in linking with Social Services. Recent policy initiatives have sought to improve partnership working between health and social service departments and agencies, in an effort to improve the nature of care management and delivery by combining services and professionals. One of the defining features of new health and social services policy is that services should now be 'needs led' (SSI/SSWG, 1991), and that the artificial boundaries that exist between services should be removed (Twigg, 1997). At present, demarcations between services provided by the NHS and Social Services leave coverage 'black-holes' where there is a risk that vulnerable users may fall through gaps left by the failure of services to coordinate. Accordingly, by health and social care working together, PCGs might

develop seamless services that achieve full population coverage. Traditionally, the NHS and Social Services have failed to coordinate effectively with each other, resulting in a number of commissioning dilemmas, including bed-blocking, unnecessary admissions to hospitals, and instances where services dispute responsibility over the payment of out-of-hours services (Rummery, 1998: 432). As the responsibility for commissioning moves from health authorities to PHCTs, there is more emphasis placed on effective collaboration and for social service departments to engage with health care agencies to jointly develop and provide more integrated and targeted services. The involvement of social services in new primary care groups and local health groups provides a bridge between health and social care.

Chapter 4 and 5 outlined the potential benefits of collaborative working and commissioning in primary care. Since 1999, the Government has set about redesigning the primary care sector to put in place the infrastructure for joint-working arrangements. However, while the benefits of enhanced integration and networking are clear (chapter 1 and chapter 5), the realisation of these benefits is less clear. Firstly, there are complex financial frameworks for funding primary care organisations, with primary health care funded through national taxation, social services through local taxation, and local government agencies through mixed means. In addition, PHCT members are also funded differently, GPs being independent contractors, while nurses remain employees of hospitals, practices, or community trusts. Secondly, there are varied lines of accountability and differing organisational and professional allegiances (Friedson, 1970; Abbott, 1988). Social workers, GPs and nurses possess very different professional identities, with GPs having their practice regulated through national professional bodies like the British Medical Association and the General Medical Council, and nurses and social workers having their professional standards set by their respective associations. The diversity of organisational and professional loyalties that exists within the NHS presents a unique challenge not found in non-professionalised private sector firms. One such issue is that of professional rivalries or professional tribalism (Dalley, 1989; Abbott, 1988). The manifestations of professional rivalry between health professionals may in some way disrupt the ability of primary care organisations to achieve effective and speedy outcomes, yet this subject is often omitted from policy publications. Dalley (1989)

suggests that professional mistrust originates from a lack of understanding of the organisational context within which each professional works. Importantly, the primary care group might address traditional professional rivalries by bringing together multiple groups of professionals and by offering a forum for cross-professional communication and multi-professional decision-making. PCGs present opportunities for inter-professional networking, particularly between GPs and community nurses. Community nurses were largely excluded from commissioning responsibilities during the internal-market (1979-1996). The 1997 White Paper on Health and the NHS Plan 2000 explicitly tackle this exclusion, by placing nurses at the heart of primary care policy:

*“Primary Care Groups will...bring together GPs and community nurses in each area to work together to improve the health of local people...by better integrating primary and community Health Services and working more closely with social services on both planning and delivery”* (Secretary of State for Health, 1997: 33/34).

Community nurses have been given a representative position on the governing bodies of primary care groups. This policy has moved nurses from a peripheral position to a central role in the commissioning and provision of services. The issue of inclusiveness of PCGs continues to draw debate. The inclusion and exclusion of different professional and non-professional groups is a contentious issue in primary care. For instance, the justification for the inclusion of nursing versus the justification for the exclusion of other care workers, such as physiotherapists, occupational therapists, speech therapists, dieticians and chiropodists. These issues raise some interesting questions concerning the selection of members, and the exclusivity of new primary care bodies.

Primary care teams have been given the role of integrating health services. It is envisaged that as PCGs move to become PCTs, this will go one step further towards the abolition of divided services. While the main emphasis of cooperation has focused upon GPs, community nurses and social services, there are other intra-NHS relationships that need to be addressed, such as the acute health care sector (Hudson, 1999: 167). In principle, PCGs have the potential to oversee the whole process of care, covering pre-admission, admission, treatment, discharge and post-discharge care. Surprisingly, hospital consultants were not offered places on PCG boards, and

there is some evidence to suggest that health professionals in acute trusts feel disenfranchised (Christie and Blades, 1998). In addition, the health authority gains membership through a single HA non-executive director. There is some argument that PCGs are not representative of the whole primary care sector.

Chapter 5 raised a number of potential barriers, obstacles and challenges, that might impede the effectiveness of network-based organisational collaboration between services and agents in a primary health care setting. Firstly, logistical and administrative issues related to the population size covered, and secondly, choice of organising unit. Hudson (1999) points to an inconsistency in previous and existing localisation initiatives, in terms of population coverage. Previous locality-based commissioning, such as total purchasing projects, involved small population catchments (Burns et al, 1994; Mays et al, 1998; Hudson-Hart et al, 1998). Local health institutions have little experience of operating larger localities of 100,000 population, as required by PCGs. In addition, plans to network primary groups to each other and to develop primary care trusts (PCTs) will increase the size of localities. The paradox is that as PCGs increase in size, they will move further away from small-scale community operations and may lose a community or local focus. Secondly, the devolution of power to PCGs/LHGs increases the power of GPs, which can only come from a loss in, or a transition in, health authority control. Shapior et al. (1996) point out that while a health authority has the negotiated power associated with budgetary control, GPs have the ability to direct services due to their detailed clinical and local knowledge. Conversely, there is some concern that health authorities serve an important role in viewing health care from a more strategic vantage point, something primary care organisations may find hard to do. One of the key criticisms of fundholding was that practice-based needs assessment and subsequent purchasing was limited in its vision (Hudson, 1999: 167). The devolution of power away from health authorities may result in some loss of independent strategic decision-making.

The devolution of power away from health authorities to PCGs also reflects a democratisation movement in primary health care. This democratisation is aimed at achieving a higher degree of participation in localisation initiatives. This marks a shift in healthcare policy, from an emphasis on accountability to the centre, to the

localisation of healthcare management. PCGs and LHGs are expected to enhance local accountability and professional judgement. Primary care groups have been instructed to address the significant lack of user involvement in the provision and determination of services provided to patients. Primary care groups are under an obligation to “*have clear arrangements for public involvement*” (Secretary of state, 1997: 36). LHGs in Wales are under a similar obligation. However, despite the new emphasis on user involvement, recent White Papers offer little explanation of the incentives to involve the public in commissioning services. The evidence suggests that these requirements will not been met, for example, patient consultation and involvement has been historically weak (Redmayne, 1995; Smith et al., 1997; Hudson-art et al., 1998; Hudson, 1999: 168). The Audit Commission (1996) found that only 4% of fundholders’ plans included a description of patient ‘feed-back’ on the quality of practice, hospital, or community services. In addition, such plans rarely mentioned how patient involvement would be used to improve services. GPs have also been criticised for their inability or unwillingness to collaborate with community groups (Mays et al., 1998a; Taylor et al., 1998). This is worrying given GPs central position in PCGs. Myles et al. (1998) study of TPPs criticises the GP position, concluding that:

*“... it is no longer sustainable for GPs to consider themselves to be reliable proxies for their patients, or to be confident that they are aware of all their needs .”*

PCGs are required to solve the problem of low user involvement and participation in health care planning and provision, however the evidence so far suggests that public involvement will fall far below the level desired by Government.

Developments in health care outlined in chapter 4 and 5 point to a change in cultural orientation in the NHS, towards dynamic inter-agency collaboration across occupational boundaries and organisational structures. While the NHS has historically been dominated by centralised hierarchical management and a cultural orientation of valuing uniformity and consistency, new localisation initiatives imply an acceptance of diversity and creativity that goes beyond traditional ways of working. One of the key elements of the reform agenda has been the focus on more flexible forms of working. This need for flexibility has moved primary care services away from the

managerialist approach of health authorities. Smith and Shapiro's (1997) study of locality-commissioning, *'Holding on While Letting Go'*, encapsulates the dilemma of changing relationships between the power-base of the health authority and the general practitioner. The emphasis for change is towards new models of locality-commissioning and integration that promote flexibility. The promotion of collaboration between services and professionals is a principal goal of a primary-led NHS (*'NHS Plan'*, DoH, 2000). PCGs and LHGs represent the vehicle to deliver this flexibility and integration.

As chapter 5 discussed, recent developments in primary care have highlighted a number of areas of conflict. Increasing democratisation and the changing of organisational boundaries challenges the existing power-base of general practitioners. GPs have traditionally been accorded a high degree of autonomy and flexibility in the way they work. GPs are increasingly expected to work in partnership with the wider primary care team, and to work more closely with social services, carers, and patients, in the planning and commissioning of services. While the TPP experience showed little evidence of working across the health-social care boundary (Myles et al., 1998), it did contribute to an overall improvement in the level of communication between primary and secondary care providers, as noted by Robinson et al. (1998). PCGs and LHGs aim to achieve a much higher level of collaboration (NHS Executive, 1998: Paragraphs 8 and 9). However, some commentators suggest that PCGs might be viewed as a threat to the professional autonomy of GPs (Hudson, 1999: 169), as observed by Exworthy (1994) in a study of community health services, and similarly by Burns et al. (1994). The paradox here is that while GPs would be the main beneficiaries of devolution and decentralisation, they are the main potential source of professional resistance. Hudson (1999: 166) concludes that in PCGs, the lead role has been given to a professional group, "...which has yet to exhibit strong collaborative tendencies beyond its own professional concerns...". There is some argument that GPs are more comfortable dealing with other medicine-based health care professionals, for example with secondary care medical consultants, than with non-medicine-based health practitioners, or patient representative groups (Ferlie and Pettigrew, 1996: 90). As decentralisation and devolution pushes responsibility down the healthcare chain-of-command, general practitioners are finding themselves in the front line of decision

making, especially in terms of resource rationing. As Marks and Hunter (1998) found, many GPs were uncertain about the extra demands on time that would arise from involvement in new initiatives, the lack of reward or incentive for involvement, the threat their patient advocate role. The introduction of new collaborative commissioning PCGs and LHGs pushes the medical profession into the realms of a managerial function. There is some suggestion of the 'managerialisation' of the medical profession over recent years (Ferlie et al., 1996; Flynn, 1998; Exworthy and Halford, 1999). Medical professionals are increasingly involved in managerial functions, such as budgeting, allocating resources and evaluating performance, such as the clinical audit. The introduction and development of new primary care initiatives arguably enhances the managerialisation of the medical profession, as some GPs will take on new responsibilities, including representing groups, communicating and soliciting agreement from colleagues and other professionals, concerning commissioning decisions. This raises a number of socio-political issues concerning the politics of decision-making, power relationships within groups, and changing occupational and professional roles. Marks and Hunter's (1998) survey evidence shows GPs are both optimistic and pessimistic about their new responsibilities. PCGs might also be viewed as more democratic and egalitarian as they give a voice to all GPs and primary care teams.

The challenges outlined above reflect the complex nature of the primary health care setting, with the general practitioner as the central figure in health care provision. The shifting of power from health authorities to primary care groups represents an experiment in health care commissioning and provision, where the PCG or LHG is the organisational coordinating mechanism for integrating services and professionals. This collaborative organisational of working presents a unique range of challenges for policy makers, NHS managers, and health professionals.

## **8.7 Networking at the Regional Level of NHS Wales**

Chapter 6 reported on the implementation of health policy and the move towards new collaborative forms at the regional level of the National Health Service in Wales. The review focused on the implementation and adaptation of central health policy in

Wales. The National Assembly for Wales is responsible for policy direction and for allocating funds to the NHS in Wales. The Assembly allocates funds annually to each of the five regional health authorities: Bro Taf Health Authority; Dyfed Powys Health Authority; Gwent Health Authority; Iechyd Morgannwg Health Authority and North Wales Health Authority. The role of each health authority is to purchase health services from professionals within primary care, such as family doctors, dentists and opticians, and from NHS Trusts that provide secondary and community health care services (the purchaser-provider split). The 1998 White Paper, '*NHS Wales: Putting Patients First*' (Welsh Office, 1998a), set out the framework for the development of health services in Wales. In policy terms, the 1998 White Paper broadly followed the same themes as the 1997 White Paper for England. However, the modernisation agenda in Wales has led to some amendment of central health policy. In primary care, local health groups (LHGs) were established in 1999 within each health authority area. The LHG represents a variant on the PCG found in England. Exactly 22 LHGs were established in Wales covering the same geographical boundaries as 22 local authorities. The National Assembly for Wales asserted that the introduction of LHGs would make a major contribution to the development of health improvement programmes (HIPs), developing the principles of clinical governance to improve the quality of primary health care, and informing and developing the commissioning of hospital and community Health Services (Welsh Office, 1998b).

In their first year, LHGs acted as advisory sub-committees of health authorities. Over the following four years (1999-2003) the remit of LHGs has increased to include the commissioning of local health services. LHGs are a multi-professional organisations, encompassing one general manager, six general practitioners, two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member and one lay member. In contrast to PCGs, LHGs in Wales have taken on a broader range of objectives. In particular, the publication of the Green Paper, '*Better Health Better Wales*' (Welsh Office, 1998f), in conjunction with the Strategic Framework document (Welsh Office, 1998e), set out the Assembly's plans for improving health care via LHGs. The National Assembly has specifically set out policies to tackle social and economic deprivation across Wales. LHGs in collaboration with other agencies, particularly local authorities, have been



required to take a central role in promoting social inclusion and strategies aimed at improving health and social services at community level. ‘*Better Health Better Wales*’ (1998f) and ‘*Developing Local Health Alliances*’ (NAW, 1999a) established a best practice framework by which local authorities need to focus attention on action to improve the social, environmental and economic determinants of health. Following ‘*Improving Health in Wales: A plan for the NHS with its partners*’, the equivalent to the English NHS Plan for Wales (NAW, 2001a), local authorities and local health alliances have collaborated with local health groups to tackle health inequalities and the wider issues that impact on peoples’ health, including housing, education and economic development. Accordingly, the building of effective collaborative joint-working relationships has been a prerequisite for identifying needs and as a mechanism for addressing inequality in Wales.

In Wales, the integration of service providers and health professionals via collaborative networks has become an increasingly important agenda item for the regional Government. A recent report on health care by the Chief Medical Officer for Wales (2002: 17) illustrates the emerging importance of networks in the delivery of health care:

*“One a way of addressing shortages of expertise, as well as of raising standards, is by medical and other staff working together in networks. Networking can assist with the optimal deployment of resources and skills and the avoidance of duplication of effort. It can also allow more uniform provision of essential services and specialist expertise, and can improve training, professional development and job satisfaction.”*

While the report focuses more on developing managed clinical networks in secondary care, it also suggests that networks be implemented in primary health care, particularly as part of the public health function in Wales. In primary care there have been increasing efforts to form new relationships and linkages with a range of agencies and stakeholder. Significantly, the LHG is the central point for an array of inter-linkages and joint-working initiatives across a number of levels, from the internal relationships between professional members, to the external relationships between LHGs and other agencies, such as social services and local authorities. Partnership and inclusiveness between mainstream health care providers and voluntary groups, particularly carers and community health groups, has also emerged

as an important topic in recent policy publications in Wales. However, in Wales there has been less emphasis on public-private collaborations.

The local health group form represents the introduction of a formal networking organisation that links a web of professional and agency interests. Each LHG is controlled by an Executive Board of one general manager, six general practitioners (GPs), two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member and one lay person from the community. LHGs also have the option to include additional co-opted members, to advise them on specific issues. Chapter 6 (6.5) showed how LHGs have a more diverse membership than PCGs, including a range of primary care professions other than medicine: a community pharmacist, a dentist and an optometrist; a second Local Authority (LA) representative, two officers (one from social services and one from another department such as environmental health, environmental safety, housing or strategic planning); a representative of a local voluntary organisation; and a lay LHG board member, specifically appointed to represent the local community (figure 1, chapter 6). However, this does mean that LHGs vary considerably in size. This diversity among LHGs also means that LHGs vary in the extent to which GP members have experience of working in commissioning, either through former fundholding arrangements or locality commissioning groups (chapter 6, figure 2 and tables 3 and 4). The key strategic role of the LHG is to give a more local focus to health planning and to develop integrated health and social care services that better meet the needs of local communities. LHGs are under a statutory obligation to develop collaborative partnerships with other relevant stakeholders. LHGs have been directed by the National Assembly of Wales to engage in devising and implementing local health improvement programs (HIPs), develop primary care, integrate care delivery, and commissioning services (*'Putting Patients First'*, 1998a; 1998b).

There are a number of observable differences between the focus and composition of LHGs in Wales and primary care groups (PCGs) in England. In particular, LHGs encompass a broader approach than that of the 'primary care lead' role of PCGs (Audit Commission, 2000: 1). In addition, LHGs tackle a wider prescribed list of health care issues, a direct result of the localised initiatives of the National Assembly

for Wales. In structural comparative terms, LHGs involve a larger board of executive members, representing a wider collation of primary care professionals. Lastly, the LHG maintains common boundaries with unitary local authorities. This congruence between existing health and local authority zones and LHG areas of coverage arguably provides LHGs in Wales with considerable advantages for joint-working and integrated planning of local services, as compared to PCGs in England, that operate according to geographical and population boundaries. In policy terms, '*Better Health Better Wales*' (Welsh Office, 1998f) and '*Improving Health in Wales: A plan for the NHS with its partners*', (NAW, 2001a) places greater policy emphases on fostering new partnerships to tackle wider public health issues, as opposed to the primary care lead strategy of PCGs in England. LHGs in Wales, in cooperation with health alliances, tackle wider health and social care issues in a more inclusive and cooperative framework than in England. Since 1999, LHGs have been steadily building new partnerships with a range of agencies and professional groups. Notable links are being formed between LHGs and the following agencies or services as part of the new remit of LHGs set out by the National Assembly: local community professionals, GPs, nurses, optometrists, dentists, pharmacists; local government and local authorities; health authorities; NHS Trusts; secondary care hospitals and specialist care services; social services; patient advocacy groups; voluntary groups; public health; and police, fire and ambulance services. The expectation is that almost 75% of the health budget will be devolved to LHGs or their successor groups (local health boards), to jointly tackle local health and social care needs in cooperation with the partners outlined above (NAW, 2002b).

As part of a review of secondary data on LHG activities in Wales, chapter 6 showed how there have been relatively few studies of joint-working initiatives in NHS Wales, particularly when compared with studies of PCGs in England. Of particular interest are the Audit Commission report, '*Local Health Groups in Wales, The First Year*' (2000), and studies by Lyne et al. (2000), on the effectiveness of interventions designed to reduce or remove barriers to change in inter-agency working, by Hayes et al. (2000), an assessment of health care outcomes from collaboration between health and local government agencies, by McClelland et al. (2001), on the effectiveness of models of primary and community care commissioning, and more recently by Link et

al. (2001), a study of the inter-agency working capabilities of local health groups (detailed in chapter 6). Findings from the Audit Commission report of LHGs over their first year revealed how LHGs have devoted considerable effort to building new collaborative relationships with local clinicians, healthcare providers, voluntary organisations and local authorities. LHGs have been instrumental in contributing to the newly formed local health alliances and in setting clinical governance baseline assessments and structures, embracing all local health care providers. However, LHGs have made less progress than many PCGs on specific aspects of clinical governance, primary care development and commissioning. The Audit Commission report concluded that the overall performance of LHGs has been positive. The Commission recorded LHG boards appear generally to be working well on issues of inter-professional working and wider local health needs assessment, care pathways, and on collective decisions on the future of practice-based services. However, a number of factors have inhibited LHG development including, time pressures, inadequate staffing (averaging 8 WTE), poor information and IT; insufficient funds to facilitate change, and a loss of interest among members due to a perceived lack of influence and a lack of clarity as to the future of LHGs. The Audit Commission report (2000) suggests the development of LHGs over the next five years might be varied, depending on two critical factors, the size of the LHG, or existing experience of joint-working or joint-commissioning among members. Overall, it was concluded that LHGs need to make effective use of their resources and that members should work collaboratively to formalise support arrangements with HAs and NHS Trusts. The Audit Commission report also concluded that LHGs require an agreed development path, involving organisational audits to identify development needs, in conjunction with clear long-term goals, tailored to local circumstances.

The study by Lyne et al. (2000) adopted a systematic review of 'the effectiveness of methods for removing the barriers to change to improve collaborative working'. This study revealed very little evidence of effectiveness of methods to overcome the barriers to change. There study showed some evidence that shared learning in is an effective way to reduce inter-professional stereotypes between doctors and social workers, but weak evidence of the effectiveness of quality improvement programs and inter-agency training. Lyne et al. highlight that critical success factors for programs

designed to remove barriers to change can be inferred from the experience of those who have tried them, and that the reporting of program evaluations requires methodological and policy improvements. The study by Hayes et al. (2000) conducted a systematic review of health outcomes from collaboration between health and local government agencies. The study showed no clear evidence of a link between collaboration and health gains, and suggested that more research is required on how to make collaborative working arrangements successful. McClelland et al. (2001) also conducted a systematic review into the effectiveness of models of primary and community care. The study found that no one model of commissioning offered a template for effective commissioning. McClelland et al. (2001) concluded that: GP lead commissioning models effected some changes in the delivery of primary care based services but few changes were made to hospital based services; concerns over equity of access to services emerged in all models; responsiveness and accountability to service users and the general public remained under developed; partnership with other agencies remained difficult to achieve in all models except joint-commissioning. The study by Link et al. (2001) into how local health groups can collaborate effectively with other partners to improve health in line with the combined health and social care agenda, is one of the few primary empirical studies into LHG activities, and runs in parallel to this study. Interim study outcomes by Link et al. (2001) revealed that: 70% of LHG members were fully involved in setting LHG objectives and agreed with these objectives; almost 45% of members were satisfied with the achievements of their LHG; LHGs are most commonly collaborating with primary secondary health care and health promotion agencies, followed by local authorities and the voluntary sector; time and resource constraints were cited as major inhibitors of relationship building; training and joint-working with other agencies as useful for developing and forming relationships. None of the above studies adopted a network approach to the study of cooperative working in the NHS in Wales.

In July of 2001, the National Assembly for Wales published its strategy plan for the future development of the National Health Service in Wales titled '*Improving Health in Wales: A Plan for the NHS with its partners*' (NAW, 2001a). The overall objectives of the 2001 Plan are to achieve wide scale improvements in patient services and to raise standards in quality of care. To achieve these aims the National Assembly for

Wales has followed the model set by the NHS England however, the main divergence from England has been the plan to abolish health authorities and move HA responsibilities to new local health boards, the equivalent to English PCTs. Local health boards (LHBs) will take on new responsibilities for commissioning, securing, and delivering, healthcare in their localities (NAW, 2001e). LHBs are to be directly accountable to their local population and more formally to the Director of the NHS Directorate (NHSD) and the Minister for Health and Social Services (table 5, chapter 6). The role of local Government in health matters is to be enhanced by extending the membership of local health boards to include representation from local authority members and the local population. In an attempt to elicit higher levels of accountability from the NHS, the National Assembly for Wales is currently seeking to hold both local health boards and NHS Trusts fully accountable for their actions and the services they provide and commission (Naw, 2001f: 1). This strategy involves reasserting the Assembly's direct democratic control over the NHS and includes a dimension of health economics for the implementation of nationally agreed strategic priorities. Across national and local levels, the Wales Government has sought new ways of achieving health gain with increasing emphasis on health measurement and health outputs. This goal has heightened the role of public health as a specialist service with NHS Wales. Public health is to form an integral part of the agenda for public protection, health promotion and preventative health. LHBs are viewed as an attractive alternative to health authorities, and as such will take over the existing responsibilities of Has, as well as attempt to meet the criteria set out in *'Improving Health in Wales: A Plan for the NHS with its partners'* and *'Improving Health in Wales: Structural Change in the NHS in Wales'*. The Assembly views the removal of the health authority system as "...abolishing a tier in the current hierarchy between the Assembly and patient" (NAW, 2001: 1-5). This example of change in managerial and administrative systems supports earlier argument in chapters 2 and 4, of a move away from hierarchy and bureaucracy to newer network forms in the NHS.

Overall, chapter 6 demonstrated and articulated the many changes that have taken place in NHS Wales since 1997. The Welsh NHS reform Plan has involved a number of changes to NHS structures, principally in primary health care. The Welsh Assembly has sought to create a more inclusive and people-centred Health Service that is easier

to access and understand, that is more accountable for the actions it takes and the services it delivers, and is a more democratically governed service (NAW, 2001a). As in the precursor 1998 White and Green Papers on Health '*Putting Patients First*' and '*Better Health Better Wales*', the current approach to health care management is based around the development of new and dynamic partnerships within NHS Wales. The introduction of local health groups has been an important part of this collaborative strategy. The distinct approach to Health Service reconfiguration in primary health care in Wales has been founded on co-terminosity between the remit of local authorities and local health groups. This congruence of local government and local health agencies is perceived as an effective platform for the health and social agenda in Wales.

Local health groups have been at the centre of the introduction of an experiment in health care delivery in Wales, that of networking a wide range of health and social care agencies, professionals, local government, patient advocacy groups, and the voluntary sector; to jointly ascertain local level health care need, and to respond locally by commissioning or directing services to meet such need. The structure of LHGs is shaped by a myriad of local health alliances that have been established to widen the range of service interests in the broader health and well being agenda. It has been proposed that there should be a new statutory duty on each local authority and local health boards to work collaboratively to implement a Strategy for Health and Well-being in their area. LAs and LHBs will also be required to cooperate with relevant NHS trusts, and service providers in the independent and voluntary sectors; patient, user and carer groups; the voluntary sector; and a wide range of related service interests including housing, education and community development. Another important area of strategic partnership building is the interface between health and social care services. The joining-up of mainstream health and social service departments is one area in which new alliances are being formed. The National Assembly's aim is to promote wider health and well being at the local level via integrated care and commissioning models that tackle health inequalities from multiple perspectives. As such, the future role of LHBs will be vast, having to recognise and respond to disparities of scale, health status, inequalities in health and local working arrangements (NAW, 2001e).

## 8.8 Networking at the Local Level

According to Provan and Milward (2001: 414), networks in the public sector, particularly in health services, require evaluation from a number of important levels of analysis, such as community, network, and participant (chapter 7, table 1). In response, chapter 7 moved the focus of analysis downward to the level of the community. Local level investigations focused on one large health authority area, Health Authority Zone-X, encompassing four community-based local health groups, LHG-1, LHG-2, LHG-3, and LHG-4, situated with the primary care sector of NHS Wales. Field investigations were divided into three main tasks. The first task involved observing the workings of the four Local Health Groups to draw inferences about the workings of individual LHGs and the forms of relationships involved. This involved the researcher attending a number of LHG Executive Board meetings across all four LHGs over a two-year period between 2000-2003, as part of the *observational stage*. The second key stage involved an extensive review of archival and internal documentary data relating to each Local Health Group, to document work practices, aims and objectives, achievements, and interactions between professionals and agencies. This *documentary stage* involved a review of internal reports and minutes of meetings for each of the four LHGs studied. The third stage involved interviewing key informants drawn from across the four LHGs and from representatives from affiliated agencies linked to these LHGs, to explore a range of research questions and relational issues, as part of the *interview stage* (appendix 2 and 3). The process of interviewing principally involved face-to-face interviews with LHG members from across the four LHGs in the HA-Zone, but also involved supplementary interviews with LHG members from other LHGs in Wales. Face-to-face interviews were also supplemented by telephone interviews where contact with LHG members proved difficult due to constraints of access, time, or non-participation (detailed in chapter 3).

Importantly, LHG-1, LHG-2, LHG-3 and LHG-4, strategically situated within this locality context were the focal point for an examination of collaborative behaviours and relational processes. Table 2 of chapter 7 illustrated the range of network attributes and network dimensions explored during empirical field investigations. These network attributes and dimensions identified in chapter 1, helped guide field investigations and the development of the interview questionnaire instrument



(appendix 2 and 3). The interview questionnaire was divided into different sections in accordance with the objectives of the study and included sections on: network awareness, network objectives, network membership, network collaboration, network stability, and network performance. Each section of the questionnaire covered a range of issues such network members' perceptions of trust, level of commitment, history of conflict, or understanding of performance. The questionnaire was rigorously devised with questions purposively linked to network theory, following Knoke and Kuklinski's guidelines for network research (1994: 176-177).

One of the first tasks of field investigations involved investigating the role of the four Local Health Groups working within the Authority area. The four Local Health Groups within HA Zone-X began operations as a shadow bodies of the HA up until 1998, but were formally enacted as fully operational committees of the HA Zone-X on the 1st of April 1999. At first, the four LHGs operated in an advisory capacity, but have since taken on greater responsibilities for planning and commissioning health services over the period 1999-2003. Their responsibilities encompass the planning, provision and development, of primary health care services, and the commissioning of community and secondary health services. They also play a part in shaping and delivering NHS contributions to improvements in the health and care of the communities they serve, and provide data to help tackle health inequalities. The four LHGs are multi-professional organisations, encompassing one general manager, six general practitioners, two nurses, one pharmacist, one dentist, one optometrist, two local authority officers, two health authority executives, one voluntary group member and one lay member. As well as involving GPs, nurses, local government and community groups, LHGs ensure that other health professionals, including professions allied to medicine and secondary care clinicians, are engaged in decision making around service commissioning and delivery. The LHGs also work collaboratively with public health agencies, patient groups and the voluntary sector. These primary care service providers link with a range of secondary care providers in the HA Zone-X area, including hospitals and other community based services. The LHG is responsible for coordinating these services to provide an efficient and effective Health Service, in accordance with UK Government, National Assembly for Wales and NHS guidelines (chapter 6). A key function of the LHG is to work with the

Health Authority in leading the development and implementation of a health improvement programmes to address the health care needs of the local population (chapter 7: 7.5).

While many members of the different LHG Executive Boards started with only limited experience of NHS management or strategic governance, over the past three years constituent members have been working on creating cohesive primary care teams and collaborative relations across the services, agencies, and professional groups, involved. This process of development, improvisation, and adjustment, has been particularly evident in the four LHGs studied in Health Authority Zone-X (chapter 7: 7.5 and 7.6). Despite the demands placed on the managers and professionals involved, the majority of LHG Executive Board members interviewed as part of this study confirmed their Boards and Local Health Groups were working effectively and had made good progress towards meeting the objectives of each individual board from 1999-2003. In particular, interview data revealed a high level of enthusiasm among LHG members for the role of LHGs in service development at the community level. Observational data showed high numbers of attendees at LHG Executive Board meetings (chapter 7: 7.15). All four LHGs showed signs of organisational development from Level 1 to Level 3 of the Government's progress plan for increasing primary care organisations responsibilities (table 5, chapter 7).

Local Health Group 1 is the largest of the four LHGs studied. LHG-1 occupied a central position within Health Authority Zone-X, being located close to the Health Authority, covering the largest population group within the authority area, attracting the largest funding budget, and being heavily involved in Health Authority programmes, and in influencing the three smaller and peripheral Local Health Groups. LHG-1 developed four Locality Steering Groups (LSGs) during 2001-2003, to cover four different areas of Area-1 of approximately 80,000 population groups. The LHG set up four LSGs in response to the size and complexity of Area-1, covering four designated community areas. Each LSG was allocated a small budget and a designated team from within the LHG, including a pharmacist, health promotion specialist and lead senior manager. The existing GP-oriented group, 'Quality, Equity and Development (QED)', was also supported and maintained by the LHG. In July

2002, Area-1 LHG ratified a service level agreement with each LSG and QED. This document provided a framework to ensure that intended work was undertaken in accordance with objectives and actions set out within '*Local Health Action Plan for Improving Health and Health Services in Area-1*' and the '*Primary Care Development Plan: A Contextual Document*' (LHG-1 Internal Publications, 2002). The steering groups address local issues in each of the four areas they cover and are headed and operated by LHG professionals working within the designated areas. Members from Area-1 LHG, including the medical adviser, health promotion specialist, prescribing adviser and primary care development manager, and others, support each LSG. LHG-1 has focused much of its resources on tackling a core range of health issues, such as rehabilitation and intermediate care and health promotion (LHG publications, 2001; 2002). LHG-1 has developed a range of partnership working arrangements with LHG-2, LHG-3, and LHG-4, to pioneer and fund the development of better outpatient services and primary care services designed to relieve pressure on secondary care hospitals. Some notable service improvements identified include, the establishment of a back pain management scheme for non-surgical cases; physiotherapy in the community; a domiciliary hip assessment service; elderly care assessment service (ECAS); a rapid response reablement team; and an emergency admissions local action teams (EMA LAT). LHG-1 has also been instrumental in developing a range of mental health services in Area-1, such as counselling projects and assessment teams. The LHG has also focused on health promotion initiatives, tackling poverty and related health problems and in improving access to secondary care and specialist care services. LHG-1 has been particularly proactive in organising and coordinating health services in Area-1 and has adopted a collaborative approach by developing and strengthening relationships with other partners, including Area-1 County Council, local NHS Trusts, the voluntary sector, South Wales Police and the Probation Service.

Unlike Area-1, Area-2 LHG covers a relatively small population with a high percentage of elderly patients and rural patients, and has very high levels of social and economic deprivation. The LHG has attempted to focus attention on improving the breadth of primary care services provided in the area, such as access and referral systems, health promotion, and staff and service development (chapter 7: 7.7). The LHG has addressed concerns about emergency services and access to secondary care.

The LHG held a number of management seminars on this issue during 2000-2002 and has been actively engaged in building a range of partnerships with secondary care providers like the HA Zone-X, the local NHS Trust and organisations in the voluntary sector, such as Age Concern. The LHG has helped develop an action plan to address deficiencies in ambulatory services, via links with the local ambulance service and the County and Borough Council, and the HA Zone-X emergency planning team. The ambulance service has already achieved a number of successes, including the use of new rapid response vehicles, better non-emergency and high-dependency transport systems, and a fast track system to the critical care unit at two of the local hospitals (CHI Report, 2002: 57). In addition to access to emergency care, access to standard and specialist secondary care services has been a prime focus of the LHG-2. Notable service developments included the funding of a liaison manager to study referral patterns and waiting times, that resulted in development of a guideline document for GPs in LHG-2 concerning referrals to hospital/specialist services, such as x-rays and imaging, orthopaedic assessment and cancer care. LHG-2 also established a lower back pain clinic to provide more timely access to alternative treatments for patients, and a primary care support unit (PCSU) that has helped establish a number of local clinics, coronary heart disease, asthma, diabetes and women's and children's health. The LHG successfully attracted new general practitioners to the area, by developing a new salary and training scheme for new GPs.

Area-3 LHG has sought to tackle some of the most urgent health needs of the community since its creation in 1999. The work of the LHG over the past three years has been primarily concerned with assessing local needs, improving access to secondary care, the development of local auxiliary services and targeted health promotion. The LHG has drawn up an orthopaedic action plan with the local NHS Trust to address the waiting lists for hip and knee operations. The LHG also developed a glaucoma screening project, that allows optometrists to screen for glaucoma at local practices, thus reducing the number of GP referrals and outpatient admissions. The LHG has also responded to the need for better sexual health screening, treatment and education, by providing access to pregnancy and contraception advice and by helping create a new youth drop in centre. The LHG has also communicated with local pharmacists to offer advice and emergency

contraception to young people in the area. LHG-3 has also targeted its efforts at developing dental care services in the area, improving drug prescribing, and modernising estates and staffing arrangements. LHG-3 has developed a number of key partnerships to help develop local services and meets its objectives, with the Area-3 County Borough Council, Social Services, and neighbouring NHS Trusts. These partnerships helped the LHG secure special grants and funding from the National Assembly to develop services. This funding has been used to provide care rehabilitation for stroke patients and improve diabetic services provided in Area-3, including a diabetes nurse facilitator; allied health professional support; a peer support programme; a diabetes care pathways project; and a primary care physiotherapist. LHG-3 has been instrumental in the development of diabetic services in the County Borough and has been able to relay its expertise to neighbouring LHGs, and has helped establish a diabetes strategy group to diabetic care in Area-3 and Area-2, in partnership with the Community Health Council and patient groups. A 'diabetes peer support programme'(DPSP) emerged from the diabetes project, led and managed by diabetic members of the public that work to help diabetics in the local community. The LHG has been able to develop a diabetes care pathway project to map services and identify areas for improvements. LHG-3 has also improved access to dental services, develop a managed clinical network for ear, nose and throat services, and establish a primary care resource team (PCRT). The team currently consists of a diabetes nurse facilitator, two coronary heart disease nurses, a practice manager support officer, and an administrative assistant. One area in which the PCRT have been particularly active is in the area of coronary heart disease (CHD). An example of the work currently undertaken in CHD is the 'risk factor intervention project'. The project commenced in January 2002 and is funded by the Inequalities in Health Fund from the Welsh Assembly. The project aims to reduce the incidence of coronary heart disease across the Borough of Area-3. For patients who have existing coronary heart problems, such as heart surgery cares or have heart attack victims, a voluntary peer support group called HEARTBEAT 95 was established, providing a telephone help-line for patients providing information and advice on a range of coronary issues. This reflects the level of interaction between LHG-3 and voluntary groups and the new emphasis placed on public health.

LHG-4 has focused on tackling a core range of local health issues, such as access to continuing care, drug prescribing, and developing better links between primary and secondary care services. Like LHG-1, LHG-2, and LHG-3, LHG-4 has attempted to develop a multi-disciplinary primary care team to develop and provide services at the local level. One area where LHG-4 has focused is in providing nursing and residential homes, particularly to vulnerable patients in the local community. This has been partly achieved by the introduction of a number of new schemes like the emergency admissions local action team (EMA LAT), in partnership with LHG-2 and LHG-3, that ensures social care input for vulnerable patients on discharge from hospital. The LHG has sought to improve the secondary care referral system, as seen in LHG-2, to modernise local admissions procedures and relieve pressure on hospitals by offering alternative services to patients. LHG-4 has worked closely with the local NHS Trust and LHG-1. This partnership has led to the joint funding of a demand management post. Service improvements include: a higher number of available intermediate care beds at a local hospital; taking part in an intermediate care review undertaken by Area-1 and a local NHS Trust; a short-term intervention scheme to provide therapy and social care input in patient's homes; and the introduction of an acute response team in the community served by Area-1 and the local NHS Trust (LHG Publications and CHI Report, 2002). Other notable areas of service improvement include the introduction of a drug prescribing policy to improve quality and cost effectiveness of prescribing and the development of a primary eye care acute referral scheme (PEARS) to ensure appropriate assessment of patients by optometrists and allowing for direct referral to secondary care specialists. This has reduced pressure on GPs and reduced the number of inappropriate referrals to hospital specialists (chapter 7: 7.9). LHG-4 also established a clinical governance team to oversee the quality of Health Services available to residents. In 2001/2002, the clinical governance team completed a report that looked at important aspects of healthcare, such as how long patients have to wait for an appointment, access for disabled patients, and how the public are informed about how to make a complaint. Other important issues that come under the umbrella of clinical governance include patient confidentiality and involving the public in planning services. The LHG has sought to tackle the issue of patient involvement. LHG-3 has helped set up GP-patient liaison groups, to provide a forum for communication between GPs and patients, aimed at identifying service gaps and

areas for improvement. These groups have produced information booklets and newsletters for patients, established self-help groups, and organised health-education talks and discussions.

Chapter 7 detailed how the four LHGs of Health Authority Zone-X have engaged in the process of relationship building across agency and professional boundaries. Each LHG is a multi-professional body responsible for integrating primary care organisations and professionals at the community level. Since their establishment in 1999, the four LHGs have moved from simple advisory bodies of the Health Authority to more proactive health care commissioning and provisory bodies. Each LHG has been involved in an array of vertical and lateral relationships that span between health and social care, health and public health, and between health and local government. The range and breath of ties and relations in primary health care is vast and complex, exemplified by the array of lateral and vertical, inter-professional and inter-agency, relations across the four LHGs of HA Zone-X (chapter 7, figure 4). All four LHGs studied were actively engaged in a wide range of relationship maintenance and building. Chapter 7 mapped out the range of vertical and lateral links the four LHGs had evolved (figure 2). The most prominent links were lateral inter-service relations, with Public Health, Social Services, Mental Health; inter-agency relations, with Local Authorities, Community Health Councils, Patient Interest Groups and Voluntary Organisations; and inter-professional relations among community health practitioners, GPs, community nurses, dentists, pharmacists, and optometrists. This level of cross-linking of health care reflects an innovation that goes beyond the traditional remit of health authorities. The consensus of opinion to emerge from formal and informal interviews with members of the four LHGs studied in Health Authority Zone-X, is that the introduction of Local Health Groups has been a positive policy move in primary health care in NHS Wales, and this move has been welcomed by a range of health professionals, general practitioners, community nurses, pharmacists, optometrists, dentists, and patient groups. However, chapter 7 detailed professionals' concerns about workloads, under-funding, and future changes in policy direction that might undermine the work of Local Health Groups. Field investigations revealed that inter-professional relations appeared cordial and functional, however evidence shows that GPs dominate the health development agenda (chapter 7: 7.15).

Importantly, in organisational design terms, the introduction of LHGs has provided a platform for the inclusion of previously marginalised health professionals, such as community nurses, pharmacists, optometrists. Interviews and dialogue with these professionals revealed their enthusiasm for being involved in health planning. One of the key features of the LHG is the way it is able to connect at the community level. Each LHG in HA Zone-X has been able to react to the micro-community needs of patients. Before the introduction of LHG-1, LHG-2, LHG-3, and LHG-4, Health Authority Zone-X was responsible for the commissioning and provision of all primary care services. Following the introduction of LHGs in the four sub-community localities of the Health Authority, each LHG has been established by members of the primary care team that works within that specific locality area. For instance, LHG-2 is headed by a local GP, incorporates a committee of doctors, nurses, social workers, local authority officers, health authority officers, and lay members from the voluntary sector. Since 2000, LHG-2 identified a lack of provision around key areas of health need, in coronary care, mental health, diabetic care, and family planning/sexual health. In response, LHG-2 devised and implemented a Health Action Plan (LHG-2, 2000-2003), that brought together a range of agencies and professionals, such as doctors, nurses, therapists, health authority officers, the NHS Trust, the community health council, local authority, and user groups, to establish a Primary Care Support Team (PCST) and two Primary Care Resource Centres (PCRC). From 1999-2003, LHG-2 was able to establish a coronary care assessment programme, a diabetic care centre, a mental health assessment team and intervention protocols and a young persons drop in centre for sexual health advice and family planning. Such achievements were made across all four Local Health Groups and demonstrate how these local-level bodies have been able to address very specific local health needs.

The four Local Health Groups (LHGs) investigated as part of this study have arguably brought a more local perspective to planning and service development: contributing to a health improvement programmes (HIP); developing primary care; integrating care delivery; and taking part in a more holistic form of service commissioning. Findings from this study highlight the potential value of LHGs in the delivery of community-level health care services. All four LHGs were actively involved in improving access to services and involving stakeholders in the commissioning and provision of health



care, although as chapter 7 revealed, LHGs have found it difficult to increase direct user involvement. However, LHGs have been able to reach out to communities via intermediary voluntary groups and patient support groups, such as the Diabetic Care Group in LHG-3. LHGs have attempted to enhance service utilisation by better focusing resources to geographic areas of high health deprivation, as seen in LHG-1's work on economic deprivation in Area-1 (chapter 7: 7.6). The remit of local health groups arguably goes far beyond that of early initiatives in primary health care, such as total purchasing pilots. Chapter 7 also elaborated on the inter-professional relations that have developed via LHG working, between professions, medicine, nursing, optometry, dentistry, between health professionals, health managers and policy makers, and between health and social care agencies. The wider and more inclusive nature of LHGs has raised complexity in health care design, however this has been offset by the potential gains that come from enhanced service integration, that reduce service overlaps, enhance inter-professional coordination and communication, and results in a more bottom-up health care planning. Chapter 7 recorded some of the main achievements of the four LHGs studied, across a number of important areas of primary health care including: contributions to clinical governance; developing referral protocols and clinical pathways; tackling prescribing protocols and costs; oral health issues; research on determinants of health; establishing new alliances across boundaries and between health and other agencies, such as the voluntary sector. All four LHGs in Health Authority Zone-X produced documents recording their achievements up until 2003, as part of the process of transfer of power from the four LHGs to the new Local Health Board of Zone-X. Table 8 of chapter 7 shows an extract from the Legacy Statement of LHG-4, detailing the LHGs main achievements before handing over to the new LHB. LHG-4 is the smallest LHG in HA Zone-X, yet has been involved in a wide range of activities and programmes, and exemplifies some of the achievements made by LHGs.

The nurturing of partnerships between primary health care providers and agencies responsible for health commissioning has gone some way towards creating a more integrated and networked system of health care. The inference drawn from the accounts illustrated in chapter 7 is that (1) there has been an overall positive response to the introduction of LHGs from health care practitioners and allied representatives

working in primary care at the community level, (2) a wide grouping of health professionals have been brought together to jointly plan and provide primary care services, this contrasting starkly with the previous system of service planning and commissioning conducted by the health authority, (3) professionals such as community pharmacists, dentists, optometrists and nurses have been given a platform to relay their experiences and knowledge of patient need and service development, (4) there is a higher degree of networking and integration via the LHG system than previous fundholding or total purchasing arrangements, (5) this cooperative system of working is in an early stage, and while it is possible to identify some improvements in service delivery and planning, the overall success of LHGs will not be known for some years to come. LHGs reflect a more inclusive form of joint planning that crosses organisational boundaries, service boundaries and professional boundaries. The LHG offers a more flexible form of working that allows for a wider range of partnerships to be forged in primary health care. The LHG also allows for a pooling of funds, expertise, knowledge, experience and talents; that goes far beyond the scope of existing health authorities, and brings about a more integrated format of provision and commissioning in primary care. In addition, the LHG offers a more holistic approach to health care that takes into account wider socio-economic and public health issues. The aligning of local authorities with LHGs and the linking of new public health institutions has arguably contributed to the broader perspective taken by LHGs in health planning and provision in NHS Wales. However, while the initial enthusiasm for joint-working between the different professionals and agencies involved in the Local Health Groups of Health Authority Zone-X undoubtedly helped the initial development of these new institutions over the short term, the question now arises as how well these organisations can succeed to deliver health benefits through collaborative working over the long term. From April 2003, the four Local Health Groups of Health Authority Zone-X will cease to exist. Their responsibilities will pass over to one new large Local Health Board '*Improving Health in Wales*' (NAW, 2001a). The LHB will combine the responsibilities of the Health Authority with those of the four Local Health Groups of Area-1, Area-2, Area-3, and Area-4. The concern is that by moving to one large health commissioning and provision body, the local focus and high level of professional involvement generated via the work of the LHGs, might be lost, where the LHB becomes a Health Authority under a different name.

## 9.1 Introduction

This final chapter reflects on the outcomes of the study. The chapter addresses the principal research questions posed by the study, by drawing a number of conclusions from the study's findings. Accordingly, the chapter accounts for the recent move away from market and hierarchy to network forms in the UK National Health Service; the salient processes and factors involved in the integration of agencies in health care; and the implications of networks for the management and organisation of the National Health Service. The chapter positions this study's outcomes against the prevailing literature on collaborative networking in health care, and more widely, the across the public sector. This study positions itself between the fields of organisational theory and public management theory, and it is within these subject fields that this study contributes. This chapter reflects on the major outcomes to emerge from the different levels of investigation undertaken to study networking in the UK National Health Service, and relates how these findings contribute to theory and practice within the field. The chapter goes on to assert the merits of the methodology applied and presents an agenda for future research on networks in the health care and the wider public sector. The chapter offers a number of recommendations for the organisation and management of the National Health Service and for health policy.

## 9.2 The National Health Service: From Bureaucracy and Market to Network

The NHS has been subject to a number of reforms since its birth in 1948. Significant changes have taken place in 1974, during the mid-1980s, and early 1990s. The Conservative Governments of 1979-1997 were principally responsible for the introduction of '*Working for Patients*' (DHSS, 1989) and the creation of an internal-market in health care, where district health authorities focused on purchasing, and hospitals and GP fundholders on providing services. During the 1980s and 1990s, the NHS centralised its control mechanisms with the establishment of the NHS Policy Board and the NHS Management Executive (now the NHS Executive). These changes marked a move away from the consensus approach towards professional management. Much of the academic literature on quasi-markets in the UK public sector has been

critical of the internal-market, describing it as divisive and restrictive (Flynn et al., 1995; Davis and Walker, 1997). The suggestion has been that internal-markets raised monitoring costs, increased opportunistic behaviour, adversely effected service coordination, and increased the levels of uncertainty and instability across those public services. Research by Flynn et al. (1995: 539) and Wistow et al. (1996: 156), suggest that contracting is not an appropriate mechanism for public service provision. Studies of contracting in health and social services (Walsh, 1995; Lewis et al., 1996; Charlesworth et al., 1996; Baggot, 1997) voiced concerns about falling morale among public sector professionals. In the NHS, Renade (1995: 253-4) found that the internal-market had resulted in the existence of 'information deficiencies' and a reliance on 'block contracts', that allowed some providers to claim "*increased costs and hence prices which the purchasers found difficult to verify...*". Maddock and Morgan (1998) suggest that the introduction of competitive forces led to combative and hostile internal and external relationships in public services. The division between purchaser and provider roles, many suggest, led to the erosion of existing and long-standing relationships between services (Maddock and Morgan, 1998: 237).

The perceived failure of the internal-market experiment during the late 1980s and early to mid 1990s, arguably led to the contemporary belief that arms-length contractual relationships are less appropriate than trust-based methods. Flynn et al. (1996) suggest that '*the complexity and inter-dependent nature of services requires more open-ended contracts based on mutual trust*'. In health services, it has been argued that the most effective outcomes came when purchasers stepped outside contractual relationships into closer network-based collaborative exchanges (Flynn et al., 1996: 61). Wistow et al. (1996: 171) add that:

*'The most appropriate form of governance structure in future will be some intermediate form of quasi-market, embedded in social networks, where relationships are more integrated and collaborative'*.

Critics of market-based approaches advocate a move away from adversarial arms-length relationships towards more partnership-based practices (networking), where services are integrated, rather than fragmented. This preference for new hybrid organisational forms has often been based around the arguments generated by transaction cost economics and principal-agent theory (detailed in Chapter 1),

whereby the cost of writing and maintaining contracts may be reduced by the development of trust-based relationships between principal and agent. Milne (1997: 18) for example, asserts that the success of voluntary contracting in the private sector might be replicated in the UK public sector, given appropriate policy and conditions. As such, there has been a growing preference for collaborative relationships between purchasers that has arisen from studies that reveal an array of lingering organisational and administrative failings, including, falling morale among service professionals, regional variations in service quality, rationing, and a lack of coordination between agencies (Locock, 2000; Flynn et al., 1995, 1996). In health care, internal-markets and quasi-competition are implicated in fragmenting public service organisations and creating an environment of combative and arms-length relationships between the purchasers and providers of care. During the late 1990s, a growing consensus emerged with the critique that quasi-competition failed to deliver efficiency improvements and undermined the unique collaborative nature of public services. Critics of quasi-competition between services in the public sector expressed the need for a new approach to the structuring and coordination of public services, one that moves away from obligational-contracting to more relational-based modes of coordination and delivery (Kirkpatrick, 1999: 8), based on constructive trust-based relationships between service providers and purchasers (Sako, 1992). It was within this environment of anti-market sentiment and research that the Labour Government came to power in 1997, whereby the ongoing critique of the internal-market during the 1990s influenced the incoming Labour Government to seek out alternative modes of governance, specifically new collaborative forms of working.

Since 1997, public management policy moved away from the competition/markets approach. The 1997 White Paper on health '*The New NHS: modern, dependable*' (DoH, 1997) set out the Government's plans for modernising the National Health Service. At the heart of these reforms has been an implicit belief in a 'third-way' approach to organising and managing the public sector. This alternative or compromise approach retains elements of hierarchical or centralised principles of financial management and performance monitoring, but also seeks to decentralise some functions in an effort to coordinate services and improve performance through a partnership and cooperation management philosophy, what might be termed *New*

*Collaborative Governance.* In political terms, new Labour's policies for developing public services represent an ideological move away from traditional socialist-left ideals of complete State provision, towards a more neutral stance, combining the ideas of market incentives with that of public provision (Freedon, 1999, Powell, 1999a). Political commentators have labelled new Labour's strategy for public management as the 'third-way', something between the free-market approach and total command-and-control of State services. Sceptics or critics of this alternative ideology view the third-way as managerial rhetoric: a new language that evokes notions of change, a political discourse that emphasises cooperation and partnership, replacing competition and efficiency (Klein, 2000). While the Labour Government rarely uses the term network, there have been many references to the associated features of collaborative governance across policy publications, such as altruism, trust, cooperation, collaboration, partnership, alliances, multi-agency, inter-agency, and equity (identified in chapters 4, 5 and 6). In much of the literature surrounding the topic, similar references have been made in relation to organisational and cultural change in the public sector (Rhodes, 1997; Thompson, 1991; Kickert et al., 1997; Clarence and Painter, 1998). Rhodes's (1997) notion of a link between the rhetoric of the third-way and a network paradigm is increasingly evident across public sector organisations post-1997, particularly the National Health Service. A review of developments at the institutional level conducted in chapter 4, showed how service organisations are being increasingly integrated into joined-up service delivery systems, characterised by chains of connections and linkages, and by new collaborative organisational arrangements. The latest collaborative ideology is clearly visible in recent moves away from structural hierarchy and bureaucracy to more network-based structures based on mutuality and reciprocity. Examples of recent change in the NHS noted by this study include the removal of competitive contracting and internal-market devices, such as fundholding, in favour of more long-term and cooperative service agreements, like primary care groups (PCGs). The relationship between NHS health authorities and NHS Trusts has also moved away from a principal-agent type relationship, towards more relational forms of contracting, with NHS Trusts and partners participating in strategy and planning. A similar review of developments at the primary care level conducted in chapter 5, showed how new primary care organisations, PCGs in England and LHGs in Wales, have been introduced to

integrate and coordinate health care at a local community level. In conjunction, new health promotion initiatives, such as health action zones (HAZs), as well as new health care commissioning and delivery protocols, epitomise a strategy of collaborative networking. Such strategies are evident at all levels in the NHS, at the level of the individual employee, service professional, organisational unit, and on a larger scale at the level of the hospital, health authority and NHS Trust. As Goddard and Mannion (1998: 106) state:

*“The policy aim of nurturing long-term relationships based on cooperation and trust can be viewed as an explicit attempt to solve the basic principal-agent problem in the purchaser/provider split”.*

The review and identification of recent changes in the structural and procedural practices of the UK NHS, point to a shift away from hierarchy and market, to a more collaborative approach in health care governance and management. Academic commentary tends to be more qualified regarding periods of change in the NHS. Exworthy et al. (1999) partially reject such a chronology, suggesting to the contrary that the NHS has and continues to exhibit signs of hierarchy, market, and network. However, the transition argument, outlined in chapter 2 (2.5) concerning the changing pattern of management philosophy in the NHS is important from the point of view that it draws attention to the contextual properties the UK public sector, as compared with environmental conditions in the private sector. As chapter 1 and 2 of this thesis highlighted, network theory in the UK public sector and the NHS is relatively underdeveloped, whereby network theory continues to draw from studies of competitive firms in the private sector. This study draws our attention to the recent shift to network forms of organising in the Health Service and across the wider public sector, and to the need to develop a robust theory of network that accounts for the dynamic public sector environment.

While such insights take account the complex and diverse nature of public sector institutions like the NHS, the idea of some kind of progression from market to network, as outlined in chapter 1 (1.9), provides a useful framework for an examination of change in coordinating mechanisms in the UK National Health Service, and offers a unique perspective on recent changes in health care, and in the public sector more widely. Hierarchies, markets and networks have been described as

three basic or alternative modes of organising (Thomposn et al., 1991). As chapter 1 showed, there is some consensus among organisational theorists that networks signify an advanced and unique form of governance (Powell, 1991: 265-276). There is also some suggestion of an evolutionary path from market to hierarchy, and from hierarchy to network (chapter 1, 1.9). There has been an ongoing discussion in academic quarters as to whether the National Health Service has moved away from traditional forms of hierarchy and market modes of governance, towards newer collaborative forms of network organisation. Ferlie and Pettigrew (1996: 81) ask:

*“The question arises as to whether there is now a deep-seated shift underway from organisation forms based on markets and hierarchies and towards more network-based forms of organisation?”.*

Significantly, this study presented evidence to support the view that the UK National Health Service has moved away from market and hierarchy to more network type forms. Findings from this study suggest that there has been some shift in dominant ideology and design strategy for reforming public services. While the National Health Service of 2003/4 retains many of the principles that lead to its creation in 1948, notably equity and being ‘free at the point of delivery’, the management philosophy and the structures of the NHS have changed considerably since then. Today’s Health Service differs greatly from the large monolithic bureaucracy of the 1970s, or the quasi-market system of the 1980s and 1990s. This study supports the view of a shift away from hierarchy and competition towards more specialised and collaborative systems in health care, as detailed in chapter 4, 5, and 6. Across the spectrum of organisations that make up the public sector, issues of inter-agency cooperation and networking have taken hold and are assuming greater importance, such as the contemporary focus on multi-disciplinary teams and inter-agency networking in primary health care (chapter 5 and 6).

Since 1997, the National Health Service has undergone considerable restructuring. The new administrators of the Health Service have sought to dismantle the mechanisms of the internal-market in favour of a more conciliatory and collaborative approach to public management, epitomised by the Government’s ‘modernisation agenda’, an array of elaborate reforms detailed in chapter 4, designed to achieve higher levels of performance in key public services, specifically health care. A key



feature of recent policy has been the integration of service providers around joint-working and cooperative groups, particularly in primary health care, exemplified by the introduction of primary care groups in England and local health groups in Wales, along with similar reforms in Scotland and Northern Ireland. The PCG reflects the current trend in health care towards more cooperative and integrated working methods. PCGs are a new tier in the primary care hierarchy and are the focal point for an array of inter-professional and inter-agency relations. The primary care group reflects an attempt to keep a community or local focus at a time of large-scale integration and is a means of engaging with health professionals in community care, linking-up allied agencies, such as local government and social services, and interacting with user groups and the voluntary sector. In this respect, the PCG represents an ambitious and innovative project of networking in primary health care.

#### 9.2.1 The Changing Role of Market in the NHS

Upon coming to power, the Labour Government enacted a course of action to remove the mechanisms of quasi-markets, the abolition of fundholding for example. Labour's early thinking was evident in the approach taken by Frank Dobson, the 1997 Secretary of State for Health, whereby health authorities were instructed to redress the use of contractual relations with the private sector. Despite early signs of a move away from markets and competition in health care, it has become clear that the private sector is to play some role in the new NHS. Policy developments, such as the '*NHS Plan*' (Department of Health, 2000) and '*Delivering the NHS Plan: next steps on investment, next steps on reform*' (Department of Health, 2002), have incorporated a reinvigoration of market mechanisms and incentives designed to increase efficiency, responsiveness and choice, in the health care. The view of the public user as a stakeholder and investor clearly has some link with the notion of the consumer publicised as part of the internal-market. New Labour's desire to build wider relationships between public and private bodies reintroduced some of the incentive-based rhetoric publicised throughout the internal-market era. Despite the constant invocation of the word 'new', there is in fact a large element of continuity between Conservative and Labour health policy, as noted by Klein (2001: 193-194). The switch to performance based on incentive is a clear return to previous market-type policy. The NHS Plan (2000) refers to the need to establish new incentives to improve

care in the NHS. PCTs will be free to purchase care from the most appropriate provider, public, private, or voluntary. In addition, hospital payment systems are to switch to payment by results, using a regional tariff system to reward performance. Hospital clinicians, principally consultants and surgeons, are to be offered incentives to work out-side traditional working times, on weekends for example, and hospital or surgical units that do more, will attract higher rates of investment and funding.

The concept of 'choice' has been another important factor in the Labour Government's plans for reforming the NHS. Importantly, the UK NHS will move toward a more Scandinavian system of health provision, where patients are given information on alternative providers and are able to switch to hospitals that have shorter waiting times. Additionally, the aim for 2008 is for all patients and their GPs to be able to book appointments at both a time and a place that is convenient to the patient. This might include NHS hospitals locally or elsewhere, diagnostic treatment centres, private hospitals, or hospitals overseas. In addition, one of the most remarkable additions to NHS policy has been the move toward public-private provision of services in the UK. In an effort to increase the capacity of the NHS the Government is seeking to craft new partnerships with private sector investors. This strategy is most visible in the building of new hospitals where Public-Private-Finance-Initiatives are being used to access the resources and expertise of the private sector. In the case of new hospitals, private investors will build and finance the development of new hospitals in the short-term, following this, the hospital will move into public ownership once financial investors receive a return on principal investments. In an effort to increase capacity of the NHS the Government plans to involve the private sector and foreign health agencies in providing health services to UK citizens, by outsourcing to private sector providers, either in the UK or in the European Union, where there is excess capacity.

Overall, it is clear that the NHS has partly moved away from the internal market model introduced by previous Conservative Governments. The mechanisms of competition between NHS Trusts and GPs associated with fundholding, has given way to a more inclusive and cooperative system of health care commissioning and provision, designed around more integrated care systems, particularly in the primary

care sector with the abolition of fundholding and the introduction of new primary care groups. However, it is becoming increasingly evident that the new model of the NHS is one based on plurality and diversity of provision. The NHS Plan (DoH, 2000) has reintroduced many of the market-based ideas of incentives, performance, appraisal and value-for-money, associated with the internal-market. The evolving vision of the National Health Service is primarily as a system that provides universal coverage of health services to citizens regardless of ability to pay, whereby the provision of service may originate from a mix of public and private ownership.

### 9.2.2 Continuance of Bureaucracy with Peripheral Autonomy

There is often a suggestion that the National Health Service, from its birth in 1948 until the present day, has remained a monolithic bureaucracy of departments and committees (Klein, 2001). This study suggests that bureaucracy has partly given way to a more collaborative governance model. This shift is not universal in the NHS and requires some qualification. The NHS continues to operate as a top-down styled bureaucracy, exhibiting all the usual artefacts and features of Weber's classic bureaucracy (1947). Critics of recent health reforms suggest that the Government has further centralised executive authority and power (Ferlie et al., 1996). The role of the Commission for Health Improvement and the proliferation of national service frameworks and guidelines are illustrative of a more top-down bureaucratic model of organisational governance. This study outlined recent developments in primary health care in chapter 5 that show a clear shift in the balance of power and administrative control away from bureaucratic organisations like health authorities, down the organisational hierarchy to professionals working at the ground level. The most significant changes since 1997 have been the devolution of power from Whitehall to Regional Governments like the Welsh Assembly, and the introduction of free-standing primary care bodies, PCGs in England and LHGs in Wales. The Labour Government has transferred a degree of decision-making authority away from traditional power centres to lower or peripheral regions of the NHS. The movement of commissioning and provider roles from health authorities to new primary care organisations is one example of a power movement down the hierarchical chain of command. There are plans to further increase the independent status of primary care trusts and local health boards. PCTs and LHBs may well become autonomous quasi-independent entities,

free from direct accountability to the State (statement by Secretary of State for Health, May 2002). Chapter 6 showed how the new National Assembly of Wales has utilised its new powers to evolve and amend central health policy to meet regional-level requirements. This has resulted in the Wales Assembly's radical abolition of health authorities in 2003, in an effort to redress bureaucratic dysfunction in the delivery of primary health care services. The abolition of health authorities in NHS Wales marks a point in time where control over service commissioning and provision moved from the bureaucratic control of health care managers, to health care practitioners. The continuing shift in the balance of power and control in primary care has been overwhelmingly welcomed by health care practitioners interviewed during this study (chapter 6 and 7).

This study finds that the UK National Health Service continues to exhibit all the signs of Mintzberg's (1979) large professional bureaucracy, but also shows that at the peripheries of the Health Service, specifically at the service interface in primary care for example, there is an increasing degree of decentralisation and moves away from bureaucracy to more autonomous forms led and managed by health professionals. The work of the four LHGs in chapter 7 and the central role played by health professionals in delivering and shaping community-based health services, exemplifies this empowerment of health professionals since the introduction of PCGs and LHGs in 1999. In this respect, the NHS might be compared with an arm and hand, the arm representing a core centralised hierarchy, while the hand reflects a more loose structure that networks across services and agencies. This study has also shown how recent restructuring in primary health care has enhanced the role of professionals allied to medicine, for example, the enhanced role of community nurses in LHG decision-making, or the inclusion of dentists, pharmacists, and optometrists, in LHGs in Wales. This contradicts the New Public Management thesis (Ferlie et al., 1996), that professional autonomy is under threat in health care, and shows some continuance of Friedson's (1979) 'professional dominance model' in the UK NHS.

### 9.2.3 The Theory of Mixed Modes of Governance

The above picture appears to support Exworthy's et al. (1999) suggestion that the NHS is a confusing melange of all three governance modes: *quasi-market*, *quasi-*

*hierarchy* and *quasi-network*. This view is echoed in Sullivan and Skelcher (2002)'s argument that while there has been a rise in partnership working, it coexists with other forms of organising. This viewpoint raises the important question of whether or not these mixed modes of governance are in contradiction or create unwanted tensions within the health care system, whether managers within public organisations may hold competing values, as some suggest (Quinn, 1988), or whether they are driven by one dominant logic which screens out other logics? (Ferlie, 2003). Organisational hybrid forms, such as networks, may well need to balance two quite different logics, 'perform' and 'collaborate'.

This study suggests that while there has been a visible move towards a more *governance model* approach in health care post-1997, the NHS continues to be influenced by conflicting modes of governance. The top-down NPM model, with its emphasis on targets and efficiency, continues to dominate vertical lines and underpins many of the generic objectives of the NHS. There is some evidence that hierarchical bureaucracy might be increasing under new Labour (Paton, 1998; Klein, 1998; Le Grand, 1999). In addition, the creation of new strategic health authorities and the future introduction of foundation hospitals signify the continuing influence of quasi-market ideals in health policy and planning. At present, new public management is in conflict with the underlying objectives of *collaborative governance*. The governance model is based on the need for cooperation and partnership (Glendinning, Powell and Rummery 2002), and a hollowing out of the State (Rhodes, 1997) that allows for increased participation and involvement among public sector professionals, managers and staff. While NPM is mainly concerned with short-term quantitative returns, such as waiting lists or referral times, collaborative governance is more about the development of longer-term relationships and new cooperative relational norms, in which the outputs are often less tangible or more difficult to calculate, like quality of patient experience or quality of service (described in chapter 1 in theory and reported in chapters 4, 5, 6 and 7, as practice). The NPM model and the governance model reflect a dichotomy in health policy that requires some reconciliation.

The market-hierarchy-network debate is particularly useful in demonstrating the complexities of governance mechanisms within the UK National Health Service.

However, rather than merely state that the environment is complex, there is some need to make sense of these different and often conflicting health care strategies. As outlined above, the UK health care system currently exhibits aspects of hierarchy, market, and network modes of governance. There is however, an important distinction concerning the prevalence and magnitude of these alternative governance philosophies, particularly within different sub-sectors of the NHS. Accordingly, this study finds that while market-mechanisms are being reintroduced in the secondary care sector, for example in the form of foundation hospitals, in primary care there has been a clear move away from fundholding and internal-markets towards a more networked system of commissioning and provision in the form of PCGs and LHGs. Chapter 6 and 7 illustrated the inclusive features of local health groups in NHS Wales and the many new relations being formed between different agencies and professionals groups in primary care. In addition, the underlying governance ethos within these newly founded organisations is to form links with new partners on an ad-hoc need driven basis. This contrasts with the previous bureaucratic system of the health authority primary care management, based around the allocation of budgetary funds against top-down policy directives from the Department of Health. While there is considerable complexity within the wider health care system, within micro-institutional sectors of the NHS, such as the front-line of the primary care sector, networking has emerged as an important form of organising and operating.

### **9.3 Contributions to the Theory of Network Management in Health Care**

Despite the growing enthusiasm for relational-contracting in health and social care, collaborative forms of organisation create new and dynamic organisational and managerial challenges. According to Mintzberg the network model does not represent a universal panacea of management (1996: 60). One weakness of the literature on inter-organisational networking is that it provides little in the way of a comprehensive review or explanation of the potential for network failure. As outlined in chapter 1, there is increasing evidence to suggest that organisations are entering into collaborative network relations with little prior consideration of the potential problems or costs. For instance, the Government's modernisation agenda, as outlined in the 1997 White Paper, *'The New NHS: Modern, Dependable'* (DoH, 1997) and the

'NHS Plan' 2000 (DoH, 2000), make little or no reference to the investments of time, reciprocity, communication, finances, and the training required to make collaboration deliver positive benefits or improve organisational performance. According to some commentators, relational-contracting may not match the Government's objectives given the contradictory expectation of increased accountability and monitoring, "*calling for trust on the one hand and showing a lack of trust on the other*" (Davis and Walker, 1997: 53). This view holds some relevance in this study, as interviews with health professionals in chapter 7 recorded their underlying fear of continual change in the Health Service. As one GP stated:

*"...things are always changing, this Government has its own ways of doing things and then when the next Government comes into power things might change again...at the end of the day I will be still here doing my job, seeing my patients"* (General Practitioner: 43).

Hudson's (1999: 168) assertion that, "*public sector managers and professionals will face many new challenges in turning collaboration into a workable and effective reality over the long term*", resonates with professionals involved in primary health care. One of the recurring themes of this study is the complex nature of the National Health Service. The NHS is a diverse organisation, encompassing a range of professions and services, all of which exhibit different organisational, historical, and cultural features. The UK National Health Service differs greatly from the archetypal private sector organisation: the profit maximisation imperative is absent, there are no competitors, and the NHS remains a large professionalised bureaucracy (Friedson, 1979). All of the above produce a unique environment and set of additional challenges for developing cooperative networks and collaborative work strategies. While there is less risk of market-type opportunistic behaviour in the NHS, there are other risks, such as professional rivalry and competition over the control and allocation of budgets. The network literature reviewed in chapter 1 and chapter 2 put forward a range of major issues relevant to managing public sector networks including: how to control these new forms; stability and longevity over the short and long terms; the need to maintain a high trust and high commitment environment; aligning goals and congruence; evaluating performance; remaining innovative; and eliciting the potential benefits of networking (Miles and Snow, 1992; Ring and Van de Ven, 1994; Park, 1996; Provan, 1998).

The view in Literature Guide 1 is that network effectiveness is likely to be greatest where external mechanisms of control are direct and not fragmented, and where mechanisms of control, monitoring, and accountability, are clearly defined (Provan and Milward, 2001). In the case of the introduction of local health groups introduced in NHS Wales in 1999, this has occurred under conditions of strict control. LHGs were established in NHS Wales as the formalisation of the Welsh Assembly's plans to improve primary health care by promoting primary care-led commissioning and provision as set out in the White Paper '*Putting Patients First*' (Welsh Office, 1998a). In their first year of operation, each of the four LHGs in Health Authority Zone-X operated as advisory subcommittees of the Health Authority. Over the following three years (2000-2003), the remit of these LHGs widened to include the commissioning of local health services. The LHG sits at the interface between the community and the Health Authority. The LHG is subject to monitoring and control by the Health Authority, which itself is accountable to the National Assembly of Wales, whereby the Assembly is responsible for policy creation and implementation, holding authority over the National Health Service of Wales. There is a clear and direct line of control and accountability. In addition, there is the indirect control that stems from the external monitoring of performance by national health monitoring bodies, such as the National Institute of Clinical Excellence (NICE), the Commission for Health Improvement (CHI) (now called the Commission for Health Care Audit and Inspection) and the NHS Executive. Provan (1995: 15) suggests that, "*systems in which external fiscal control by the state is direct, and to a lesser extent not fragmented, are more effective than directly controlled systems in which the allocation and control of state funding is delegated to a local funding authority*". Provan's (1995) study of community mental health systems in the US contradicts the prevailing wisdom that decentralised systems of fiscal control are best because they allow greater flexibility at the point of service delivery. Provan (1995) argues for the State to directly control local funding of public services and to centrally monitor financial performance, rather than trying to set up a local intermediary that itself must be monitored and controlled (Provan, 1995:13). This logic appears to be prevalent in health care in the UK. On the one hand, the objective behind the creation of new PCGs and LHGs is greater organisational flexibility and community focus; this is counter-balanced by high levels of direct control and increased levels of external



control and monitoring by CHI, NICE and audit agencies. This finding presents a more complex scenario than the simple view expressed in the literature, that there has been a shift away from centralised control to more decentralisation of control.

Literature Guide 2 suggested that networks operate more effectively under conditions of general system stability and require flexibility to react to environmental changes. There is some concern about the long-term stability of collaborative inter-organisational arrangements in the NHS. For some, networks represent a purely temporal or intermediary governance arrangement (Williamson, 1985: 4). Ring and Van de Ven (1994) suggest that networks are vulnerable to disruption from a range of sources, both internal and external, including changes in influential personnel, changes in corporate alliances and fluctuations in business cycles. According to Contractor and Lorange (1988), networks are more vulnerable to environmental changes than more established forms of hierarchy. In UK health care, the stability and effectiveness of new organisational arrangements, such as LHGs and PCGs, or LHBs and PCTs, is threatened by continual change within the sector. One of the overarching aspects of this study, a feature that emerged early on and that permeates throughout, is the highly politicised nature of the Health Service. Health care is a highly topical and contested policy area and receives a great deal of attention in the media and in political party manifestos. When the Labour Government came to power in 1997, one of its first policy outputs was the 1997 NHS White Paper on health. Since then, the Government and the Department of Health have drafted and implemented an extensive range of additional policy briefs (detailed in chapter 4 and 5). The health care organisations investigated within this study reported an increase in top-down directives, exemplified by large number of national service framework (NSFs). The evidence shows that health care organisations are bombarded by frequent policy initiatives that are often temporary in focus (chapter 4, 5, 6 and 7). This study found the political environment in health to be fast moving and often uncertain, with little or no consideration given to change management. Many of the practitioners interviewed expressed concerns about the frequency, timing, and short-termism, of many policy initiatives. Practitioners, particularly medical professionals, reported needing more time to adapt to the changes imposed upon them. This study raises concern about the pace of reform in health care and the continuous introduction of new policy

initiatives. While the NHS Plan 2000 set out a ten-year framework for change, there have been a raft of add-on policy briefs between 2000 and 2003, and there are likely to be many more up until 2010. In addition, many professionals expressed concerns that any future change in Government might result in the dismantling of existing organisational structures and potential changes in policy direction away from cooperative working. The uncertainties and insecurities perceived and experienced by health professionals and managers poses a significant obstacle to professional commitment and ownership. Burns and Stalker (1961), Amburgery, Kelly, and Barnett (1993), and Provan (1995: 13), note that, *'inducing rapid change in a system, such as the redrawing of organisational boundaries, the restructuring of organisations, changes in organisational responsibilities, personnel and funding, can reduce the effectiveness of the existing system by increasing feelings of uncertainty'*. To avoid such a problem, policy makers need to allow NHS organisations and staff adequate time and resources to engage in networking practices, so that productive relationships develop, as shown by the multitude of vertical and lateral relations, formal and informal, being formed by Local Health Groups in NHS Wales (chapter 7, 7:10). Health policy needs to take account of the pace of change and the insecurity that surrounds continual change, to help maintain the commitment of NHS staff.

One of the main advantages networks have over traditional forms of market or hierarchy is the flexibility networks offer. A number of prominent writers on organisations, most notably Granovetter (1973) and Weick (1976), have professed the benefits of loose ties. Granovetter (1973) argues that by maintaining loose ties, there is an opportunity to gain the advantages of linkage without the potential negative effects brought about by system changes. Post-1997 system restructuring of the UK NHS has arguably induced newer and more flexible forms of organising. The imposition of LHGs in NHS Wales has introduced an organisation that is arguably more flexible and user-focused than ever before. This study's investigation of LHG-1, LHG-2, LHG-3, and LHG-4 in chapter 7, revealed an extraordinary degree of inter-connections and relationships between professions, service groups and stakeholder groups. Figure 3 of chapter 7, shows the wide range of professional groups represented by Local Health Groups. Figure 4 of chapter 7, shows the wide range of vertical and lateral relationships being formed between LHGs and health and social

care agencies, including public health, mental health, local government, and service users. The example of the work of LHG-2 (chapter 7: 7:14) illustrated how this LHG was able to conduct a survey of the local needs of the sub-community within the HA Zone-X area. This survey was conducted by professionals that reside within the locality, that have many years experience working within the community. The LHG was able to respond to local health needs by developing a primary care support team (PCST) to oversee staff recruitment, training and development, and the introduction of two Primary Care Resource Centres (PCRC), designed to support the development of primary care in Area-2. The LHG arguably sits closer to the inter-face between users and providers and represents a unique organisational form in the modern NHS. One of the most striking features of the work conducted by LHGs in NHS Wales, is the innovative and flexible way in which these organisations work. Across the four LHGs of HA Zone-X, there were many examples of innovative solutions to local health needs, such as diabetic centres, back pain clinics and new referral systems. The LHG in one respect reflects an experiment in health provision and commissioning. This study has shown that LHGs are community focused and respond to local needs with new and innovative services, perhaps in a way that markets or hierarchy might never achieve. The concern is that as LHGs take on the responsibilities of health authorities post-2003, they may lose such flexibility and community focus, and in essence become health authorities under a different name, local health boards.

Literature Guide 3 suggested that networks are more likely to form where there is a significant degree of trust between partners, particularly if trust is more freely evolved. The vast literature on networks suggests that collaborative arrangements require high levels of trust between members. Definitions of trust tend to centre on feelings of security, commitment and control (Lorenz, 1991: 185). This study did not explore the theoretical and conceptual rudiments of trust in great detail however, the issue of trust between network partnerships formed part of the study design. While the network literature proclaims that a high level of trust is required for effective networking, some authors raise the problem of manipulating trust. Sako (1992) argues that trust as a concept and phenomenon is something that is more often found, than created. Lane and Bachmann's (1996) work on networks between private sector firms, reveals how trust emerges from pre-existing social ties or in particular institutional

frameworks. The Government's collaborative policy in health runs contrary to such wisdom. Since 1999, PCGs and LHGs have been centrally directed to form new relations and connect with service providers and users. This is a rather formal approach, that runs contrary to the autonomous nature of networks. The concept and consequences of trust between actors in public service organisations have been relatively under-investigated, compared with studies of trust between partners in inter-firm networks. In many instances, public sector trust is often an implicit assumption, given that market place conditions of profit maximisation and opportunism are far less prevalent, if they exist at all. There is some argument that an element of institutional trust, deeply embedded in the values of service providers, already exists in the UK public sector, which might support any effort to institutionalise collaboration. Pratchett and Wingfield (1996: 654) for example, note how the public service ethos continues to provide "*a degree of coherence and consistency of values amongst staff delivering a diverse range of public services*". Observations made during this study, support this view of institutionalised trust in the NHS. Across the many interviews conducted during field investigations, health professionals working in primary care in HA Zone-X, and other organisations outside this area, overwhelmingly supported recent developments in health care and expressed a common enthusiasm for the work of the NHS and LHGs. This high level of support may be a result of 'self-selection bias', given that the members of LHGs are highly motivated and engaging professionals that put themselves forward to work for these organisations.

The above discussion begins to tap into the vast literature on trust and issues of trust in networking in primary health care, but show how, while trust is a prerequisite of networking and cooperation, it is a difficult relational value to control or manipulate; rather trust often forms from pre-existing relations between partners over time. In HA Zone-X health professionals formed friendships and bonds. While the Local Health Groups brought a wide range of professionals together to formally network with each other, members also formed less formal networks with colleagues and friends. General practitioners across the four Local Health Groups studied reported being in communication with each other on a regular basis, whereas pharmacists or dentists did not appear to be informally linked in a similar way. This perhaps begins to highlight the collectivism of the medical profession versus that of other professions;

and the difference between formal networking, as in the case of the multi-professional, multi-agency, working carried out by each LHG, and less formal forms of networking, between friends, colleagues, or associates. This issue relates to the theory of social networks raised in chapter 1. Networking is inherently a social phenomenon (Burt and Minor, 1983), led and directed by social actors forming weak or strong relations with each other (Granovetter, 1973, 1985). The importance of the Local Health Group over an alternative managerialist form, such as the Health Authority, is that it not only provides community-based health professionals, as well as allied professionals from other agencies, with a formal platform to engage with each other, it also empowers such professionals to form less formal networks with each other, something that arguably occurs naturally. These formal and informal relationships inform decision-making act as channels for information exchange and routes for innovative practices; such as the elderly care assessment service and rapid response team (ECAS) and the emergency admissions local action team (EMA LAT) established in LHG-1, or the diabetic and coronary care clinics established in LHG-3.

Literature Guide 4 suggested that long-term and stable networks reduce the innovative capabilities of network members by creating secure relationships that reduce flexibility and the influence of external innovative drivers. As in all social relationships, the bond between parties often leads to dependency (Lorenz, 1991: 185-187). The very phenomenon that brings organisations together can actually work against them over the long-term, where network relationships turn in to coalitions that resist innovation and which offer security and safety for under performing forms (Miles and Snow, 1992). Uzzi (1997: 58-59) refers to this problem as “*over-embeddedness: over time, the social aspects of exchange supersede the economic imperatives*”. In this case, competition is the necessary incentive driving innovation and where competition is removed innovation slows down. As Miles and Snow (1992: 65) suggest, the process of working within a collaborative framework between multiple organisations aligned via a network of relationships introduces a new set of problems, particularly how to keep the network productive and innovative over the long-term. Accordingly, even a long-surviving network with improved norms of equity and trust will eventually slip into decline. This study tracked the introduction and development of new forms in primary health care, from the inception of LHGs in

April 1999, until the transition of LHGs to LHBs in April 2003. The new links made between services such as local authorities, social services, and public health, have arguably led to a range of performance and quality improvements in primary care such as: contributions to clinical governance; developing referral protocols and clinical pathways; tackling prescribing protocols and costs; oral health issues; research on determinants of health; establishing new alliances across boundaries between health and other agencies, as well as involving user groups and the voluntary sector, as recorded by LHG-4 during a performance review in 2003 (chapter 7, 7:18, table 11). There is some requirement to look at the performance of new collaborative forms in the NHS in more depth and over a longer time period. It is important that any performance review include not only quantitative outputs, but also less quantifiable outputs, such as quality improvements or staff commitment levels. The analytical framework developed in chapter 1 (1.12, illustrated in figure 3) provides a useful analytical tool to aid such an assessment of network performance, something that might be used by other researchers studying the network form in public services.

Literature Guide 5 showed how in order for a network to achieve positive sum gains for its members, partners entering into and operating networks should share similar goals and objectives. Where goals are incongruent, network failure is likely. For writers such as Mayo (1945) and Barnard (1968), cooperation poses a fundamental problem of how to coordinate the multiple and divergent goals of the parties involved. Blau and Scott's (1962) definition of a formal organisation, '*as a purposive aggregation of individuals who exert concentrated effort toward a common and explicitly recognised goal*', as an explanation for the existence of organisations, is somewhat limited by the organisational realities, as captured by Simon (1945: 257-78), whom suggests that individuals within organisations rarely possess a common understanding of goals. In networks, the management and coordination of goals is a particularly difficult task, as the number of organisations increase from the singular to the multiple. Very often organisational members of the network possess very different goals and priorities. Park (1996: 795) writing on this topic raises the potential problem of coordinating multiple players to accomplish common objectives. The institutional and managerial arrangements that are established to control and manage inter-organisational collaboration are critical to the success or failure of network

relationships (Kogut, 1988; Parkhe, 1993). Pollitt (1993: 122) states that public service organisations like the NHS, often find it difficult to maintain collaborative relationships between services with multiple and conflicting goals and priorities. According to Provan (1995), in the public sector where a public interest motive is involved, network outcomes are especially salient and the rationale for organisations cooperating to accomplish system goals rather than organisational ends is often stronger than in the private sector. For key groups like policy makers, service professionals and users, emphasis is often on achieving outcomes that enhance the overall well-being of clients, without regard to whether the goals of the provider organisation are being met (1995:1). As Provan (1995) concludes, such outcomes may not have any direct impact on the effectiveness of the organisations that make up the network. Thus, a paradox or conflict exists, between professional goals and organisational goals. This summation concurs within Abbot's (1988) theory of professional jurisdictions, in which professional and non-professional goal congruence is important to the operations of public sector organisations, where contributors to the institutional network are often high-ranking professionals with professional autonomy and allegiance. This is certainly the case in this study of networking in primary health care. This study engaged with a range of professionals including: community doctors, nurses, optometrists, dentists, pharmacists, and allied health professionals and managers. In most cases, professionals elaborated on the role of their individual profession within the Local Health Group, rather than the role of the LHG. In this sense, there is a large degree of 'group-think', as health professionals tend to respond to policies and situations as one group of like-minded professionals. This is perhaps a consequence of the structuring of professions in the UK, and goes some way to explain the dominance of the medical profession. Professionals working in LHGs approach problems from a professional position, doctors tended to dominate discussions and decision-making, evidenced by attendance at a range of LHG Board meetings over a two-year period (chapter 7). In such cases, GPs frequently challenged discussions around the allocation of resources or the establishment of new services. Like the issue of trust discussed above, the issue of goal congruence is another complex issue in health care. The challenge for the NHS is how to align professional groups, with strategies that challenge professional power or autonomy. This is the dilemma and aspect of goal incongruence identified by this study.

The above observations about the existence of trust, stability, goal congruence, longevity, and innovation, offer informative insights into networking and collaborative relations in the NHS. While these constructs were derived from the extant literature on networking reviewed in chapter 1 and 2, the outcomes of this study, particularly findings from the local level analysis of LHG networking in chapter 7, highlight the difficulties of applying concepts derived from studies of networking in the private sector, to multi-professional networking in public sector organisations, such as the UK National Health Service. The notion of trust between partners in the private sector around writing contracts to jointly deliver a product or service, differ somewhat from the type and form of trust between health care professionals, such as community nurses and doctors, working together to develop primary care services. While there are similarities, there are distinct differences. One such difference is the power differential between doctors and nurses. While a potential power differential exists, the fact that nurses have a position on LHG Boards goes some way to redress any power imbalance. This goes for other professionals groups also. In this study, issues such as professional rivalry, inter-service conflict and communication, and consensus decision-making, emerged as more important and recurrent themes. While only minimal levels of conflict were recorded, there was some evidence of conflict between GPs and managers working in LHG-1. Additionally, GPs in LHG-1 refused to support a proposal for an out-of-ours service, despite the support of other professionals and the Community Health Council representative (chapter 7: 7.15). This exemplifies doctors continuing or potential blocking power in collaborative networking in the NHS. This study thus adds to a developmental theory of networking in health care that takes account of the many idiosyncrasies of inter-professional working and the complexities of multi-professional and multi-agency working in the National Health Service, specifically within the community-based primary care sector.

#### **9.4 Study Implications for NHS Relationships and Practices**

The rise in collaborative governance in the National Health Service has arguably increased the complexity of working relationships in health care and induced a number of new challenges, as described above. Public sector managers and



professionals are now facing more complex and multi-faceted responsibilities in relatively new institutional settings. The networking phenomena is changing traditional management, moving the management function away from control and monitoring towards ideas of mediation, bargaining and consolidation. This study has illustrated the rising role of the network in health care and how collaborative governance is reshaping the design and culture of the NHS. In the UK, some health commentators have put forward sceptical views about the potential for service improvement via the network model (Kirkpatrick, 1999; Hudson, 1999; Exworthy et al., 1999). There is concern that network forms might drain resources and divert precious time and effort. There are also concerns about the duplication of work and responsibilities, as roles become more interlocked. This study challenges the view of Kirkpatrick (1999: 7-13), that networks and collaborative governance are unsuitable modes for public service organisations. As shown in chapter 1, the incentives for entering into networks are vast, ranging from improved knowledge transfer and communication to increased flexibility and responsiveness. Empirical findings from this study suggest that networking has the potential to deliver a number of key benefits in health care, such as increased information exchange, increased professional commitment, more informed decision-making, better service coverage, more integrated service delivery, task duplication minimisation, and more user involvement. Firstly, the move to LHGs in Wales has transferred ownership of a health agenda to wider groupings, both within and outside the NHS. This has arguably raised professional morale and commitment. There have also been significant efforts made to increase the involvement of patient and user groups, although as chapter 7 noted, there is a lot more work needed to achieve full professional and user involvement. Secondly, LHGs have been able to engage in the commissioning and provision of health services, bringing a more local focus to health delivery, as exemplified by the service developments across the four LHGs in chapter 7. Thirdly, the inclusion of many more professionals, services and agencies, has reinvigorated the primary care system and has moved primary care towards a more seamless system that focuses more on patient need at a community level (chapter 6, 7, and 8). This study concurs with the views of Rogers and Whetten (1982), Alter and Hage (1993), Powell (1991) and Provan and Milward (2001), that ultimately, new collaborative ways of working have the potential to improve the effectiveness of the overall system.

#### 9.4.1 Opportunities for Joint-Working in Health Care

Recent developments and restructuring of the primary health care sector of the UK NHS, as detailed in chapter 5, have raised a number of potential opportunities to new joint-working initiatives, but also a number of potential barriers, obstacles or challenges, that might impede the effectiveness of network-based organisational collaboration between services and agents in a primary health care setting. Two of the clear benefits of primary care groups, illustrated by the work of the local health groups, are the increased involvement of professional groups, such as community doctors and nurses, and the enhanced coordination of services. One of the important findings of this study is that networking has the potential to overcome traditional barriers between professional groups working in primary health care. According to Rummery (1998: 435), many, if not all, of the obstacles to effective joint-working, both within agencies and across professional and service boundaries, can be traced back to a lack of knowledge and understanding on the part of all sides. Chapter 5 set out the Government's policy for bringing professional groups together to jointly provide and commission primary health care under the 1997 White Paper on Health and the 2000 NHS Plan. Chapter 6 showed how the National Assembly for Wales took this policy agenda forward by introducing local health groups as the organisational forum for multi-professional and multi-agency working. Chapter 7 showed how four Local Health Groups within one community area have been able to network a range of health professionals and agencies, to plan and deliver services to users within the separate micro-localities covered by these LHGs. One of the key benefits of the work of these LHGs has been in bringing fragmented professionals groups and stakeholder agencies, and user groups, together to influence the commissioning process. One of the main professional groups to gain from the introduction of local health groups are community nurses. Community nurses were largely excluded from commissioning responsibilities during the internal-market era (1979-1996). As employees of Trusts, they were perceived as providers and were consequently excluded from purchasing roles. The Labour Government has sought to include community nurses in its most recent vision for commissioning services. Community nurses have taken up representative positions on the governing bodies of PCGs and LHGs. This policy has moved nurses from a peripheral position, outside of having any influence over purchasing decisions, to a central role in the commissioning and provision of services.

The benefit of this inclusion is the wealth of experience and perspective community nurses bring, as an alternative source of patient advocacy to medicine. Similarly, the inclusion of local pharmacists, dentists and optometrists on the boards of LHGs in Wales, not only goes beyond the scope and inclusiveness of PCGs in England, it widens the networking potential of LHGs. In essence, the LHG represent the central hub for hundreds of health professionals working within a community, that were previously excluded from the majority of health care decision making under the bureaucratic health authority system. The problem of inclusion and exclusion arises as a contentious issue. For instance, the justification for the inclusion of nursing versus the justification for the exclusion of other care workers, such as physiotherapists, occupational therapists, speech therapists, dieticians and chiropodists. These issues raise some interesting questions concerning the selection of members and the inclusiveness of new primary care bodies.

Reforms in primary care have raised the possibility of a vast range of new inter and intra-organisational networks in health care. In principle, an LHG has the potential to oversee the whole process of care, covering pre-admission, admission, treatment, discharge, and post-discharge care. Surprisingly, hospital consultants were not offered places on LHG or PCG boards. Given the increasing emphasis on continuity of care in the NHS and on patient care pathways, it is surprising that primary and secondary care services have not been networked in a more formal sense. However, chapter 7 showed how LHGs are beginning to link primary and secondary care, such as the example of LHG-1 working in partnership with local NHS Trust to pioneer and fund the development of better outpatient services and primary care services designed to relieve pressure on secondary care hospitals. Figure 4 of chapter 7 showed the breath of vertical and lateral relations formed between LHGs and other agencies. Significantly, the LHGs in NHS Wales have been involved in forming relations that go beyond the boundaries of traditional health care agencies. LHGs have formed links with the Department of Public Health, social services, secondary care providers, and mental health services. LHGs have also formed links with agencies such as local authorities, community health groups and patient interest groups, voluntary organisations, and services such as accident and emergency services, including fire, ambulance and the police. Chapter 7 detailed some of the many relationships that

have formed since 1999. One of the most interesting of these relationships is the relationship between LHGs and local authorities. Partnership working between the four LHGs and Local Authorities in Health Authority Zone-X helped raise the profile of wider socio-economic issues at the community level, for example, by making sure that housing, environmental and social issues, were considered when allocating LHG and Health Authority resources. This phenomenon was often noted during observations of LHG meetings, whereby local authority officials would raise the importance of wider health and well-being issues. In LHG-2, the local authority representative worked closely with the LHG members to develop a drug awareness and rehabilitation service in the locality. This service creation involved the LHG, community nurses, the police, and probation service, and specialist care centres, and exemplifies the level and complexity of inter-professional and inter-agency working that LHGs have been able to achieve. In addition, each LHG in Health Authority Zone-X has engaged with a number of voluntary sector groups to work in partnership to develop and provide services to patients in the community, helping to meet the needs of vulnerable groups in society. The four LHGs of HA Zone-X have also made tentative links with the police, fire, and ambulatory services, to address service development issues, such as improved ambulatory coverage. It is this breath of evolving relationships, that LHGs have been able to form, that is a remarkable feature of these new organisational forms. As Fombrun (1982) states, a network is '*a set of nodes and relations that link incumbents*'. In this case, the LHG is the central node connecting a wide set of other nodes that interact around 'health problems' that are identified at the community level by community professionals. There is a degree of fluidity in health care networks, that has previously not been achieved by more traditional or fixed forms of organising, such as centralised allocation of budgets via the health authority system.

#### 9.4.2 Challenges for Joint-Working in Health Care

The Government's 'third-way' approach to reform in the NHS has arguably brought with it a change in cultural orientation, towards dynamic inter-agency collaboration across occupational boundaries and organisational structures. While the NHS has historically been dominated by centralised hierarchical management and a cultural orientation of valuing uniformity and consistency, new localisation initiatives imply

an acceptance of diversity and creativity that goes beyond traditional ways of working and administering services. The collaborative governance model, articulated in the policy review in chapters 4 and 5, has attempted to deliver improved inter-organisational working and enhanced inter-professional working in health care. This study has recorded a number of observations about the challenges of delivering a more networked health care system. One of the key elements of the reform agenda in health care post-1997 has been the need for more flexible forms of working, that devolve power to grass route health and social care professionals. In primary care, the introduction of PCGs in England and LHGs in Wales in 1999, epitomise this adoption of more flexible models of locality-commissioning. The devolution of power away from health authorities to PCGs and LHGs reflects a democratisation movement in primary health care. This democratisation has aimed to achieve a higher degree of participation in localisation initiatives and marks a shift in healthcare policy, from an emphasis of accountability to the centre, to the localisation of healthcare management. The Government's strategy has been to devolve some powers in return for increased local accountability and professional involvement, as well as increased user involvement. The LHG or PCG represents a committee of interest groups that make decisions concerning the allocation of resources and the prioritising of needs at the local level. In this regard, members of primary care teams perform a managerial role. This view supports the suggestion of a 'managerialisation' of health professionals (Ferlie et al., 1996). The creation of new primary care groups has accelerated this trend, as not only GPs, but community nurses and allied health professionals, have been required to take on new responsibilities, including representing professional groups, communicating and soliciting agreement from colleagues, and commissioning decisions. The rise in professional autonomy and commissioning power via LHGs and PCGs might be in conflict with the pursuit of increased accountability under the NHS Plan (DoH, 2000). There is a fine balance to be struck between the need for accountability and the autonomy of individual professionals. GPs have traditionally been accorded a high degree of autonomy and flexibility in the way they work; a product of the strength of the medical profession and a product of their specific role in both society and within the National Health Service. Some commentators (Hudson, 1999) have suggested that recent restructuring in primary care and the introduction of new multi-professional primary care groups might be viewed as a threat to GPs strong

professional identity and might lead to GPs resisting collaborative initiatives. This study found that on the contrary, GPs were particularly encouraged by the move toward more multi-disciplinary working and the introduction of LHGs in NHS Wales. One GP in LHG-1 commented that GPs were more resistant to health authority decision-making than that of the LHG, and stated that he looked forward to the abolition of health authorities in Wales (Int. 22). Interviews with GPs across LHG-1, LHG-2, LHG-3 and LHG-4, found a consensus of favourable opinion towards the work of LHGs, although GPs did raise concerns about inadequate levels of funding and instability in the system. This study suggests that unlike fundholding arrangements, where many GPs remained outside of such arrangements, in the case of LHGs, representative GPs have been keen to seek out positions on local LHG Boards in order to influence the decision-making apparatus in primary health care.

Doctors have taken a leading role in the development of LHGs in Wales. In LHG-1, LHG-2, LHG-3, and LHG-4, of Health Authority Zone-X, GPs took up major positions within these LHGs, such as chairing the LHG Executive Board and many of the sub-committees. This study raises some concern about the dominance of GPs in new collaborative arrangements. Critics of previous collaborative initiatives in primary care point to apathy demonstrated by the medical profession and their unwillingness to engage fully in cooperative working, viewing it as a distinct threat to professional autonomy (Burns et al., 1994; Exworthy, 1994). The paradox here is that while GPs would be the main beneficiaries of devolution and decentralisation, they are the main potential source of professional resistance. This raises two quite complex arguments that have emerged during this study. The first is that the introduction of new collaborative forms of working has given a voice to the many allied health professionals, such as community nurses, pharmacists, dentists and optometrists, in a way that forces GPs and other professionals to work in partnership with the wider primary care team and to work more closely with social services, mental health, public health, the voluntary sector, and patients, in the planning and commissioning of services. The second is that the powerbase of GPs has been enhanced by removing the managerial authority of the health authority and devolving power to GPs in LHGs, or future LHBs. One interesting example in LHG-1 involved the need for an out-of-hours clinic in Area-1. The LHG Board and the Community Health Council officer

had proposed the introduction of an out-of-hours clinic to service the large student population in Area-1. GPs opposed the proposal on the grounds of the new GP contract. In this case, while a need for such a service had been identified by the LHG, GPs opposed the service improvement from a professional stand-point, exemplifying the blocking power of the medical profession in collaborative arrangements like LHGs and a continuance of Friedson's (1970) medical dominance thesis in the UK National Health Service, as well the ongoing protection of professional jurisdictions among the medical profession (Abbott, 1988; Dalley, 1989).

The requirement for all GP practices to be involved in primary care groups or local health groups has generated a greater degree of stability and certainty, arguably lacking under fundholding or total purchasing projects. However, while the move to PCGs and LHGs has enhanced inter-professional working and gone some way to enhance inter-agency working, collaborative arrangements with Social Services have remained under-developed. There were few instances of joint LHG-Social Service projects uncovered during field investigations. LHG-4 for example, worked closely with the local NHS Trust and LHG-1 to improve the number of available intermediate care beds at a local hospital as part of an intermediate care review undertaken LHG-1 and the local NHS Trust, as a short-term intervention scheme to provide therapy and social care input in patients' homes (LHG Publications and CHI Report, 2002). However, while the introduction of LHGs has gone some way to move primary health care agencies closer to social service departments, there is a significant amount of relationship building yet to be undertaken: before health and social services become fully integrated.

Another major challenge facing LHGs and collaborative arrangements in health are is how to improve on user involvement. Traditionally, there has been a marked history of poor patient and user involvement in health care (Redmayne, 1995; Audit Commission, 1996; Smith et al., 1997; Hudson-Hart et al., 1998). Hudson (1999: 168) suggests that there has been a lack of user sensitivity in health purchasing and a failure to engage with users in localities, particularly among GPs that have been criticised for their inability or unwillingness to collaborate with community groups. It has also been argued that there is a tendency by GPs to undermine patient

involvement (Mays et al., 1998a; Taylor et al., 1998). This study has shown how the issue of patient involvement has risen to the top of the health care reform agenda. In England, the NHS Plan (DoH, 2000) raised the profile of patient involvement as a priority. In Wales, the Welsh Assembly Government has clearly indicated that public involvement in health service planning is important. Involving the general public in health care and social care decision-making, is well articulated in a number of strategic documents, '*Putting Patients First*' (Welsh Office, 1998a) and '*Improving Health in Wales*' (NAW, 2001c). The National Assembly for Wales commissioned the Office for Public Management (OPM) to carry out a review of all public and patient involvement initiatives in Wales to identify existing best practice from across Wales. The OPM subsequently produced a guidance document for LHGs and NHS Trusts to carry out baseline assessments of public involvement and annual strategy plans for improving involvement. '*Signposts: A practical guide to public and patient involvement in Wales*' (OPM, 2001), clearly marks the way forward for this agenda, with guidance for all local health groups to produce baseline assessments and action plans for ensuring public and patient involvement in local planning of services. Despite the clear rhetoric of increased public involvement, all four LHGs investigated in this study reported relatively moderate levels of direct public engagement. This study recorded that very few members of the public (none in most cases) attended LHG Board meetings (observational records between 2001-2003). Public involvement in LHGs appeared to take place via collaboration with community health councils or as part of local projects, such as the diabetes project in LHG-2. All four LHGs stated that they were involved in community-based networks and were keen to expand the profile of the work they do in the community. Each of the four LHGs reported working with local patient groups around a range of specific health related issues, for example health awareness in LHG-3, drug abuse in LHG-2 and LHG-4, and economic poverty in LHG-1. Each of the four LHGs studied expressed a desire to develop more effective communication and participation strategies. The best examples of public and patient involvement included the direct involvement of community health council representatives on LHGs and sporadic examples of partnership working between LHGs and patient interest groups, such as the diabetic group project in LHG-3. As such, the majority of patient involvement remains collectivist, with little or no individual patient interaction with LHGs. While, each LHGs and HA Zone-X publish



basic information about their activities on the internet, it was noted that this medium remained under-exploited as a means of communicating with the public.

Together, the challenges outlined above reflect the complex nature of the primary health care setting. This study suggests that while GPs continue to dominate decision-making in primary health care, the introduction of LHGs has provided a forum for other allied professionals to becoming more involved. In addition, GPs and other professionals are taking on greater managerial responsibilities and are becoming more involved in the strategic planning of health care. The shifting of power away from health authorities to practitioner groups represents an advanced form of health care commissioning and provision, where the LHG is the organisational coordinating mechanism for integrating services and professionals and involving users. It is envisaged that as local health groups in Wales take on greater responsibilities, following their move to local health boards (PCGs to PCTs in England), the NHS will move further towards the abolition of divided services, perhaps towards some form of holistic service integration. The paradox is that as primary care institutions increase in size, they will move further away from small-scale community operations illustrated by this study, and thus may lose the benefits of a community or local focus.

## **9.5 Study Implications for Health Policy**

While the potential benefits of collaborative working and commissioning in primary care are well established and the infrastructure in primary care is now in place, the realisation of these benefits may take some time to accrue. During the course of this study, the issue of change and its consequences has remained a central theme. The National Health Service is arguably the most perpetually reformed institution within the public sector sphere. Since 1997, the pace of change in the NHS has been formidable. One reason for this might be the increasing media spotlight on health care that has resulted in health rising to the top of the political agenda. The result of the high profile status of health care in the UK has resulted in ongoing reforms and change strategies in the NHS. This study suggests that the pace of change is too rapid and perceived negatively by the professionals responsible for implementing change. Many health professionals and managers report feeling apathetic towards continual

change. In response, there is some argument for a more gradual introduction of policy and a more medium to long-term approach to health service design. The concern is that political uncertainty and any future change in Government might lead to a change in policy direction. Such uncertainty causes insecurity among health professionals and counteracts policies aimed at increasing professional commitment and involvement in new collaborative forms, such as primary care groups and local health groups.

The NHS Plan 2000 (DoH, 2000) specifically calls for a more strategic approach to the implementation of health reforms over the ten years between 2000 and 2010. The National Health Service is only beginning to view change management as an important element of service modernisation. In response to the White Paper '*A First Class Service*' (DoH, 1998), the National Coordinating Centre Strategic Development Organisation (NCCSDO) of the NHS commissioned a review of the evidence in the field of change management. During the autumn of 1999, the SDO programme carried out a consultation exercise to identify groups within the NHS that might require change management training and expertise (Fulop and Allen, 2000). Fulop and Allen (2000) found a lack of understanding among NHS professionals about how to manage change, but also a clear desire among professionals to adopt the principles of change management. In response, the NCCSDO commissioned research into the science of change management. Iles and Sutherland (2001) subsequently carried out a review of change management literature and compiled a reference document for dissemination among NHS professionals. Iles and Sutherland's findings (2001: 7) are echoed within this study, where there has been little evidence of change management programmes across the four LHGs studied.

The review and analysis of health policy developments conducted during this study also revealed a number of underlying contradictions and tensions in the State's plans for modernising the NHS. Firstly, since 1997 there has been a growing tension between the power of central Government to control and manage public service organisations from the centre, that contradicts the Government's call for increased decentralisation of power and local decision-making. In primary health care, policy directives are principally top-down, originating from the Department of Health. While, the creation of PCGs in England and LHGs in Wales has given a new voice to

some health professionals, it is not clear to what extent these professionals might influence national level health policy. Secondly, the Government's requirement for increased performance and accountability counterbalances the need for organisational flexibility and professional autonomy. A prominent feature of the Government's strategy to improve performance has been the writing and dissemination of national service frameworks (NSFs) and the creation of external monitoring agencies, the National Institute for Clinical Excellence (NICE) being responsible for promoting 'best practice' across NHS services, and the Commission for Health Improvement (CHI) responsible for monitoring and facilitating quality initiatives. Accordingly, NSFs have taken on priority status and act as a model of best practice. This reflects a national standardised approach managed centrally. The policy emphasis is on national-level universal targets. This contradicts the dogma of local level flexibility and autonomy of decision-making and responsiveness. Thirdly, there is a growing tension between the needs and expectations of the public and the responsiveness of policy and the health care system. The public are increasingly seeking an input into the health system, however despite attempts to increase public participation and involvement, the system is slow to respond to public needs, as seen in the low level of public involvement in Local Health Groups (chapter 7, 7:16). This is true in the case of out-of-hours services in primary care, identified during field investigations of LHG-1 in HA Zone-X. Despite a consensus for the need for such services, there was a lack of professional commitment to out-of-hours services, particularly among general practitioners. There is growing tension between the implicit paternalism that characterised the original NHS model versus the new consumerist modern NHS. The challenge for Government is how best to meet the needs of the public as well as the needs of the staff that deliver services.

The move away from hierarchy and clear lines of authority, towards more integrated network forms in the NHS has arguably created a more complex health care system. As elaborated throughout this thesis, networking is unique in that it requires more informal modes of communication and decision-making, networks are built on principles of trust, reciprocity, flexibility, understanding, involvement and participation (table 2, chapter 1). Such elements espouse a level of 'closeness' and 'friendliness' that goes far beyond traditional market-place cooperation between

competitive firms. The network requires substantial relational norms that are difficult, if not impossible to manipulate, artificially create, or manage. However, in the relatively formalised setting of health care, primary care organisations have been able to build and sustain new network relations, such as the new links made between LHGs and local authorities, between LHGs and the new Centre for Public Health in Wales, or between LHGs and local emergency services (detailed in chapter 7). The inter-personal component of the network organisation brings with it a level of risk that might not be as important in more structured organisations. In this regard, networks are vulnerable to changes in influential personnel, gatekeepers, mediators, and advisors (Ring and Van de Ven, 1994). This is an important point to raise; for if a champion of a network, for instance the chairman of an LHG, leaves the network (the LHG in this case), the network may not be able to maintain the relationships formed.

An additional question mark hangs over the sustainability of networks in public services such as health care. There are a number of theoretical concerns regarding network stability over the long-term. The literature suggests that trust-based network relationships are subject to rapid change and potential disintegration (Sako, 1992). The longevity and stability of new forms of organisation arguably take on greater importance in a public sector setting. Not only are there more stakeholders, even if not directly involved, change is arguably more constant and publicised. Chapter 1 noted that network relations operate best where there is a high degree of commitment from network incumbents and where there is available time and resources to promote the development of relationships. While this study shows a general level of enthusiasm for collaborative working among professionals involved in local health groups in Wales, professionals reported being concerned that future changes in Government might undermine present relations in the NHS. In this regard, there is a perceived short-time frame in health care and a continuous level of insecurity that sometimes discourages NHS professionals from fully committing to new initiatives. The institutionalisation of the network is thus an important consideration. This study raises the concern that the level of participation shown by LHG members and partners will be difficult to maintain if there are radical changes in NHS policy, a concern previously expressed by Ferlie and Pettigrew (1996: 95).

This study also highlights the theoretical and practical problem of how to appraise the performance of network forms of organisation in health care, and how to intervene if performance falls below expectations. Chapter 1 discussed the general problems of performance appraisal and suggested that there is some difficulty in associating network-level inputs to network-level outputs (chapter 1, figure 3). Provan (1995, 1996), highlights the difficult task of causally relating network organisation as a system, to system-level value creation. In the UK, some health commentators have put forward sceptical views about the potential for service improvement via the network model (Kirkpatrick, 1999; Hudson, 1999; Exworthy et al., 1999). There is concern that network forms might drain resources and divert precious time and effort. The issue of 'value-for-money' and 'performance appraisal' have been shown to be significant factors influencing current service developments in the NHS (chapter 4 and 5). While there is an obvious requirement to show how public funds are used and add value, the need for monitoring and some quantitative analysis of performance, contradicts the rationale behind cooperative networks, in which performance is not measured in merely monetary or quantitative terms, but in more subtle or tacit terms. This study rejects the view of Kirkpatrick (1999: 7-13) that networks and collaborative governance are unsuitable modes for public service organisations. As shown in chapter 1 the incentives for entering into networks are vast, ranging from improved knowledge transfer and communication to increased flexibility and responsiveness. Findings from field investigations in chapter 7, show how networking has the potential to deliver a number of key benefits in health care, such as increased information exchange, increased professional commitment, more informed decision-making, better service coverage, more integrated service delivery, task duplication minimisation, and improved user involvement. This study concurs with the views of Rogers and Whetten (1982), Alter and Hage (1993), Powell (1991) and Provan and Milward (2001), that ultimately, new collaborative ways of working have the potential to improve the effectiveness of the overall system. The caveat is that any assessment of organisational arrangements, such as PCGs or LHGs, should take into consideration a wide range of issues, not just simple quantitative performance indicators. While the benefits of networking in primary health care range from the more quantifiable cost-cutting that results from the elimination of task duplication and budgetary sharing, to the less tangible benefits of knowledge and information

exchange, it is perhaps the later that demonstrates the interesting and exciting aspects of cooperative relations, particularly in relation to tackling local health and social care problems in a more holistic and targeted way. The concern of this study is that as the less-tangible benefits of networking are not easily quantifiable, primary care organisations may not be given the time or resources to pursue collaborative relations in the current climate of '*performance measurement*' in the NHS, detailed in chapters 4 and 5. As such, a long-term policy approach needs to be adopted to ensure that network relations are free to embed and evolve, to realise the potential benefits for service improvement in the NHS.

## **9.6 Reflecting Upon Methodology and Methodological Advancement**

The design and methodological instruments applied during this research have both purposeful benefits, but also inherent limitations, which are open to criticism. This study opted to utilise a range of qualitative research methods and instruments including: policy analysis, secondary data analysis, observations, and interviews. These different methodologies delivered a comprehensive range of data for analysis. One potential problem of this study's broad research design has been that of data management and interpretation. As Yin (1994) and others have commented, qualitative research generally produces large volumes of 'rich data' that require logical treatment (Eisenhardt, 1989; Glaser and Strauss; Miles and Huberman, 1994). For researchers involved in qualitative studies there is often a risk of becoming lost within the range and depth of data retrieved. The solution to the problem lies in the logic and procedures for data collection and analysis (Yin, 1994). Accordingly, this study collected and analysed data according to a logical research process, detailed in chapter 3, with a clearly specified analytical framework. Qualitative exploratory research is most often criticised by authors from the positivist tradition. Silverman (2000: 102-108) highlights this, noting that findings from qualitative studies are not easily generalised or representative of a wider population. Frankfort-Nachmias et al. (1996: 113) questions the validity of inductive qualitative research findings. In response, Yin (1994) and Ragin (1994) argue that qualitative research should not be judged against positivistic principles of validity and reliability, as the role of such work is to take a subjectivist or interpretivist exploration of social phenomenon using

a different scale or focus of inquiry, whereby the search is for meanings and understanding, not verification or falsification (supported by Glaser and Strauss, 1976; Eisenhardt, 1989; Miles and Huberman, 1994; Yin 1994). This study aligns with the later view. This study combined the use of multiple methods to support the credibility of the study's findings. As discussed in chapter 3, the use of multiple methods acts as compensation for the individual weaknesses of specific methods. This study adopted a multi-levelled approach to investigate networking at the national level, at the primary care level, at the regional level, and at the local level. The viability of this study has been enhanced by the use of multiple methods that triangulate the 'research problem' (Morgan and Smirich, 1980; Blacker and Brown, 1989; Hassard (1993). As Hakim (1987: 61) states, *'this allows for a more rounded, holistic study'*. Overall, the explanatory power of the study has been established by selective, appropriate, and purposive sampling, in comparison with the need for 'random selection' associated with more quantitative methods (Miles and Huberman, 1994; Eisenhardt, 1989; Glaser and Strauss, 1967). Issues of poor reliability have been further addressed by linking key concepts and theory, outlined in chapter 1 and 2, to an appropriate empirical setting (Miles and Huberman, 1984), in this case the UK National Health Service, whereby a broad range of data sources were utilised to collect data. The study also links different exploratory and descriptive methodologies (Silverman, 2000).

Fulop et al., (2001) and Ferlie (2003), writing on the topic of methodology in public management research, suggest that research within the field needs to become more rigorous and quality orientated. Ferlie (2003: 10-17) proposes a number of important research domains and indicators to assess the quality of research: relevance, reliability and validity (chapter 3, table 6). These indicators of quality have been applied during this research project, and act as benchmarks for the overall credibility of the study and its methodology. In terms of relevance, the National Health Service is the largest public sector organisation in the UK, employs a vast number of staff, and attracts a large proportion of public funds and public attention. This study has attempted to capture an important period of change in the NHS following the introduction of a Labour Government in 1997 and the array of policy changes that followed, particularly the move away from market principles and traditional forms of hierarchy

towards new network modes of working. This study tracked the development and implementation of this contemporary policy and elaborated on the relationship between policy and practice and in doing so, follows the work of Lewin (1951), Hammersley (1990), Argysis (1999), Huxham (2001) and Huff and Huff (2002), in seeking to engage in research that holds relevance to issues of broad public policy or concern.

Reliability is a key domain within most discussions of research methods (Lee, 1999). However, reliability is problematic within qualitative work. Reliability has been simply defined in terms of 'consistency in scores' (Lee, 1999). Yin (1994: 36-37) suggests that reliability can be achieved if a study has followed a specified set or procedures that are well documented and that might be replicated by other researchers, in this way, '*an auditor could repeat the procedures and arrive at the same results.*' For this study, a clear protocol of work has been established and documented in chapter 3, that sets out the study's rationale, philosophical basis, design, process, strategy and methods, that might be followed by others. Additionally, the implementation of the study and the findings to emerge have been documented in detail in chapters 4, 5, 6, and 7, and are clearly summarised and discussed in chapters 8 and 9.

Internal validity is the measure by which research accurately accounts for and portrays the social and organisational setting studied; while external validity is the measure by which findings are of wider significance beyond the immediate setting: both are important in the assessment of qualitative public management research. This study has dealt with a number of different sub-contexts, including the public sector as a whole, the health sector, the institutional sector of the National Health Service, the primary health care sector, and the micro-institutional setting of the Local Health Group. Across all these settings, this study has sought to accurately portray a true and consistent picture of contemporary activities within these contexts. This has been achieved by the use of a broad range of methods that triangulate the research subject, and a multi-levelled approach that has sought to capture the idiosyncrasies and attributes of the different sub-contexts. This raises the study's internal validity claims, while this study's emphasis on exploring the 'process dimensions of networking,'



means it holds relevance for other organisations undergoing similar networking initiatives, not just within health, but for other areas of the public sector, and beyond.

Yin (1994) stresses the importance of construct validity. The domain of construct validity suggests the importance of careful theory operationalisation, from theory to the field, and reconnection. from data to theory, within qualitative work; so that the themes or processes studied are clearly related to an operationalised theory. In this study, chapter 1 outlined the general theoretical field of network research, drawing on concepts and theory from economics, sociology, social-psychology and organisational-management theory. Chapter 2 moved forward to relate network theory to the research setting of health care and presented a range of research, conceptual work, and theoretical frameworks, for examining networks in the public domain. The outputs of the empirical phases of this study have been presented in detail in chapters 4, 5, 6 and 7, and have been elaborated on and discussed in chapters 8 and 9, in relation to the research questions posed in chapters 1 and 2. In this way, outputs and findings to emerge from this study of networking in health care have been related back to both the theoretical field of study and the empirical research setting. In doing so, this study has arguably met much of Fulop et al., (2001) and Ferlie's (2003) guidelines for establishing credible research. The external validity of the study has been established from theoretical inference and analytical generalisation drawn out from the empirical data. The study began by highlighting weaknesses in network theory and showed a lack of theoretical and empirical research on networking in the public domain. The study subsequently went on to address some of these deficiencies by elaborating on the adoption and implementation of network practices in the NHS. The study has attempted to relate its findings back to the theoretical and literary field, to advance both network theory and public management theory and practice. As Ferlie states (2003: 14) "*...a strong relationship to a body of theory is an important indicator of external validity and construct validity*". The reliability and internal validity of the study have been established via an explicit description of the research design, methods and data analysis used, detailing an 'audit-trail', set out in the methodology chapter that might be followed by other researchers. The power of this study's findings lies in the broad set of rich and descriptive data presented, and the linking of study findings to network theory and practice.

## **9.7 Directions for Network Research in the NHS and the Public Sector**

The study of networks and collaborative forms and relations has become an increasingly popular research topic within organisational and managerial fields over recent years. Despite the current popularity of network research and the increasing volume of research on the subject, the number of network studies in the non-profit sector remains low. This study has shown that it is both desirable and feasible to study network organisational forms and associated governance mechanisms within a non-profit public sector setting. There remains however, the need for further research into the dynamic network form, particularly in the often under-researched public sector sphere. This study suggests that future research focuses on developing a deeper understanding of the mechanics of collaborative relations between organisational actors. The task of understanding what processes are involved in bringing multiple institutions together and what factors impact upon the effectiveness and long-term viability of the network, remain high on the research agenda. The rise in the networking phenomenon across public and private sectors, suggests that the profile and status of network research will take on greater importance over the next decade and on into the future. Over this period, there will be considerable scope to explore shifting governance arrangements in the public sector, specifically the implementation of major change strategies such as the NHS Plan (Department for Health, July 2000). Importantly, research must be directed toward an examination of conflicting governance initiatives that seek to devolve power to provider agencies, as seen in the creation of PCGs/PCTs (England) and LHGs/LHBs (Wales), while also seeking to enhance the monitoring and lines of accountability between the State and public service organisations. Additionally, there is a need for more comparative research that examines governance and management across the public sector, in education, mental health, and social care, and research that compares reforms across nations, particularly in the European Union. In terms of traditional inter-lateral relations, there is considerable scope to examine new network and boundary spanning practices, for example between health and social services, an area highlighted within this study as needing more focus and effort to overcome barriers to integration.

The ongoing and developing myriad of market, hierarchical and network relations within the macro public sector environment, and within unitary bodies like the

National Health Service, provides a rich context in which to study the dynamics and implications of inter-organisational networking. Primary research within the field needs to take account of new empirical phenomena, the need for methodological advancement and theoretical advancement, based upon more detailed and comprehensive explorations of empirical network studies. There is also a great opportunity for multi-disciplinary research. The spectrum of existing and proposed developments in health care requires ongoing evaluative research. Particular attention needs to be paid to the role and impact of foundation hospitals; vertical relationships between central government; regional bodies like the National Assembly for Wales; the Scotland's Parliament and the Northern Ireland Assembly; and the role and impact of organisational hybrids, such as public-private partnerships (PPPs) and public finance initiatives (PFIs).

One of the most challenging areas of network research is in linking the network form, either in structural or relational terms, to organisational performance (table 4, chapter 1). Network outcomes are very important to network theory as they represent the proposed incentives for organisations entering into collaborative partnerships. In health and social care, the rationale for bringing organisations and agencies together is often to involve practitioners and users in the commissioning and delivery process. The network acts as the medium for knowledge sharing, professional support and commitment, and as the mechanism for reducing task duplication and barriers between agencies. Given these objectives, there is some requirement for network research to draw tentative causal linkages between network governance and organisational performance. The work of this study in drawing inferences about the power of networking to improve organisational performance and overcome traditional system failures, requires further and more concentrated research that clearly defines and measures such performance outcomes. As Provan and Milward (2001: 422) have already articulated, network studies should consider issues of performance and process from the perspective of those organisations or agencies that make up the network, those who are served by the network, and those policy and funding actions that affect the network. An appropriate means of evaluating public sector networks is to test how well the network can enhance the capacity of organisations to solve problems and serve clientele (Provan and Milward, 2001: 414). This might lead to

research that examines how well recent changes in health care in the UK, specifically the introduction of LHGs and PCGs, and current LHBs and PCTs, have widening access to primary care, or have improved the health and well-being of service users. The current body of literature only draws on highly intermediate process outcome indicators, Huxham's (1996; 2000) focus on the development and implementation of joint agendas, or Glenndinning's et al. (2002) attempt to define successful collaboration in terms of ownership and trust. Network research needs to move towards more specified process and performance outcomes and linkages, as shown in Provan (1995), and illustrated early on in this study in chapter 1 (1:12, figure 3).

There has been some suggestion that recent UK health care management research has become disconnected from social science theory and that there is an over-reliance within much UK public policy and public management research, on 'once-off' or 'snap-shot' evaluations of health management and governance Ferlie (2002; 2003: 46). This study identified and reviewed a large number of cross-sectional studies of networking, in comparison to the parsimony of more longitudinal studies. As such, there is a clear research gap for studies that track collaborative relations over longer periods of time. Such studies may reveal the evolving nature of collaborative relations and the vulnerability of cooperation following environmental changes, something highlighted within this study. In addition, collaborative research in the public sector sphere has tended to approach networking from singular theoretical perspectives. Accordingly, a broader programme of multi-disciplinary research that brings together theories, concepts and knowledge, from different theoretical disciplines and fields, may prove more useful in transcending unitary perspectives and dualistic discussions of network activities. The use of more pluralistic studies that broach the issue of contracting and relational coordination between public services from multiple theoretical perspectives might be useful in addressing many of the topics and concepts of network relations highlighted by this study, where cross-referencing of ideas from economics, sociology, psychology and management research, will be of particular importance and interest.

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## APPENDIX I

### Research Analytical Framework and Strategy

#### Initial Points of Inquiry and Preliminary Research Questions

##### Exploring the Theory and Practice of Inter-Organisational Networking

1. What are networks?
2. How and why do they form?
3. What form do these organisational arrangements take?
4. What are the benefits of inter-organisational networking?
5. What are the features of successful networks?
6. How and why do networks fail, what lessons might be learned from past experience and practice?
7. Are networks superior to hierarchies, and under what conditions?
8. Can a conceptual model be developed that captures the salient features of networking?

#### Network Theory and its Application to Understanding Change in Public Sector Management and Organisation – with Reference to the NHS

##### Exploring the Theory and Practice of Networking in the Public Sector

1. Is the UK public sector characterised by markets, hierarchies or network arrangements?
2. Given recent developments in the public sector management, are services such as the National Health Service becoming network organisations?
3. What factors are influencing Government policy and public management practices?
4. Are networks forms of coordination suitable for public services like health care?
5. Are the context conditions appropriate and supportive of network arrangements?
6. What are the implications of network forms for public sector management and service co-ordination?

#### Literature Search and Review

##### Summary of Findings from Network Literature

- 'Network studies, while documenting the propensity for network formation, have focused comparatively less attention on the processes of networking post-formation' (Grandori and Soda, 1995).

'Relatively little is known about networking, in particular how and why networks fail or succeed' (Park, 1996).

- 'Little scholarly attention has been devoted to studying the developmental processes of inter-organisational relationships (IORs)' (Ring and Van de Ven, 1992: 90).
- 'There is a lack of empirical knowledge/understanding on how to manage network processes' (Jenson and Meckling, 1970).
- 'While collaboration is a good concept, in both specific application and general spirit, it will eventually prove to be no more a panacea than hierarchy or market ever were' (Mintzberg et al., 1996:60).
- 'Despite strong interest in the study of inter-organisational networks, very little attention has been devoted to assessing the effectiveness of multi-organisational networks' (Provan, 1998: 453-454).

#### **Findings from the Public Sector and Management Literature**

- 'The introduction and development of network arrangements in the public sector appears to be linked to a favourable perception of networks in the private sector' (Pollitt, 1995).
- 'There is a distinct lack of empirical research relating to the development, implementation and outcomes of network-based approaches in public administration and management' (Exworthy et al., 1999).
- The network form may be unsuitable for public services (Kirkpatrick, 1999; Hudson, 1999).

#### **Outputs from Literature Search**

**Statement I**      The processes and salient features of inter-agency collaboration via network modes of organisation are little understood, the network literature is weak in linking input factors to network performance, and in explaining why some networks are more effective than others.

**Statement II**    Organisational and Management Theory often asserts that networks are a superior mode of governance and co-ordination than either market or hierarchy. This belief in networks is currently influencing change across private and non-profit sectors. This phenomenon is visible in recent developments in the UK Public Sector. Services such as the National Health Service are being integrated around the network model.

**Statement III** The public sector represents a unique organisational and cultural context in which to develop networks where there is relatively little understanding, from the literature, about network management and network performance.

**Statement IV** The UK Public Sector represents a unique organisational context in which to develop loose network relationships between service organisations and agents. The literature on networks in non-profit sectors and public providers remains limited. The literature in this area provides little explanation about the implications of networks on service delivery and performance.

### **Network Theory: Theoretical and Conceptual Limitations**

- That the literature on inter-organisational networks has underestimated or failed to explicitly explore/identify the potential problems associated with multi-organisational networking.
- That the network literature has not focused on the factors and processes influencing the potential success or failure of inter-organisational networks, particularly those in terms of their effect on network performance.
- That the processes of network-based collaboration, with respect to initiatives at the primary care level of the UK health care sector have not been extensively explored.
- That the public sector is a unique organisational setting exhibiting unique cultural characteristics, where environmental and contextual issues might inhibit the ability of managers to implement and control network-based joint-working initiatives.
- That inter-agency network-based collaboration in the public sector will have a higher probability of success when the influential and contributory process factors are understood and managed appropriately.



### Analytical Framework – Identifying Key Network Constructs

Factors identified important in influencing the development, processes, and outcomes of organisational networking

#### Trust

##### Theoretical and literature-based considerations

- 'Relationships based on trust can only be found and not created' (Sako, 1992)
- 'Trust is grounded in pre-existing social ties or in particular institutional frameworks' (Lane and Brackmann, 1996)
- 'High-trust, while necessary for collaboration, has the potential to become a liability, reducing pressures that stimulate innovation and raising the probability of abuses of trust' (Miles and Snow, 1992; Ring and Van de Ven, 1994)

##### Research Question:

Q1. Does an appropriate level of trust exist between parties in the public sector at the primary care level that is conducive to network-based collaboration?

##### Propositions:

P1. A high level of 'natural' freely evolved trust is required for effective network-based collaboration.

#### Commitment

##### Theoretical and literature-based considerations

Commitment is an important factor in organisational networking, and is linked to other factors such as opportunism, stability and trust.

##### Research Question:

Q 2. How committed are parties in primary health care to the long-term development of collaborative networking relationships between multiple agencies?

##### Propositions:

P2. A high level of commitment is required for effective network-based collaboration over the long-term.

### Goal Congruence

#### Theoretical and literature-based considerations

- 'The alignment of goals is an important factor in networking and is linked to the commitment of members to the network, however goal congruence is difficult to manipulate' (Parkhe, 1993; Ring and Van de Ven, 1994)

#### Research Question:

Q3. Do parties in primary health care (services and professionals) align themselves with the government's policy goals for primary health care structuring, management and delivery?

#### Propositions:

P3. A high degree of goal congruence is required for effective network-based collaboration.

### Opportunism

#### Theoretical and literature-based considerations

- Networks often fail because of the transaction hazards of opportunistic behaviour by parties seeking personal utility from the collaborative relationship (Williamson, 1985)

#### Research Question:

Q4. What degree of opportunistic behaviour exists, can be detected or is exhibited, between parties in primary health care, and what effect, if any, will this have on the performance of the network?

#### Propositions:

P4. The higher the level of opportunism the lower the expected performance of the network.

### Stability / Certainty

**Theoretical and literature-based considerations**

- 'There is some concern surrounding the longevity of the network form. Networks are sometimes viewed as a short-term temporal phenomenon or as an intermediary governance arrangement' (Williamson, 1985: 4)
- 'Networks are fragile and dynamic forms of organisation that are based on unstable and uncertain social relationships' (Powell, 1991; Van de Ven and Walker, 1984)
- 'Networks are vulnerable to disruption from a range of sources, internal and external, including changes in influential personnel, corporate alliances and business cycle turbulence' (Ring and Van de Ven, 1994; Contractor and Lorange, 1988)

**Research Question:** Q5. What are the potential effects, if any, of instability and uncertainty on network relationships and network performance at the primary health care level?

**Propositions:**

P5a. Instability and uncertainty are features of networking and have the potential to cause inefficiency or failure.

P5b. The unstable nature of networks may make them unsuitable for some settings, situations, or sectors – e.g. the public sector where certainty and stability are important elements of provision.

P5c. A high level of instability/uncertainty reduces the probability of achieving successful/effective networking.

### Innovation and Dependency

**Theoretical and literature-based considerations**

- 'Network relations may result in coalitions that resist innovation as a result of over-dependency' (Miles and Snow, 1992; Pfeffer and Salancik, 1978)
- 'Over time, the social aspects of exchange supersede the economic imperatives which often results in overembeddedness and a subsequent loss in innovative capacity'

**Research Question:** R6. How does network dependency reduce innovative capacity of innovative abilities of network organisations in primary health care contexts?

<b>Propositions:</b>	<b>P6.</b> The higher the degree of dependency and embeddedness the lower the probability of innovative success and capacity.
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**Operational Definitions of Research Constructs**

Construct	Operational Definition
X1 Trust	Perceived level of trust between individuals, professionals groups, or organisations/services.
X2 Commitment	Perceived level of commitment to the LHG, to carry out the objectives of the LHG, and to participate fully as a member.
X3 Goal Congruence	Perceived alignment of goals between individuals, professional groups and organisations/services and the perceived alignment of LHG members goals with government policy.
X4 Opportunism	Perceived level of opportunistic behaviour, by individuals, professionals groups, or organisations/services.
X5 Stability/Certainty	Perceived level of instability (in terms of longevity of the LHG) or uncertainty (in terms of future expectations).

**Proposition/Hypothesis Development**

Construct	Hypothesis
X1 Trust	H1: The higher the level of trust that exists between partners in primary health care (LHGs) the higher the likely success of the network (and vice versa).

X2 Commitment

H2: The higher the level of commitment by partners in primary health care, the higher the likely success of the network (and vice versa).

X3 Goal Congruence

H3: The higher the level of goal congruence between partners in primary health care, the higher the likely success of the network (and vice versa).

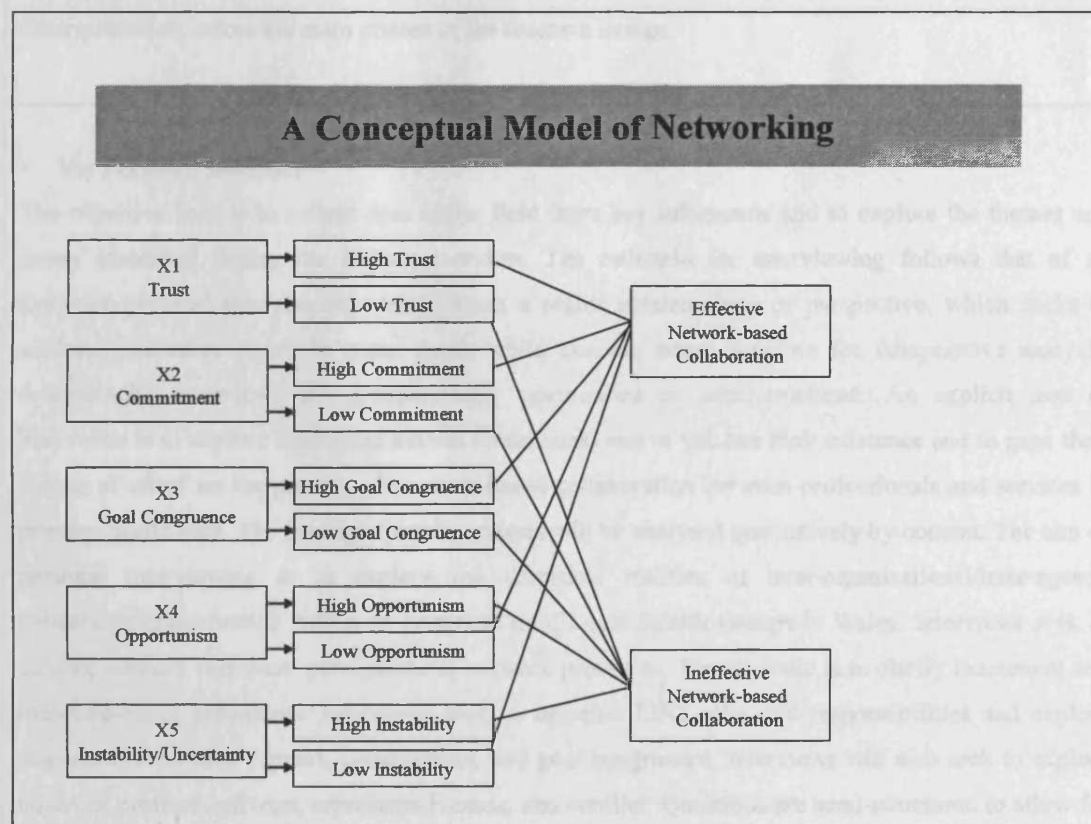
X4 Opportunism

H4: The higher the level of opportunism by partners in primary health care, the lower the likely success of the network (and vice versa).

X5 Stability

H5: The higher the level of stability that exists in primary health care, the higher the likely success of the network (and vice versa).

**Path-diagram of Influential Factors Relating to Network Performance**



## Methodology Development and Application

### ▪ Via Observations

To observe and describe the context in which collaboration is taking place and to describe the processes at work: via Local Health Group Executive Board meetings, over two-year period.

### ▪ Via Documentary Inquiry and Secondary Data

To review government policy publications on the structuring and organisation of primary health care, and to review secondary research existing academic and internal (NHS) publications. To review recent published research on networking and inter-agency working in health care, specifically primary health care.

### ▪ Via Survey

In response to feedback from specialists in the field, extensive literature searches, and interviews with health care representatives, a survey instrument was abandoned in favour of a broader set of investigative research methods, namely; documentary inquiry, observation, and interview. In keeping with the objectives of the study, to achieve greater understanding and explanation of networking in health care, these instruments would be used to collect and analyse a wide range of exploratory and descriptive data across the main phases of the research design.

### ▪ Via Personal Interview

The objective here is to collect data in the field from key informants and to explore the themes and issues identified during the literature review. The rationale for interviewing follows that of an exploratory-descriptive research design from a realist epistemology or perspective, which seeks to explore qualitative issues in some depth while keeping some structure for comparative analysis. Accordingly, interviews are predominantly open-ended to semi-structured. An explicit aim of interviews is to explore theoretical themes (constructs) and to validate their existence and to gauge their degree of effect on the process of network-based collaboration between professionals and services in primary health care. The findings from interviews will be analysed qualitatively by content. The aim of personal interviewing is to explore the empirical realities of inter-organisational/inter-agency networking/collaboration within an empirical unit, Local Health Groups in Wales. Interviews seek to explore network members' perceptions of network processes. The rationale is to clarify theoretical and literature-based precedents. Interviews seek to describe LHG roles and responsibilities and explore respondents' level of support, commitment, and goal congruence. Interviews will also seek to explore issues of professional trust, representativeness, and conflict. Questions are semi-structured to allow for probing and clarification.

## APPENDIX II

### Interview Questionnaire Schedule

Section 1	Introduction
Interview Introduction	<ul style="list-style-type: none"> <li>▪ Hello my name is Keith Geraghty, I am a doctoral researcher from Cardiff Business School. I am currently conducting research into collaborative working in primary health care. I would like to ask you a number of questions about working as part of a Local Health Group?</li> <li>▪ With your permission I would like to tape-record this interview.</li> <li>▪ Any comments made during this interview will remain confidential. All material from this interview will be treated ethically and interviewees will remain anonymous. The real names of either people or LHGs taking part in this study will not be reporting.</li> </ul>
Section 2	Rationale: to identify respondents profession and position within the LHG
Respondent	<ol style="list-style-type: none"> <li>1. What is your name?</li> <li>2. What is your occupation?</li> <li>3. What position do you hold on the Local Health Group (LHG)?</li> <li>4. What are your main responsibilities?</li> </ol>
Section 3	Rationale: to assess respondents perceptions of the type of organisation the LHG represents
Network Awareness	<ol style="list-style-type: none"> <li>5. How would you describe the LHG?</li> <li>6. What is unique about the LHG as a primary care organisation?</li> </ol>
Section 4	Rationale: to assess respondents understanding and/or interpretation of organisational objectives

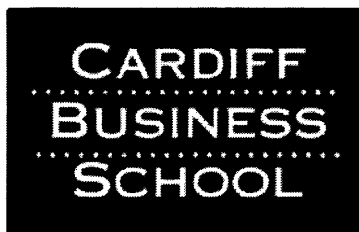
Objectives	<p>7. What are the main objectives of the LHG?</p> <p>8. How have these objectives been derived and agreed?</p> <p>9. How have the objectives of the LHG been communicated to you?</p> <p>10. Do you believe that the LHG's objectives are clear?</p> <p>11. Do you think the LHG's objectives are attainable?</p> <p>12. Do you fully support these objectives?</p> <p>13. Do you think clear objectives are important to the success of the LHG?</p>
Section 5	<p>Rationale: to assess the level and breath of professional representation in LHGs and to assess members' perceptions and professional inclusion and/or exclusion?</p>
Network Membership	<p>14. Which professional groups and agencies are represented within your LHG?</p> <p>15. Do you think some professions are better represented than others and if so, which groups?</p> <p>16. Do you feel other professional or non-professional groups not represented within the LHG should be included in the future?</p> <p>17. Which external agencies does your LHG co-operate with?</p> <p>18. Does your LHG work with voluntary groups?</p> <p>19. Does your LHG work with the private sector?</p> <p>20. Does your LHG work with public/patient interest groups?</p>
Section 6	<p>Rationale: to assess respondents experiences and perceptions of co-operation and/or conflict</p>
Collaboration	<p>21. Do you think that the professional groups within your LHG work well together?</p> <p>22. How are decisions made?</p> <p>23. Are there any areas where cooperation could be improved?</p> <p>24. Have there been any instances of disputes or conflicts within the LHG?</p> <p>25. Do you think co-operation is important to the success of the LHG?</p> <p>26. What are the most important factors for good cooperation?</p>
Section 6	<p>Rationale: to assess respondents perceptions of stability and longevity of LHGs</p>
Stability	<p>27. Do you view the LHG as long or short-term initiative?</p> <p>28. How do you think the work of LHGs will develop in the future?</p>



	29. Do you think stability is important for the long-term success of LHGs?
Section 7	Rationale: to assess respondents' level of commitment and/or involvement in the LHG?
Network Performance	<p>30. In your opinion, is the LHG a good or a bad initiative?</p> <p>31. How is the performance or effectiveness of the LHG measured?</p> <p>32. Do you think your LHG will meet any performance requirements set?</p> <p>33. What obstacles might impede the performance or effectiveness of the LHG in the future?</p> <p>34. What would you say are the biggest challenges of for the LHG over the short to medium-terms?</p> <p>35. What are the most important factors influencing the potential success of the LHG?</p>
Section 6	Interview Ending
Interview Conclusion	<ul style="list-style-type: none"> <li>▪ The interview has come to an end; are there any additional comments that you would like to add.</li> <li>▪ Reminder that comments are confidential and that no names of individuals or organisations will be included in the publishing of study findings.</li> <li>▪ Thanking the interviewee for participation in the interview and possible referrals to other LHG members.</li> </ul>

## APPENDIX III

### Letter to Local Health Group Members



Keith J. Geraghty

Human Resource Management Research Section - Cardiff Business School - Office X2c - Colum Road  
- Cardiff CF10 3EU – Tel: 02920 757984 – Email: [GeraghtyKJ@cardiff.ac.uk](mailto:GeraghtyKJ@cardiff.ac.uk)

Dear LHG Member,

The Department of Human Resource Management at Cardiff Business School is currently conducting research into new forms of organising in the public sector. We are particularly interested in the development and application of networks in the National Health Service.

We are currently seeking the views of health care practitioners, managers, and associated interest groups involved in collaboration between services and agencies in primary health care. Our aim is to explore collaborative networking at the Local Health Group level in Wales. We are particularly interested in LHG members' views of working as part of a collaborative primary care team.

This study provides an opportunity for health care professionals and practitioners to voice their experiences and commentary on the development of the National Health Service. We are seeking the assistance of members of your LHG by asking if you could participate in a short interview. It is envisaged that interviews will last approximately 20-30 minutes. Please be aware that interviews will be treated as confidential. All interviewees will remain anonymous, as will the names and details of all Local Health Groups. Data retrieved via interviews are expected to provide valuable insights into the workings of LHGs and inter-agency collaboration in primary health care. Findings from the study will be disseminated via future publications that will be made available to all participants of the study.

We would be very grateful if you could participate in the study and take part in an interview. We will contact you shortly via telephone, or via your Local Health Group, to arrange an interview time and location desirable to yourself. If you have any questions or comments regarding this study you may contact us by e-mail at [GeraghtyKJ@Cardiff.ac.uk](mailto:GeraghtyKJ@Cardiff.ac.uk), or by telephone on 02920 757984.

We would like to thank you in advance for your time and for your support.

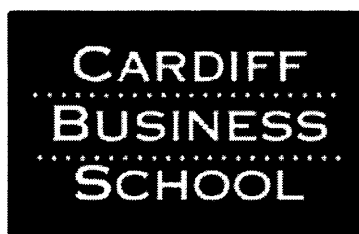
Yours Faithfully,

Keith J. Geraghty

(PhD Researcher, Cardiff Business School)

## APPENDIX IV

### Letter to Allied Agencies



Keith J. Geraghty

Human Resource Management Research Section - Cardiff Business School - Office X2c - Colum Road  
- Cardiff CF10 3EU – Tel: 02920 757984 – Email: GeraghtyKJ@cardiff.ac.uk

Dear Allied LHG Agency,

The Department of Human Resource Management at Cardiff Business School is currently conducting research into new forms of organising in the National Health Service. We are particularly interested in the development and application of networks in primary health care and the development of Local Health Groups and future Local Health Boards.

We are currently seeking the views of health care practitioners, managers, policy makers, and interest groups involved in health care in Wales. Our aim is to explore collaborative networking and inter-agency co-operation in primary care in Wales. We are also interested in exploring issues of public involvement in health decision-making, and issues such as accountability and performance appraisal in health care.

We are very keen to speak with a wide audience of stakeholders and we would like to know if a representative member of the Cardiff Health Alliance might participate in a short interview with a researcher from Cardiff Business School. It is envisaged that the interview will take approximately 20-30 minutes and can take place in person, or via telephone if preferred.

Please know that interviews will be treated as confidential. All interviewees will remain anonymous. Data retrieved via interviews is expected to provide valuable insights into the workings of LHGs and inter-agency collaboration in primary health care. Findings from the study will be disseminated via future publications that will be made available to all participants of the study.

If you have any questions or comments regarding this study you may contact us by e-mail at GeraghtyKJ@Cardiff.ac.uk or by telephone on 02920 757984 or 02920876544.

We would like to thank you in advance for your time and for your support.

Yours Faithfully,

Keith J. Geraghty

(PhD Researcher Cardiff Business School)

**APPENDIX V**

**Interviewee Database**

<b>Specialists</b>	<b>Professional Representatives</b>	<b>LHG-1</b>	<b>LHG-2</b>	<b>LHG-3</b>	<b>LHG-4</b>	<b>Allied Agencies</b>
1 Academic Specialist	11 GP Representative	21 Chairperson	31 Chairperson	41 Chairperson	51 Chairperson	61 CHC Representative
2 Academic Specialist	12 GP Representative	22 GP	32 GP	42 GP	52 GP	62 CHC Representative
3 Academic Specialist	13 GP Representative	23 GP	33 GP	43 GP	53 GP	63 Health Alliance Representative
4 Academic Specialist	14 GP Representative	24 Nurse	34 Nurse	44 Nurse	54 Nurse	64 LHG-1 General Manager
5 Academic Specialist	15 GP Representative	25 Pharmacist	35 Pharmacist	45 Pharmacist	55 Pharmacist	65 Health Alliance Representative
6 Audit Office Representative	16 Nursing Representative	26 Dentist	36 Dentist	46 Dentist	56 Dentist	66 CHC Representative
7 District Office Representative	17 Nursing Representative	27 Optometrist	37 Optometrist	47 Optometrist	57 Optometrist	67 CHC Representative
8 District Office Representative	18 Pharmacist Representative	28 Lay member	38 Lay Member	48 Lay member	58 Lay member	68 LHG-x Representative
9 National Assembly for Wales Health Official	19 Optometrist Representative	29 LA Officer	39 LA Officer	49 LA Officer	59 LA Officer	69 LHG-y Representative
10 National Assembly for Wales Health Official	20 Dentist Representative	30 HA Officer	40 HA Officer	50 HA Officer	60 HA Officer	70 LHG-z Representative

