

Performance Anxiety:

The nature of performance management in the NHS under New Labour

Shana Vijayan

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Department of Science and Technology Studies

University College London

Declaration

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

Abstract

This thesis explores both the proliferation and prominence of ‘performance’ in the NHS, focusing on the New Labour years from 1997-2010. The research’s main objective was to understand how performance policy impacts the work-place experience: to understand the nature of work undertaken by performance managers, the tools used and the effect of these techniques. The secondary objective was to understand the goals of performance management.

The introduction and rise of performance saw a change in expert authority. A new set of professionals had arrived in the NHS: regulators, auditors and performance managers. This thesis looks at the performance managers’ body of expertise, drawing upon several forms of qualitative research. The primary research tool used was institutional ethnography, which included focused interviews, a case study and experiences and notes gathered during a period based as a participant in NHS organisations.

Documentary analysis carried out in the first phase of this thesis revealed that the principal rhetoric employed by politicians concerned the function of performance management in reducing risk and harm to patients. However, further research based on interviews and ethnography suggests that performance was experienced as a process of rationalisation and stigma, with risk rarely mentioned in the same way as in policy documents. In particular, various aspects of rationalisation, including measuring, quantifying and tabularisation, were deployed, these processes being a means for state surveillance. Performance, it will be argued, was part of the bureaucratic machine by which efficiency and effectiveness were judged in areas where the state previously had little knowledge or information.

The research draws heavily on approaches in Science and Technology Studies to consider ‘performance’ and audit as a form of socio-technological intervention as well the Sociology of Health to inform issues of organisational and work-based stigma.

Acknowledgements

*“Our doubts are traitors,
And make us lose the good we oft might win
By fearing to attempt.”*

"Measure for Measure", Act 1 Scene 4

My brother humorously refers to my thesis as my memoirs and to an extent he is right. It has taken up a substantial part of my life, at moments consumed me and at times almost defeated me. Yet, now I have reached the end, it seems appropriate to thank the following people. Firstly, the girls I met in Kenya whose enthusiasm for education reminded me that learning is an attitude to life and encouraged me to return to university. The three wise men, my supervisors, Brian Balmer, Graham Scambler and Charles Thorpe, have been central to this process; they see my potential and give me confidence in my abilities. Anne Coulson, a woman with a way with words, who edited this work and enabled me to find my voice to speak with conviction during my viva. Fellow students in the STS department helped sustain my enjoyment of my subject when it was on the wane. “Team Shana”- my support squad, friends who unflaggingly believe in me and cheer me on from the sidelines. My parents, who put up with me, pushed me to be better and ensured the completion of this research project. Finally, this thesis would look very different without the input of NHS staff who gave up their time to talk to me. To all of them a heartfelt thank-you.

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“Reputation is an idle and most false imposition: oft got without merit, and lost without deserving”

“Othello,” Act 2, Scene 3

Preface

My interest in audit systems stems from working in NHS performance management between 2000 and 2010. I am interested in how the NHS is held to account and the means and methods of accountability.

My career in the NHS began within Patient Information at a hospital Trust, where I worked on Chapter 10 of the newly published NHS Plan. I ensured patients had access to clear and accurate information on all aspects of their care. This is one of the key documents I look at in more detail as part of my research. While New Labour were elected in 1997, the NHS Plan was not published until 2000, yet that intervening period of consultation and consolidation resulted in much of the foundation to NHS reform and set some long-term goals.

I moved from working in a hospital Trust to become the Senior Information Analyst in a Shared Services in 2002. A Shared Service organisation provided a number of services to local Trusts; it stemmed from the strategy of local centralization of ancillary services, usually IT, HR and Finance. While managing a team of analysts, who provided information for a cluster of PCTs, I became aware of the problems concerning information gathering to which national government seemed oblivious. Standard information requests by the Department of Health were difficult to deliver: numerous gatekeepers restricted access to information, different NHS databases held variations of the same data, and finally there was the time lag as data was cleaned.

My last role before beginning my research was as Head of Performance and Information for a Primary Care Trust. From 2004 to 2007 I monitored performance within the PCT using the newly established Annual Health Check Framework set out by the health regulator. The position I was in led me to consider certain issues, e.g. the direction of the NHS, the objectives of performance and how information was processed. However, no real reflection was possible while I worked in an organisation requiring answers immediately. I rarely got the chance to comment on these issues while at work; research seemed a meaningful way of developing my thoughts.

I moved from the PCT to a Strategic Health Authority in 2007 to lead on performance management for a geographical group of PCTs and hospital Trusts. Throughout this period

I continued my research with the consent of my employer. The emphasis here was to ensure sustainable solutions for improvement against national targets while holding organisations to account in these areas. Once again I found myself focusing on the purpose of performance: what it seeks to achieve both at a local and a regional level. Others in the SHA felt similarly. Their thoughts are considered in greater depth in the case study central to this research.

By 2009 I had taken on a position at the Department of Health in policy and performance. I now had the opportunity to watch the internal workings of government, to see how health policy was formulated and the tension between the political rhetoric of local responsibility versus national state accountability. During this time New Labour left office to be replaced by the Conservative-Liberal Coalition government in 2010. A decade had passed where I saw performance management dominate the NHS. This thesis is a reflection on that time.

Abbreviations

18 WEEKS	18 Weeks Referral to Treatment Standard
A4C	Agenda for Change
BMA	British Medical Association
BMI	Body Mass Index
BSC	Balanced Scorecard
CDA	Critical Discourse Analysis
CHI	Commission for Health Improvement
CQC	Care Quality Commission
DH	Department of Health
DHSS	Department of Health and Social Services
GP	General Practitioner
HCAI	Healthcare Associated Infections
HCC	Healthcare Commission
HES	Hospital Episode Statistics
IE	Institutional Ethnography
LDP	Local Delivery Plan
LDP _r	Local Delivery Plan return
MHT	Mental Health Trust
MIS	Management Information System
MMR	Monthly Monitoring Return
NHS	National Health Service
NICE	National Institute of Clinical Excellence
ORPI	Outcome Related Performance Indicators
PAF	Performance Assessment Framework
PCG	Primary Care Groups
PCT	Primary Care Trusts
PFI	Private Finance Initiatives
PI	Performance Indicators
PSA	Public Service Agreement
QOF	Quality Outcomes Framework
RTT	Referral to Treatment
SHA	Strategic Health Authority
SS	Shared Services
SUS	Secondary Uses Services

Chapter 1

Introduction

*“When a bedpan falls to the floor in Tredegar Hospital, its sound should echo in the Palace of Westminster.”*¹ **Aneurin Bevan, MP, Minister of Health 1945-51**

This thesis explores the proliferation of performance management in the National Health Service (NHS) with particular focus on the years from 1997-2010 under the Labour Government. My interest in this issue stemmed from working in the NHS from 2000 to 2010, a period which saw the rise of a defined performance culture. Deleting

The main objective of the thesis is to assess how performance management policy impacts the work-place experience; to understand the nature of work undertaken by performance managers, the tools used, and the effect these techniques have. The secondary objective is to understand the goals of performance management. This research set out to find why performance management was pivotal to New Labour’s governance of the NHS and to understand the impact and unintended consequences the introduction of these systems had on the NHS, its patients and the wider public. The rhetoric employed by politicians focused on reducing risk; my research suggests that performance was equally about rationalisation. The introduction of performance saw a change in expert authority; a new set of professionals had arrived in the NHS: regulators, auditors and performance managers. This thesis examines the performance managers’ body of expertise - unpacking the repertoires which served to legitimise their authority within the NHS.

¹ Nairne, P., (1984) pp33–51

It is important to understand NHS performance management because there may be a difference between political rhetoric and how a policy works in practice. Government's vision and aim can be distorted; daily performance management in the NHS may not necessarily be what was articulated and intended originally. This performance management culture is replicated in other parts of the public sector. I use as key research questions those posed by Jeremy Dent and Mahmoud Ezzamel in relation to accounting, with the latter substituted by performance management. The questions then are as follows: "1) how does accounting fit in the totality of an organisation's activities? How do such observed abuses in accounting interact with other organisational mechanism? 2) What forces shape the accounting functions in organisations? Why do accounting practices evolve over time? Such questions should, perhaps, be addressed before deriving normative accounting propositions."² The substitution of performance management for accounting is non-contentious; performance management is already formally considered a subset of accounting. With its propensity for monitoring, providing external scrutiny and internal control, it is a form of auditing.

I aim to contribute to broad debates in STS on how knowledge is created and used, both internally by the NHS and externally by the wider public. I sought to understand how technologies and conceptual tools used in performance management originate and the manner in which these are diffused throughout the NHS. The benefits and deficiencies are considered in order to understand how these technologies are shaping and skewing our view of the NHS. Technologies are immensely powerful; their application and advantages, however, cannot be separated from their detrimental effects on people's lives and labour. Therefore, assessing how performance technologies alter the way in which staff work was an important aspect in my research. I concentrate on how performance management's focus, under New Labour, on measuring certain aspects of healthcare, presented a distinct view of the NHS which had a wider audience than those immediately concerned with health policy.

Performance management, through the technologies it utilises, is like a kaleidoscope. It attempts to view an array of what would otherwise appear as haphazard data and produce a coherent meaningful picture to the observer. It looks to shed light on areas that appear unknowable, magnifying and multiplying facets of the system. The viewer has the impression that what is seen are facts speaking for themselves, untouched, unrefined and

²Dent, J., and Ezzamel, M., (1995) p39

unadulterated. The formation of facts lies in a heavily enriched process of translations and transformations and yet they appear distinct entities, separate to all that has gone before. What is seen is only that which is allowed to be displayed, the authorised account. Performance managers therefore are not only actors, but witnesses to the birth of these facts and providers of the literary technology for the official narrative; indeed they are actors in the laboratory where facts are produced.³ The tools at a performance manager's disposal that aid the production of these facts are actants, Latour's term to describe non-human actors within a process.⁴ Actants are as necessary to the production of facts as the actors, the performance managers themselves.

Performance tries to emulate science, in both its practice and culture; in so doing, like science, it has its own community, its own rules and standards of behaviour.⁵ The New Labour government prided itself in how performance management underpinned the health service. Applying methodologies in a scientific manner, that is, in an unbiased, rigorous fashion, was a sign of progress and transparency.⁶ This research considers the credibility of such an assertion and whether it is justifiable. The intention is to look critically at how performance as an activity produces figures, data and evidence, how this frames perceptions of an organisation, and what it actually means to be a successful or a failing Trust. I consider how translated information is appraised and evaluated and what these assessments and judgements mean to organisations. I look at what the idea of uniformity and standardisation, a one-size-fits-all approach to healthcare, has on those that work in it and how regulation enables the State to gather information on otherwise opaque parts of the NHS. I seek to understand the process of classification and the role performance managers play as gatekeepers of knowledge as well as their role in producing evidence cultures⁷, epistemic cultures⁸ and epistemological cultures⁹.

The concept of performance as originally implemented in the 1980s by Thatcher was one that increased efficiency, economy and effectiveness in delivering healthcare¹⁰. How then did political rhetoric move to seeing it primarily as a form of risk analysis and monitoring? If performance is to be about studying risk then it becomes necessary to examine the

³ Latour, B., and Woolgar S., (1986)

⁴ Latour., B., (1987)

⁵ Barnes, B., Bloor, D., and Henry, J., (1996)

⁶ McDonnell, O., Lohan, M., Hyde, A., & Porter, S., (2009) p170

⁷ Collins, H., (2004)

⁸ Knorr Cetina, K., (1999)

⁹ Fox Keller, E., (2002)

¹⁰ Klein, R., (1995) p139

impact of measuring the degree and effectiveness of risk avoidance measures, as well as the methodological challenges created by implementing such a system. I look at why organisations appear to grow more fragile rather than resilient to risk, an outcome that conflicts with the New Labour Government's aim of proliferating performance management throughout the entire NHS. The research shows that risk appears to accumulate steadily rather than always diminishing or dispersing throughout systems. I examine how the habit of work practices is inculcated into NHS Trusts and how staff incorporate rules without due reflection to wider consequences in striving to be a high-achieving organisation. Two types of organisations, a Primary Care Trust (PCT) and a Strategic Health Authority (SHA) were my base as an ethnographer and the location of majority of this research. Both types of organisations will be described in more detail in Chapter Two.

In Britain, when New Labour took office in 1997, no systematic research of NHS performance management existed. The only research that had been undertaken was in the United States, and its main focus was on relationship between patients and clinicians as insurance companies were keen to make experiences more cost-efficient.¹¹ This was of limited value as the approach to healthcare in Britain is very different, based on general taxation rather than private health insurance,¹² with patients being seen by general practitioners (GPs) in the first instance rather than specialists. This work deals with issues of modernity, trust, professionalism, accountability and regulation, all of which underpin the performance management agenda of the NHS. At the start of the work for this thesis, there was no specific analysis of NHS performance management under the Labour government. This research was an attempt to fill that void.

The next chapter considers the formation of the NHS. Explaining to an outsider all aspects of performance in the NHS is often difficult. It is necessary to explain the healthcare system in Britain from its inception, considering the ideological forces and historical context that shaped its conception but also led to its reform. This chapter looks at the roots of the performance culture and how it came to exist. It also gives a brief account of the current structure and the different levels of care within the NHS. This chapter will argue that performance management and the rhetoric employed prior to 1997, particularly under the Thatcher and Major governments, were about increasing productivity and providing greater value for money. The Conservative governments' concern was how to get the best

¹¹ Martinez, J., (2001) p10

¹² Scambler, G., ed. (2001) p198

return from the NHS on taxpayers' money. Following New Labour's success in the 1997 election, there was a shift in government rhetoric as to the purpose and deployment of performance management. This thesis considers how and why this change took place and attempts to elucidate the reason why this different narrative was employed. Chapter Two, therefore, gives a general overview of the NHS, including its structure at the time of undertaking the research, providing a description of Primary Care Trusts, Strategic Health Authorities and the role of the Department of Health.

Chapter Three gives an overview of the theoretical framework upon which this thesis rests. It draws upon literature in Science and Technology Studies as well as the Sociology of Health, which has informed and driven the research. It begins with a discussion of authors whose work was relevant as they discussed significant themes and issues that were central to the research, whether or not they have explicitly spoken about the NHS. Having worked in the NHS for over a decade in roles relating to performance, my expertise allowed me to see clear links between their work and specific issues that arose in mine. Performance management is a tool of bureaucracy, therefore this chapter discusses the different effects of bureaucracy as expounded by Weber, Marx, Foucault and Arendt, and more recently co-opted and further developed by Bauman, Ritzer and Scott with regard to rationalisation. These writers provide details on the impact of bureaucracy on the individual, the organisation and the interplay with the state. This provides both context and a basis against which the research I conducted within the NHS could be set. Additionally, this chapter considers notions of risk as presented by Douglas, Beck and Giddens, and how this impacts relationships of trust and accountability within a risk society. Power's work on audit combines ideas of rationalisation and accountability and this is studied in detail and will be central to my thesis. Finally, an examination of language as a form of work as well as in relation to stigma and work in healthcare is considered. Initially this research was based solely on a science and technology studies framework, but, as it developed, the need became apparent to draw also upon the sociology of health to bring greater understanding to the research findings. The purpose here is to understand more precisely remarks made by participants in the research interviews while giving further meaning to the ethnographic observations made.

Chapter Four sets out the methods, detailing the research aims and reasons for the approach chosen. It details how ethics approval was sought and granted and how several forms of qualitative research were considered, before finally deciding upon in-depth interviews, observations taken as an institutional ethnographer, and the use of the '18

weeks policy’ as a case study, as the most appropriate tools for this research. The key policy documents studied were ‘*The New NHS: Modern, Dependable*,’ ‘*The NHS Plan: A plan for investment, a plan for reform*’ and ‘*Shifting the Balance of Power: Securing delivery*.’

Chapter Five focuses on how the risk narrative was employed by New Labour when talking to NHS staff, patients and the wider public. The implication of political rhetoric was that a greater understanding of risk through increased performance management would simultaneously lead to a change in staff behaviour and a safer environment for patients and public. Documentary analysis suggests New Labour saw performance management as a tool for reducing harm. This chapter considers how effective performance has been in reducing perceived risks. Through studying the daily work of performance managers I assess if this is the case, whether there is a correlation between the normative and descriptive accounts and whether the rhetoric holds substance. Evidence from interviews and the ethnographic research shows, contrary to government rhetoric, that risk rarely features in the workplace and is not a principal part of performance culture.

This chapter looks at the introduction of performance managers into the NHS, studying all aspects of the work undertaken; tools and technologies used; the impact of such features as of star ratings and league tables in order to strengthen accountability through choice and consumer deliberation; the increase in the volume of data placed in the public arena and the publication of Trust information aimed to inform patients’ decision-making. Access to performance-related figures of NHS organisations was intended to encourage competition between Trusts, thus driving up the overall quality in healthcare, while enabling the public to assess the performance of the service provided and holding that service to account locally. This part of the thesis examines the evidence and shows the impact this has had on actual performance.

Within Chapter Five the nature of ‘planning’ is also examined as it contributes significantly to a performance manager’s work. High levels of planning undertaken by the NHS attempt to prevent a crisis but more often merely postpone the inevitable, there having been little change to the fundamental causes of the original problem. Planning, together with the implementation of greater levels of processes, procedures and protocols, is an attempt to increase local organisational accountability and I examine in detail what this means in practice for both staff and the wider NHS.

Finally, this chapter examines how, attempting to decrease risk, organisations seek to control variables and to limit internal influences and perceived external threats. However, when reviewing events, it becomes apparent that there is a generalised increase in risk-taking behaviour in order to fend off the oncoming crisis. Parties recognise the onset of a possible catastrophe and take measures to prevent such a situation. Innocent mistakes made once and with no immediate negative repercussions may be intentionally reproduced at a later date to enhance the organisation's stated performance. These actions by their nature are outside the normal and accepted range of practices and therefore increase the magnitude of the eventual crisis. This chapter raises the question: if risk-minimising technologies have the opposite effect, why did the government continue to employ them? An attempt to answer this question, more fully and in greater detail, is provided in the next chapter.

Chapter Six looks the nature of performance as both work and as a technology, particularly at various aspects of rationalisation, including measuring, quantifying, tabularisation and the use of these processes as state surveillance. It recognises how practices, procedures and protocols develop and how standards are set, later to be relaxed before being removed or disregarded. The credibility of data collection processes is examined and the impact of centralised systems and greater homogenisation is investigated. Performance managers calculate and compensate for discrepancies in data as well as providing analysis in order to create generalisations. The effect of such generalisations on real risk reduction is evaluated. The issue of rationalisation creating systematic risks, as standardization of indicators can lead to structures that exacerbate risk, is considered. Risks not dealt with appropriately can snowball; small risks build cumulatively, gaining both momentum and magnitude, resulting in significant effects on an organisation's ability to provide care safely. This chapter shows that, while risks are considered in abstraction, managers are sometimes unaware of the real and significant underlying problems; this leads to performance management systems that are overly optimistic in their view of an organisation's outlook. Performance managers may prefer to set or upgrade an indicator in order to avoid imposing penalties or sanctions on a department or organisation for an otherwise failing standard, particularly if they believe that those penalties will make no difference to the situation and have no positive impact on performance.

Furthermore this chapter considers the value and appropriateness of ratings and the pressure NHS Trusts face in complying and conforming with government directives which

in some instances may not deliver any benefits to patient care. As organisations work as autonomous units, self-interest and competition come to the fore. However, this can be self-defeating as departments vie for resources at the expense of others, to the detriment of the overall NHS system as well as at a cost to patient safety. This chapter focuses on how performance is part of the bureaucratic machine by which efficiency and effectiveness are judged in areas where the state previously had little information. It explains how performance has become synonymous with rationalisation in the minds of those working in this area.

Chapter Seven examines stigma as an expression and effect of rationalisation on individuals in an organisation. The findings detail staff experience of group and professional stigma. Discussion centres on the role and characteristics of stigma in relation to organisational change within NHS Trusts, policy implementation and the language of performance. This chapter considers the importance placed on staff involvement in consultation processes in contrast to the actual weight given to the views expressed, and how attitudes towards performance as a tool alter as managers become increasingly unconvinced of the value of seemingly arbitrary changes. Where outcomes seem predetermined, the value of the consultative approach is challenged and staff question the contrived conditions under which their responses are evaluated and the contribution their work makes to ensuring a sustainable health service. This chapter also seeks to shed light on the terminology, language and characteristics specific to performance. As in industry and the public sector, certain words are used and their meanings taken for granted in the NHS. These words, used every day embody specific history, concepts and ideologies. This chapter explains exclusive language of performance to those who do not share the same cultural context. Dealing solely with specific words is inadequate; simplifying the language by replacing jargon only leads to misunderstandings. The language of the NHS is a currency by which ideas and values are transmitted, shared and embedded. There was nothing simple about its deployment or proliferation. Elucidating and clarifying performance language brought analytical distance and perspective and was pivotal to the research.

The eighth and last chapter looks back on the central claims made in this research. I look at what has been revealed about the way in which New Labour operated in government, what it adds to our knowledge in terms of establishing the process by which performance management was embedded into the NHS and how it came to be the lens through which NHS productivity was viewed and understood. While decentralised government was

advocated publicly by New Labour,¹³ within public services this was far from the case. Performance culture allowed a command and control approach to be retained in the NHS and power to be reasserted from the centre; it was New Labour's attempt to bring order and focus to areas previously hidden from the State. However, after thirteen years, New Labour's time in office ended in May 2010; therefore, this chapter also considers the future for both the NHS and performance management given the proposed reconfiguration under the coalition government.

Finally, "Performance Anxiety," the title of this thesis, is drawn from Power's claim that the "audit society is the anxious society". Its meaning is threefold. Firstly, it ties together the initial political rhetoric of risk, where performance management was New Labour's response to the highly publicised failings in the NHS, a way to mitigate further crises. Secondly, it recognises the anxiety of the state: New Labour's need for control and oversight of all aspects of NHS functions. Thirdly, it acknowledges the stigma related to performance management work. These three themes are discussed in greater detail in the coming chapters of this thesis.

¹³ With the introduction of the Scottish Parliament (1999), the Welsh National Assembly (2006) and the London Mayor (2000), this message matched action.

Chapter 2

The History of NHS Performance Management

2.1 Formation of the NHS

This chapter provides a general account of the NHS's formation, looking at the forces, both ideological and political, that were central to its creation. Key points in its history are identified to provide the background and context to more current reforms. This chapter also details how performance was established in the NHS, having been adopted from industry. It sets out how successive governments have advanced the benefits of performance until now it is firmly embedded within the culture. This chapter gives an outline of the structure; the different levels of care provided in the NHS as well as the different tiers i.e. Primary Care Trusts, Strategic Health Authorities and the Department of Health. Initial performance management was concerned about increasing productivity and providing taxpayers with greater value for money. This was particularly the case for Conservative governments, with the focus on financial and economic metrics; however, New Labour changed the rhetoric, purpose and deployment of performance management. The purpose of this chapter then is to offer a historical perspective which highlights this context and frames this new way of seeing in order to understand this transformation.

Created on 5th July 1948 by Clement Atlee's Labour government, the National Health Service (NHS) aimed to provide everyone with free healthcare. Its founding principle was that care would be provided based on the individual's need of treatment and not on the individual's ability to pay.¹⁴ The emerging view was that healthcare was a right of all citizens; nothing as fundamental as the provision of healthcare should be left to altruism, whether from established charities or bestowed erratically by the wealthy and philanthropic. At the beginning there was much conflict along party political lines. The

¹⁴ Rivett, G., (1998)

medical professions, politicians and planners all appeared to hold entrenched and polarizing positions, views were stagnant and there was little room for negotiation.¹⁵ The British Medical Association was vocal in raising concerns that their clinical authority would be undermined and they would be inadequately remunerated.¹⁶ However, there was a bipartisan agreement amongst the main political parties that the existing services were in disarray and that voluntary hospitals were facing increasing financial difficulties. This, together with the medical profession's view that change was necessary, prompted efforts by the state to intervene in the provision of healthcare services.

After the end of the World War II, in 1945, a sense of optimism and solidarity fed the idea of a new, prosperous Britain. The NHS hoped to educate its citizens in maintaining healthy lifestyles that would enhance the physical and mental wellbeing of the nation. Health promotion and illness prevention were central to the newly founded NHS. The NHS would also provide diagnostic services, followed up by the appropriate treatment and long-term care for patients with chronic illness and disability. The State's focus was not just on individual health but on public health; the NHS was concerned with creating a strong and healthy nation. "The NHS was recognised as a remarkable experiment in healthcare ...and to outsiders an outstanding example of 'socialised medicine' in the western world."¹⁷ The NHS was revolutionary, with underlying principles that were different to all that came before. Treatment was free at the point of delivery; it was universal - everyone was eligible and entitled to NHS care irrespective of status; it was financed in its entirety through central taxation. The final point was crucial in gaining wider public support because it meant the wealthier contributed more than the poor. Other welfare schemes were different in that that they were predominantly insurance schemes.

The NHS would care for its citizens from the 'Cradle to the Grave' and be funded exclusively through taxation via national insurance contributions made by all those who were eligible to work. The NHS would come under the jurisdiction of the Secretary of State for Health, a senior cabinet post, via the Department of Health, formerly the Department of Health and Social Services (DHSS). The NHS was part of a wider welfare state, which sought to offer security not only in health care but also in education, employment and social security. Though aspects of the welfare state had existed prior to this, "The Report of the Inter-Departmental Committee on Social Insurance and Allied

¹⁵ Webster, C., (2002) p8

¹⁶ Baggott, R., (2004) p80

¹⁷ Webster, C., (2002) p1

Services” produced by William Beveridge made an urgent and compelling case for a more structured and complete welfare state.¹⁸ In identifying the giant social evils of squalor, ignorance, want, idleness and disease, his report necessitated the idea of the welfare state. While Beveridge was not alone in raising these injustices, his eloquence gained him wide support, channelled the voice of the public and ensured that these concerns could not be casually cast aside.¹⁹

The NHS became a popular and valued institution with those who remembered a time before its existence. However, the golden age of social expenditure in the developed world, considered to be between 1960 and 1975, was ending and thus the problems the NHS faced were exacerbated and obvious.²⁰ By the mid 1970s, there was a tightening of government spending on public services, due in part to the oil crisis. This saw the Labour government of the day in conflict with trade unions, a section of the electorate on whose support they had previously relied.²¹ During the Winter of Discontent, over half of the NHS staff took part in some form of strike action leading to a total of 1.4 million days lost. To date this is the “greatest episode of industrial unrest in the history of the health service.”²² There was a sense of militancy amongst staff in the NHS which had been absent in the previous decades, due partly to the monopoly-like status the NHS held for health service workers. There was conflict within the medical profession as different types of doctors sought to differentiate themselves through their professional bodies (e.g. Royal Colleges) in order to improve their pay and conditions.²³ Other staff groups with the NHS followed the medical profession and unionised in order to strengthen their voice. This friction between unions and government was further exacerbated by the change in government from Labour to Conservative in 1979. The 1979 Conservative manifesto proposed cutting bureaucracy and decentralising the service and the eventual change in government brought about a corresponding change in economic policy. There was a shift to privatisation, lighter taxation and a further tightening of public spending, the result of which was a restriction in the finances of the NHS. There was greater caution in how budgets were spent and the working environment became more overtly aware of the fiscal pressures placed upon the system. The government expected a greater degree of restraint; the years of milk and honey were over for the NHS.

¹⁸ Baggott, R., (2004) p84

¹⁹ Webster, C., (2002) p7-8

²⁰ Baggott, R., (2004) p89

²¹ Webster, C., (2002) p70-74

²² Webster, C., (2002) p75

²³ Klein, R., (1995) pp 62-63

2.2 The NHS under the Conservatives; the formative performance years

The collapse in the consensus that had previously existed over both funding and the structure of the NHS was replaced with ideas of ‘New Public Management’. Britain, like many other liberal nations, has a strong welfare state, unlike the welfare state of neo-corporatist Scandinavian countries however, Britain’s welfare state does not co-exist easily with the market. The New Public Management refers to Margaret Thatcher’s 1980s economic ideology, later picked up by New Labour, of replicating the private sector’s administrative practice including the introduction of market forces, cost control mechanisms, financial transparency and increased accountability, into the welfare state. During this period central government instituted a series of measures to reduce public spending based on the three Es: Economy, Efficiency and Effectiveness. The principles of good housekeeping were applied to the State and its institutions. The distribution and accessibility of information had become mainstream and, as such, performance indicators (PIs) were introduced in 1983 to measure progress, their aim to raise productivity. PI comparisons allowed policy makers within the Department of Health to see at a new level of detail all parts of the NHS.²⁴ Within the public health sector, changes incorporating this philosophy were most clearly seen in the management of Health Authorities.

However, while changes were made to individual policies to drive competition and efficiency, this was not done in any comprehensive way by the early Thatcher government. While Bevan had introduced one single piece of legislation, which had a huge impact, the Thatcher legacy to the NHS would be made from a series of reforms whose cumulative effect was comparable to Bevan’s vision.²⁵ ‘New Public Management’ had its own language and 1984 saw the rebranding of “efficiency saving” to “cost improvement.” Sir Derek Rayner, the then Chief Executive of Marks and Spencer’s, had been brought in from the private sector to examine the NHS. His findings led to the introduction of a competition within the tendering and procurement process in non-clinical fields such as domestic services, and the selling of NHS assets, including hospital accommodation, as well as the use of performance indicators. Following Rayner’s report there was the new and additional expectation that Health Authorities should be in a position to generate their own income. Health Authorities achieved this through a number of schemes including treating private patients. Rayner’s suggestions are important not only because they introduced competition to the NHS but because they created a culture where measuring different types of activity became the norm. That this was done in

²⁴ Klein, R., (1995) pp144-145

²⁵ Webster, C., (2002) pp142-146

relation to billing processes and finance makes it no less significant to the history of performance.

Before 1991, Health Authorities had responsibility for distributing resources to local services as well as managing those services. During the early 1990s, this changed, and Health Authorities became responsible for assessing the needs of the local population and contracting with public or private sector providers to meet those needs. Service providers, hospital and community health units, became responsible for managing the provision of services. Purchasers could choose from a number of providers and were no longer restricted to their local provider. This new system, it was hoped, would bring market forces into the public sphere, encouraging a more competitive and cost-effective service. Publicly, the Department of Health referred to this process as allowing the money to follow patients, increasing the available choice of service providers to patients. These reforms led to a redefinition of notions of consumers and to a greater degree public services.

Here, it is necessary to define the public and private sectors, because, as shown, there was a significant rise in the role the private sector played in public services. The public sector refers to services and the delivery of those services which are funded by the state purse, whether at a local or national level. Traditionally the private sector is independent of the state; it is self-funding through its ability to generate profit. As mentioned, privatisation was a central part of Conservative thinking. The private sector and the NHS were expected to compete for business; the Government wanted a level playing field on contracts awarded to the public sector. The purpose of this approach was not only to break the monopoly the NHS had on tenders but to drive the cost of services down. If its secondary purpose was to reduce the power of unions within the public sector workforce, then this policy was a success. Privatisation inevitably led to the introduction of temporary contracts for staff and thus greater use of casual staff. This 'flexible workforce' was positively encouraged by government, though Local Health Authorities continued to be sceptical about their use, as the standard of quality delivered by companies outside the NHS was thought to be inferior.

The Griffiths Report (1983) was produced by Roy Griffiths, the then Chairman of Sainsbury's, at the behest of Norman Fowler, MP, Secretary of State for Social Services (1981-87). The finding of the report spoke of 'institutional stagnation' where health authorities 'were being swamped with directives without being given direction' and where

introducing change was extremely difficult with ‘decision making through a consensus approach leading to long delays in the management process.’²⁶ His two central criticisms of the NHS were: 1) it did not make efficient use of its resources and 2) it was not patient-orientated. There was a basic change in philosophy, which saw the wants of the consumer, i.e. the patient, pushed to the fore; the producer, i.e. the medical establishment, was no longer the sole driver of the NHS. In addressing these issues, Griffiths called for the introduction of a proactive approach to management where appropriate leadership both motivated staff and encouraged a mindset that sought out new areas of cost improvement.²⁷ Prominence was given to good leadership, and at each level an individual was identified who had the necessary authority and accountability for planning and implementing decisions. The relationship between the NHS administration and Whitehall was too tight, with the NHS often suffering because of Whitehall interference. Griffiths’ belief was that consensus management should be set aside in favour of general management.²⁸ However, doctors liked the status quo, as it conferred upon them greater authority, while nurses liked consensus management as it enabled them to transfer into management with its greater status.²⁹ Conservatives hoped general management would break the professional monopoly on authority that clinicians held and give managers an equal footing when it came to decision-making.³⁰

General management was intended by the Thatcher government to call upon the brightest and the best from business to work alongside NHS staff. However, as contracts were for fixed periods and based on performance-related pay, these terms were less attractive to those already working in industry, so few were prepared to leave.³¹ Instead, general management roles were filled by senior administrators already working in the NHS. This was not the original intention, and it left open general management to the accusation that the change was merely superficial.³² Griffiths called for great flexibility between teams, clinicians and managers, with consultants encouraged now to become involved with financial and budgetary decisions. Griffiths gave several actions for making this happen but stressed that there was no time to waste in reflecting on what had been said. Government should make the changes and make them immediately because of the poor state of the NHS. The Conservative government approved the business-like approach that

²⁶ Klein, R., (1995) p147

²⁷ Baggott, R., (2004) p103-104

²⁸ Webster, C., (2002) pp170-174

²⁹ Baggott, R., (2004) p54

³⁰ Baggott, R., (2004) pp56, 102-104

³¹ Baggott, R., (2004) p103

³² Webster, C., (2002) pp173

the Griffiths report favoured. Little time was given for reflection³³ before managers at all levels of the organisation were introduced. This had the effect of creating a group of people who were receptive to change, and open to ideas about developing the internal market within the NHS.

By the late 1980s, there was a large gap between the income received by the government and the money required to meet patients' needs.³⁴ The activity of individual doctors and their departments was scrutinised by auditors, trying to stem escalating costs and the obvious tension between increasing demand and finite resources. This prompted trials in clinical budgeting, necessitating a drive for robust data and information which are crucial to implementing performance management systems. Outside the NHS, there was an explosion in audit culture; within the NHS this led to the introduction of basic performance indicators and here began the rise of performance culture.³⁵ The strain on the NHS required national intervention and, as such, Thatcher made a £101 million cash injection into the system and instigated the Review in 1987 to assess the future of the NHS and avert both an immediate and future crisis. The BMA and other medical bodies were excluded from the Review, which was made up of a small select number of ministers and civil servants. However, while the Review committee was meeting, the bodies excluded from the process were publishing their thoughts on the subject.³⁶ While it was not a consultative process, the Review was not working in a vacuum unaware of the views of those working in the NHS or those who had a vested interest in the outcome.

The conclusion of the Review was more mundane than people had expected. Having looked at other developed countries' models of healthcare, there was a recognition that no funding system was without flaws, and there was neither the impetus nor enthusiasm for change. While the Thatcher government had advanced private health insurance, the uptake by the public remained relatively low. It was acknowledged that the system of taxation in place would continue to fund the NHS. With this in mind, the spotlight returned to how to deliver services efficiently.

It was during the Thatcher government that the split between social services and healthcare was made: the Department of Health and Social Services (DHSS) ceased to exist. One of the original initiatives of the newly-formed Department of Health was to

³³ Lack of reflection is a worrying but persistent trait with regards to health policy.

³⁴ Timmins, N., (1988)

³⁵ Power, M., (1994b)

³⁶ Baggott, R., (2004) p103

ensure that there were stronger lines of accountability for doctors, which brought the NHS into line with other public services. 1987 saw the publication of the paper “Promoting Better Health”³⁷ which drew on the World Health Organisation’s principles for the developing world. Its focus was on primary healthcare, where General Practitioners were the first line of defence; prevention was better than cure and, importantly for Conservatives, less costly. However, many of the measures implemented under this altruistic banner were solely cost saving-measures with little to do with preventive medicine, such as the elimination of dental check-ups and eye tests.³⁸ Within the White Paper “Working for Patients”,³⁹ the performance of doctors was under scrutiny and non-clinical managers had for the first time an influence in clinical management decisions. Thus, the managers had both authority and power which was significant in terms of establishing the performance culture. However, it was a two-way process: doctors were expected to participate in wider management issues. At the heart of the document, “Working for Patients,” was the separation between purchasers and providers, and the introduction of the internal market. District Health Authorities would now buy the more costly services, while routine services would be bought by GP Fundholders. In both cases, the services purchased were on behalf of the patients and reflected the needs of the local population. By contrast, the providers, such as hospitals, would offer services in order to raise income. Hospitals were vying for business and the competitiveness of their individual contacts would affect the organisation’s overall financial position. During this period, hospitals were encouraged to work towards attaining Trust status. This new arrangement conferred greater autonomy; it increased self-governance, and freedom in the management of both finances and service setting. However, because of the scale of the reorganisation, these changes were phased in and dependent on local circumstances rather than national timetables.

The changes that were driven through by Thatcher were structural in nature whereas the reforms undertaken by her successor, John Major, were more patient-orientated. Quality within the NHS was now the primary focus. The Major years in government, though short in comparison to Thatcher’s time in office, nevertheless saw the initiation of some key pieces of work. Firstly, the establishment of the Patient’s Charter⁴⁰, which detailed what patients should expect from the NHS, as well as their rights and responsibilities. It was in the Patient’s Charter that a maximum time was first set around waiting times, in so doing

³⁷ DH (1987)

³⁸ Webster, C., (2002) pp178-179

³⁹ DH 1989

⁴⁰ DH 1991

highlighting the NHS' obligations to the patient. Moreover, by 1994 the Patient's Charter was used as the basis for performance measures.⁴¹ Secondly, patients for the first time would be asked their views in the Patient's Survey. The survey drove home the idea of customer satisfaction; the NHS was to model itself on private business, which was continually assessing its customers' needs and expectations in order to drive up both quality and service.

Later New Labour would continue championing the concept of patient surveys; its reasons for doing so were twofold. It made the NHS more democratic and drove up quality within the system. "Through measuring the way in which patients and carers view the quality of the treatment and care that they receive, ensuring the NHS is sensitive to individual needs,"⁴² the NHS would become more patient-focused. In this respect New Labour saw an equivocation between patient and customer and thus drives to improve performance would be the same as in industry. John Major had overseen the establishment of the Patient's Charter, a forerunner to the idea of the patient as a consumer⁴³. Hence, where business employed customer satisfaction surveys, the NHS would implement patient experience surveys as a way of delivering greater efficiency in areas of particular concern to patients. The publication of the results from these surveys together with star ratings shifted discussions about performance from the lofty echelons of the DH firmly into the public arena.⁴⁴ This was New Labour's way of fostering policies that would take the NHS into the 21st century, proactively bringing about a patient-centred NHS.

The final years of the Major government were also a time to embed the policies of the previous administration. However, by then it became apparent that the creation of the internal market had costs of its own, costs far higher than had been expected. In pre-electoral campaigning, "Labour claimed that the internal market had added £1.5 billion in total to management costs."⁴⁵ More importantly, the management costs were higher than those of the previous system primarily due to the expertise needed to implement contracts, which led to accusations of sleaze within health service management. John Major, trying to deal with these accusations, ordered a root and branch review of management costs, the outcome of which was a more streamlined management structure and contracts lasting for longer periods in order to mitigate the initial high cost in administration.

⁴¹ Hogg, C., (2009) p82

⁴² Department of Health (1997) section 8.5

⁴³ Pollock, A.M., (2004) p201

⁴⁴ Ham, C., (2004) p192

⁴⁵ Webster, C., (2002) p203

2.3 The NHS under New Labour; performance becomes modernisation

To understand the importance of the NHS to the New Labour government of 1997 it is necessary to understand the US politics of the same period.⁴⁶ The idea of an agreement by the State and its people, a ‘Social Contract’⁴⁷ was taken up by the US Republican Party. ‘Contract with America’⁴⁸ was a document that listed the actions that would follow if Republicans held a majority in the US Congress. One of its creators and most vocal proponents was Newt Gingrich, who oversaw the change from a Democratic to a Republican Congress; he was also one of Bill Clinton’s staunchest critics. Clinton had turned to the “Third Way” in order to deal with the rise of the Right and challenge Newt Gingrich’s influence as Speaker.⁴⁹ However, it was not before New Labour recognised the power and effectiveness of the ‘Contract with America’ as a rhetorical bomb, a weapon that a party in opposition could not fail to ignore or employ irrespective of its Republican roots. Labour had already taken up the politics of the ‘Third Way,’⁵⁰ where the State’s role is to bring about greater social justice and provide opportunities for wealth creation.⁵¹ Its magpie-like tendencies continued with it taking and transforming the ‘Contract with America’ into a series of manifesto pledges for its 1997 election campaign. At the heart of these pledges was a commitment to the NHS.

Tony Blair’s foreword to the first substantial document on the NHS was broken down into six paragraphs with the word ‘modern’ appearing in the title “The new NHS: modern and dependable”⁵² as well as in the fourth paragraph. The word “modernisation” appeared in first sentence of the first paragraph “Creating the NHS was the greatest act of modernisation ever achieved by a Labour government”⁵³ and later again in the third paragraph. In 2007 people were talking ideas of the legacy of Blair’s time in office, but he himself from the very start had been aware of the lasting effects of his premiership. His was a global outlook; he recognised and related the image of nation, self identity and freedom to that of the NHS. “For people of my father’s generation, the creation of the NHS in 1948 was a seminal event...the NHS was an extraordinary act of emancipation;”⁵⁴ and again, “The National Health Service (NHS) is one of our country’s

⁴⁶ Giddens, A., (1988), pviii

⁴⁷ Rousseau, J.J., *The Social Contract*

⁴⁸ 1994

⁴⁹ Giddens, A., (2007) pp 17-19

⁵⁰ Giddens, A., (1988) pviii

⁵¹ Giddens, A., (1988)

⁵² Department of Health (1997) Foreword

⁵³ Department of Health (1997) Foreword

⁵⁴ Department of Health (2000) Foreword

proudest achievements and an essential strand in the fabric of our nation.”⁵⁵ Early on he spoke of a “time to reflect on the huge achievements of the NHS. But in a changing world no organisation, however great, can stand still.”⁵⁶

Blair’s vision was of an NHS that was the “envy of the world” and the final sentence in this first NHS document was that “we can create an NHS that is truly a beacon to the world”⁵⁷. This sentiment was first voiced by John Winthrop when talking about the formation of New England as example to the world - “For we must consider that we shall be as a city upon a hill. The eyes of all people are upon us,”⁵⁸ and later by Ronald Reagan. “I’ve thought a bit of the ‘shining city upon a hill.’.... I’ve spoken of the shining city all my political life.... And she’s still a beacon, still a magnet for all who must have freedom, for all the pilgrims from all the lost places who are hurtling through the darkness, toward home.”⁵⁹ Much has been said of Blair’s fondness for Clinton’s style and rhetoric on both rights and responsibilities and globalization⁶⁰ and yet it is Reagan’s words that flow from his pen; it is Gordon Brown who is considered the Puritan and yet, with notions of saving, reforming and renewal,⁶¹ it is Blair’s evangelical zeal towards the NHS that shimmers on the page. The US President has several roles including Commander in Chief; he also has several latent roles including ‘Mourner in Chief’ and ‘Chaplain to the Country’. These last two roles are not ones we associate with a British Prime Minister but Tony Blair in fact played both these parts⁶² and has used the corresponding religious rhetoric in non-conventional ways, as seen with its use in framing NHS policy.

In its 1997 party manifesto, Blair spoke of New Labour’s vision for the future. “New Labour is a party of ideas and ideals but not of outdated ideology. What counts is what works. The objectives are radical. This means we will be modern....This is our contract with the people.”⁶³ Blair in previous years had sought to alter the electorate’s perception that Labour was outdated and irrelevant to 1990s politics.⁶⁴ It was in Blackpool at the 1994 Labour Party conference that ‘New Labour’ was conceived; by 1997 new and modern would go hand in hand. Thus, the manifesto was used to present the party as both

⁵⁵ Department of Health (2004) Foreword

⁵⁶ Department of Health (1997) Foreword

⁵⁷ Department of Health (1997) Foreword

⁵⁸ John Winthrop “A model of Christian charity”

⁵⁹ Ronald Reagan Farewell Address to the Nation, Oval Office, January 11, 1989.

<http://www.reaganfoundation.org/reagan/speeches/farewell.asp>

⁶⁰ Fairclough, N., (2000)

⁶¹ Labour Party (1997) manifesto

⁶² The death of Diana, Princess of Wales, 7th July 2005 (7/7) London bombings

⁶³ Labour Party (1997) manifesto

⁶⁴ Giddens, A., (1988) p155

modern and modernising in its approach to the NHS. And while in early performance rhetoric the actual word ‘performance’ was not mentioned by Blair, the focus was instead on delivering dependable and high quality care, combining efficiency and quality and maintaining uniformly high standards, words which were the precursor to performance language. However, by the time of the publication of The NHS Plan in 2000, the NHS itself was to become an example of modernisation. Implementation of ‘performance’ was part of this process. Performance management heralded a new approach for Labour; it was supposed to run through organisations and counter Conservative claims that Labour governments would run 1970s-style top-down management.

One of the central electoral concerns that Tony Blair sought to address was access to treatment.⁶⁵ Under successive Conservative governments resources had been steadily squeezed⁶⁶, the three Es - Economy, Efficiency and Effectiveness - led to ever-increasing financial rationing with its severe impact on services⁶⁷. The length of time that patients waited to be treated was frequently reported in the tabloid press, waiting times and their by-product lists were seen as failing patients; these personal stories resonated with the wider public. Though emergencies were dealt, with the experience in A&E, as patients readily testified, was often difficult and time-consuming, with people expected to wait hours before receiving simple treatment. Moreover, routine operations involved very long waits. Patients who should have been treated in their local community were admitted to hospital in the hope that they would be seen more speedily by the service. The consequence was “bed blocking,”⁶⁸ a situation in which patients were in hospital although this was not an appropriate or suitable place for them and which burdened hospital services and further increased waiting times. Reducing waiting times and increasing access would be a key measure by which New Labour success would be measured.⁶⁹ By the time Labour took office in 1997, the public saw the NHS as fragmented with huge variation across the service. Performance was seen as a way of pushing efficiency while providing national standards.

⁶⁵ Baggott, R., p121

⁶⁶ Mays, N., in Scambler, G., ed. (2001) p197

⁶⁷ Flynn, N., (2007) p36

⁶⁸ <http://www.publications.parliament.uk/pa/cm199798/cmhansrd/vo970606/debtext/70606-18.htm>

6th June 1997, a month into New Labour’s first term in office, David Amess MP raises the topic of bed blocking in parliament, questioning how the government intends to remedy the impact of long waits caused by bed blocking. “The issue of bed blocking is of importance not only to my constituents and to the county of Essex, but to the country as a whole, and I hope that I will be able to deploy a number of arguments and elicit solutions from the new Government.”

⁶⁹ Baggott, R., p188-190

*'The New NHS: Modern, Dependable'*⁷⁰ set out Labour's initial vision for the NHS in terms of accountability, funding and organisation. Due to the high costs, the commissioning function previously carried out by GP Fundholders would now be done by Primary Care Groups (PCGs). Moreover, the arrangement of GP Fundholding was seen to promote and promulgate disparities and hence health service inequalities within the system. In the new structure, PCGs were accountable to Health Authorities and the provider/purchaser split remained. It was during this period that Private Finance Initiatives (PFIs) were introduced to fund hospitals. PFIs, like performance, were another example of modernisation by which New Labour sought to take the best practices of private industry and apply them to the NHS. The advantages of PFI hospitals were that they could be established with little delay because initial capital was not an issue, the funding did not appear on the NHS accounts, and new hospitals were supposedly better than old and existing hospitals.⁷¹ Unfortunately, PFIs were considered inefficient in the long run with the financial burden falling on the NHS; the public remained sceptical about the use of the private sector within the NHS. Moreover, to New Labour critics this appeared a mishmash of philosophies, lacking adherence to a single ideology or method. Yet this was the application of New Labour's 'Third Way' philosophy to healthcare, a combination of old-style Labour command-and-control approach and Conservative ideas on the internal market.⁷² New Labour sought to "bridge the gap between centralised control and market mechanism through the 'Third Way,' which was a variety of mechanisms used according to the circumstances."⁷³ The 'Third Way' approach enabled New Labour to introduce competition into the NHS, stating that "ideological boundaries or institutional barriers should not stand in the way of better care of NHS patients."⁷⁴ Labour supporters felt the "lack of a coherent shopping list is no bad thing: it enables tactical flexibility and lets Government govern as circumstances change. The Tories in 1979 had a vague sense of wanting to extend the free market, but the precise mechanism - privatisation- had not even been invented yet. Labour will make progress in the same way: guided by values, but capable of innovation. The lack of a firm code of beliefs amongst Labour's modernisers is a result of the lack of serious opposition."⁷⁵ In short, without a fixed set of dos and don'ts, a rigid set of ideals to conform to, New Labour were

⁷⁰ Department of Health (1997)

⁷¹ Webster, C., (2002) p226-229

⁷² Baggott, R., (2004) p120

⁷³ Ham C. Improving NHS performance: human behaviour and health policy. *BMJ*. 1999;319:1490-1492.

⁷⁴ Department of Health (2002) p25

⁷⁵ Coddington, A., and Perryman, M., eds. (1998), p42

able to incorporate many new ways of working that would have otherwise been disregarded.⁷⁶

'*The NHS Plan*' was published in July 2000 and was both an action plan and a statement of intent for the next 10 years. Within it was the 'Concordat,' a promise to keep key services within the NHS, while strengthening the relationship between public and private sectors. Thus PFIs were not separate entities but rather very much part of the wider NHS family, and the plan made clear New Labour's intent that the private provision of healthcare would increase.⁷⁷ The NHS Plan set out measures to put patients and people at the heart of the health service. The plan promised shorter waiting times for hospital and doctor appointments; more power and information for patients; more hospitals and beds; a greater number of doctors and nurses; tougher standards for NHS organizations and incentives to reward elite organizations; improved care for older people and cleaner wards providing better food and facilities in hospitals. These promises, like the earlier election pledges, were to become the national healthcare priorities and form part of a social contract between the State and the public. The document '*Shifting the Balance of Power*' followed a year later and detailed how changes presented in the NHS plan would be carried out: putting patients at the heart of services; giving them greater choice of where they are treated; making it more convenient to access care. The transformation of healthcare would be centred on Primary Care Trusts. PCTs, it was believed, would be best placed to assess the needs of the local population and prioritise resources. However the key move in this document was not, as the title implies, about shifting the power from NHS organizations to the patient, but rather to shift power from secondary care to primary care. This was significant because, alongside this shift in power, the government increased control and monitoring in primary care, an area where previously little had existed. Performance management was the mechanism by which this was achieved.

⁷⁶ Giddens, A., (1988)

⁷⁷ Webster, C., (2002) p228

To alleviate this fear, promises were given that there would be high and active levels of intervention from the Minister of Health.⁷⁸ However, irrespective of intervention by the Minister over the years, there have been continuous accusations of a postcode lottery with regard to services. While each organisation is directly accountable to the public it serves, the Department of Health has overall responsibility for the NHS. It is worthwhile making the distinction here between the Department of Health which is a part of the civil service and the NHS which lies outside its jurisdiction. All national health directives come from DH policy documents, and, while parts of it may be locally interpreted by communities and provider organizations, most have little scope to deviate from nationally formulated policy. The DH works closely with the Strategic Health Authorities, the Care Quality Commission and the National Institute for Clinical Excellence (NICE). Beside the DH, the Modernization Agency ran from April 2001 to July 2005. Its role was to direct and drive change throughout the NHS. The NHS as an organisation was considered by government to be hesitant to change, holding back on reform, and the Modernisation Agency was there to ensure 'things happened'.⁷⁹ The Modernisation Agency, like the 1997 Labour government, was interested in modern approaches and could not be seen to allow old ways and traditional practices to continue. However the lifespan of the organisation was relatively short. It set up performance initiatives which were implemented by Strategic Health Authorities.

Health Authorities/Strategic Health Authorities. Health Authorities were the forerunners to Strategic Health Authorities; their role was to lead the planning and development of local services. Health Authorities' final accountability lay with ministers who had authority to curb their powers.⁸⁰ Strategic Health Authorities were formed in April 2002. Originally there were 28, but mergers reduced the number to ten in England. The new, larger Strategic Health Authorities (SHAs) were set up to develop strategies for the NHS, and to make sure their local NHS organisations were performing well. The new health authorities were responsible for developing plans for improving health services in their local area; making sure local health services were of a high quality and performing well; increasing the capacity of local health services to provide more services and ensure that national priorities, for example, programmes for improving cancer services, were integrated into local health service plans. A key link between the Department of Health and the NHS, they managed the NHS locally.

⁷⁸ Webster, C., (2002) p15-16

⁷⁹ Baggott, R., (2004) p174

⁸⁰ Baggott, R., (2004) p89

Primary Care is the first tier of care that an individual experiences in the local area. Primary care includes appointments with the family doctor (GP), dentist, optician, pharmacist or family planning clinic. In this level of primary care, NHS Walk-in Centres and NHS Direct are also recent additions to the service. The financial resources for the patients seen in primary care are funded by distinct organisations referred to as Primary Care Trusts. **Doctors/(General Practitioners) GPs** are independent businesses; the patients they see are funded through Primary Care Trusts. The formation of the NHS saw not only access to medical treatment universalised, but also the funding of GPs through the NHS rather than directly through their patients. Members of the public who previously were denied treatment because of their inadequate incomes could now freely access a GP, and those doctors who worked in the deprived boroughs did not have to rely on charities to supplement their income. As part of the modern NHS, GPs are usually the first port of call for members of the public if they feel unwell. They now provide local non-specialist advice and care working primarily in practices. These practices are getting bigger as they increase their provision of services.

Secondary care refers to hospital treatment which is available if a health problem cannot be resolved through primary care, or there is an emergency. This is done through a referral made by a GP who arranges treatment at a NHS hospital which provide acute and specialist services. Hospitals are managed by NHS Trusts, known as Acute Trusts or Foundation Trusts, which ensure that hospitals provide high quality healthcare and money is spent efficiently. Strategy for the development of hospital so that services improve is also decided by the Trust. Treatment at a hospital is free to British and EU citizens. Some hospitals were created in conjunction with universities and received some funds from their corresponding institutions. Other hospitals focused on specific diseases or types of patients, for example, “specialist services as diverse as rehabilitation, fractures, plastic surgery, neurology and psychiatry. The need for emergency action to introduce these services was itself a reflection of the backwardness of facilities for specialist treatment.”⁸¹ The introduction of the NHS and its pledge of universal coverage made the funding of healthcare for the first time a state responsibility.

Huge public expectations were originally encouraged in order to ensure that the public used the newly-created service. This is no longer a concern. The NHS is a mammoth beast; it not only devours cash but also generates new demands at increasing costs. The

⁸¹ Webster, C., (2002) p6

country has an increasing elderly population with associated healthcare requirements; there is a rise in complex cases and general demand on the NHS is growing and yet resources are finite. Unfortunately, the cost of new technological and medical developments has outpaced any significant savings the NHS could generate. This has left the current NHS serving a public where there is a mismatch between high expectations of speed and quality of care and that which the NHS can effectively deliver. Thus, the primary function of managerial roles in organisations has been to prioritise these conflicting demands while attempting to meet the needs of patients, staff and the public. The tensions first voiced in the early years by Bevan were repeated at the 60th anniversary of the NHS: “We shall never have all we need...Expectations will always exceed capacity. The service must always be changing, growing and improving - it must always appear inadequate.” As early as the 1950s it has been apparent that a financial treadmill had been created, and that politicians attempting to raise funds could not meet the public’s concept of adequacy. Originally conceived by Bevan to meet the needs of the nation’s health, the NHS has evolved into an institutional device for rationing resources.⁸² Consequently, the tensions of the early years endure; the question that needed answering then of ‘how best to organise and manage the NHS?’ remains as relevant a question today. Performance management as introduced by New Labour was seen as possible answer to this, in that it could contribute to producing public services that are more effective by improving productivity, introducing independent scrutiny and inspection and strengthening accountability.

2.4 Reform of the NHS

In contrast to the first half of this chapter which provided a short chronological history of the NHS as well as an organisational overview, this section looks at a number of significant reforms and ideas that facilitated the eventual proliferation of performance management under New Labour. The second half of this chapter focuses on the changing roles of trust and autonomy in the medical profession, the inadequacies of past regulatory bodies; an examination of New Public Management with regard to how the demarcation between managerial and professional work impacts on decision making; and the rising prominence given to governance and public accountability.⁸³ No single one of these reforms led to the development of the distinctive New Labour performance culture but, as a collective, they laid the foundations for its application and its initial wholesale acceptance.

⁸² Klein, R., (1995) p36

⁸³ Power, M., (1994b) p12

2.5 The role of trust: the medical profession and the NHS

It was George Bernard Shaw who wrote “They (professions) are all conspiracies against the laity; and I do not suggest that the medical conspiracy is either better or worse than the military conspiracy, the legal conspiracy, the sacerdotal conspiracy, the pedagogic conspiracy, the royal and aristocratic conspiracy, the literary and artistic conspiracy, and the innumerable industrial, commercial, and financial conspiracies, from the trade unions to the great exchanges, which make up the huge conflict which we call society. But it is less suspected.”⁸⁴ This lack of appropriate scepticism is not new; Shaw was writing in 1909. Nevertheless, blind faith towards the medical profession⁸⁵ has led to an ever-increasing number of scandals to hit the NHS.

The first scandal to hit the NHS under New Labour was at Alder Hey, Liverpool, 1998. Here the public learnt that Professor van Velzen had stripped the organs of babies who had died in the hospital between 1988-1996 without parental knowledge or consent. He also encouraged staff to falsify records and statistics. By 1999 the then Health Secretary initiated a review, which was published in March 2000, referring to the hospital and the university’s failure to supervise and performance manage the new unit⁸⁶. The second scandal was the at Bristol Royal Infirmary concerning the deaths of 29 babies between 1984 and 1995. During the inquiry, which began in 1998, the public discovered that parents of children undergoing complex heart surgery had been told that the procedures carried no risk, only to find this was not the case. The media was awash with reports of “old boys’” culture among doctors, and patients being kept in the dark about their treatment. The third scandal to rock the NHS was the Shipman case. Harold Shipman, a GP, was found guilty of 15 counts of murder on 31st January 2000; however, it is likely that he murdered 236 patients over a period of 24 years between 1974 and 1998. When sentencing him, judge Justice Forbes stated, “You took advantage of and grossly abused their trust. You were, after all, each victim’s doctor. I have little doubt that each of your victims smiled and thanked you as they submitted to your deadly ministrations.”⁸⁷

The three scandals raised two recurrent questions to the Blair government: “How could this happen?” and “How could such happenings go unnoticed for so long?” In the

⁸⁴ Shaw, G.B., (1909)

⁸⁵ Shapin suggests that moral equivalence of scientists is a development seen in the 20th Century and while Marx thought the status of scientists would decline in a capitalist society, this appears not to have happened, due to the marketisation of both science and medicine.

⁸⁶ The Royal Liverpool Children’s Inquiry: Summary & Recommendations, p10-11

<http://www.rlcinquiry.org.uk/download/sum.pdf>

⁸⁷ Whittle, B., & Ritchie, J., (2000)

inquiries that followed, attempts were made to answer these questions. The key findings in the Bristol Royal Infirmary Report were: “There were no standards for evaluating performance...imbalance of power, with too much control in the hands of too few individuals. Patients should be able to gain access to information about the relative performance of a hospital ...For the future there must be effective systems within hospitals to ensure that clinical performance is monitored.”⁸⁸ All three reports made similar statements and yet clinicians remained resistant to change, viewing the scandals as caused by the psychotic nature of individuals rather than failures of the system. However the Blair government, through the Department of Health, advocated the culture of performance to the public as means of avoiding such scandals and nullifying risks.

2.6 Autonomy within the medical profession

Occupations that are now considered professions, including doctors and surgeons, gained their status during the nineteenth century. Professional status was conferred on individuals by the gaining of a particular qualification. Here, qualification served two purposes: firstly, it established that those undertaking and completing specific exams had acquired a precise body of knowledge; secondly, a process by which through the curriculum entry to the occupation could be monitored and controlled. The Medical Act of 1858 led to the formation of what was to become the General Medical Council (GMC), requiring all medics to register with the council and giving itself control of their training. The Act created a unified profession; a lack of registration formed a clear divide, helping to foster professional exclusivity (similar to that of a gentlemen’s club) and solidarity between members.

This professional status acted as means of restricting the numbers, thereby enabling its members to command high salaries. Even today in England there are only 2.2 doctors to 1000 of population, one of the lowest rates in the E.U. The profession operated as a lobbying network discreetly pushing its members’ agenda in the political sphere. However, even from the early 1920s, there had been calls for general management to exist within the NHS, separate from the professional doctors and surgeons. These calls were dismissed, as they were perceived as a threat to professional control and autonomy. Here a distinction between what Elliot Freidson refers to as medical *dominance* and medical *autonomy* aids understanding of the status of clinicians in the NHS. “By dominance, he referred to the ability of physicians to direct and control other health care workers. By

⁸⁸ The Bristol Royal Infirmary Inquiry Final Report.
http://www.bristol-inquiry.org.uk/final_report/report/Summary2.htm

autonomy, he referred to the ability of physicians to exercise control the organisation in terms of its own work.”⁸⁹ Thus, while the medical professions remain dominant, their autonomy, since the inception of the NHS, has gradually declined.⁹⁰

The medical profession is not a single entity; there are numerous Royal Colleges to which doctors are affiliated. Like all professional bodies they protect their members’ interests, and operate under a middle class ethos of collegiality rather than the working class notions of competition. Professor Carol Black, President of the Royal College of Physicians, said of her organisation “It was previously organised as a gentlemen’s club, though significant changes have taken place in the last four years”⁹¹ What is surprising in this comment is the time factor. That an organisation such as the Royal College of Physicians exists as a gentlemen’s club well into the 21st century illustrates how far behind the medical profession is in terms of accountability and regulation.

Moran speaks of the demise of club government starting in the 1970s leading to the rise of a new British regulatory state.⁹² Government had previously been based on the ‘gentleman’s club’, a time of minimal accountability.⁹³ The language was that of the British ruling class, the elite. “The most obvious link is the connection of imperialism to social welfare reform, but empire provided much more: images of hierarchy to reinforce the domestic cultures of subjection; a stock of symbolic capital for governing elites; and a public language in which to express the country’s providential destiny.”⁹⁴ However, the following decades after the Second World War saw the images of empire, imperialism and the Commonwealth left behind as Globalisation and Europeanisation were seized upon as the new regulatory framework. The move away from club government was a constitutional revolution where the boundary between public and private shifted, moving a large number of previously public industries into private enterprises. But within the Health Service the change was slower as these old images were again imported, this time through the doctors and nurses recruited from Commonwealth countries. These new recruits reinforced and strengthened crumbling elites, fortifying old systems that in other areas of the public sector were fast disappearing.

⁸⁹ McDonnell, O., Lohan, M., Hyde, A., & Porter, S., (2009) p49

⁹⁰ McDonnell, O., Lohan, M., Hyde, A., & Porter, S., (2009) p49-50

⁹¹ 8 May 2006, LSE Health and Royal College of Physicians joint public lecture: Medicine as a profession: Challenges and solutions.

⁹² Moran, M., (2003)

⁹³ Moran, M., (2003) p3

⁹⁴ Moran, M., (2003) p11

Medical institutions like the Royal College of Physicians remained impervious to these reforms. There is now a strategic plan within the Royal College of Physicians that looks to champion the values of medical practice, improve the standards of clinical practice, support education and training and promote patient-centred care. It sets out the values that doctors remain committed to: integrity, compassion, altruism, continuous improvement, excellence, partnership (NHS reforms will not be effective without politicians working with both doctors and managers) and finally, the essentially science-based nature of the work (no matter how much the softer skills are promoted e.g. communication). Nevertheless, the medical profession within the NHS has been slow to change its practices.

Roy Griffiths in his 1983 NHS Management Enquiry Paper⁹⁵ proposed that care and money should follow patients, as patients want a service which is local to them, ideally being treated at home or at their local GP practice. However, it was not until 2005 under the New Labour government with ‘*Creating a Patient Led NHS: Delivery of the NHS Improvement Plan*,’ that we see this idea, originally articulated under Thatcher, beginning to be adopted. Previously doctors opposed it and, without professional engagement and support, it was impossible to implement many of the Griffiths reforms. The medical profession via the Royal Colleges had the ability to resist change, public demands, and government reforms. This may have served its interests in the past but I doubt that this approach will be as effective in the future, as the assumption that ‘Doctor knows best’ is being challenged. “Doctors under 30 are 3.5 times as likely (as those over the age of 30) to think of medicine as ‘a job like any other’”⁹⁶. This being so, it is possible that the coming generation of doctors will recognise, like other professions, that autonomy and accountability (assurance) can be complementary and counterpoised rather than opposing.

2.7 The New Public Management

By the 1980s, several bodies such as the British Medical Association as well as the 1983 Griffiths Report were endorsing managerialisation of the NHS. This gave such calls both weight and legitimacy, matching the political Conservative thinking of the day, which was that the public sector had to be brought under control as the system appeared to provide no natural restraint. Public sector organizations were inefficient because they existed outside the market; therefore, it was necessary to introduce market-promoting competition to drive out complacency. New Public Management was an attempt to mitigate these inefficiencies

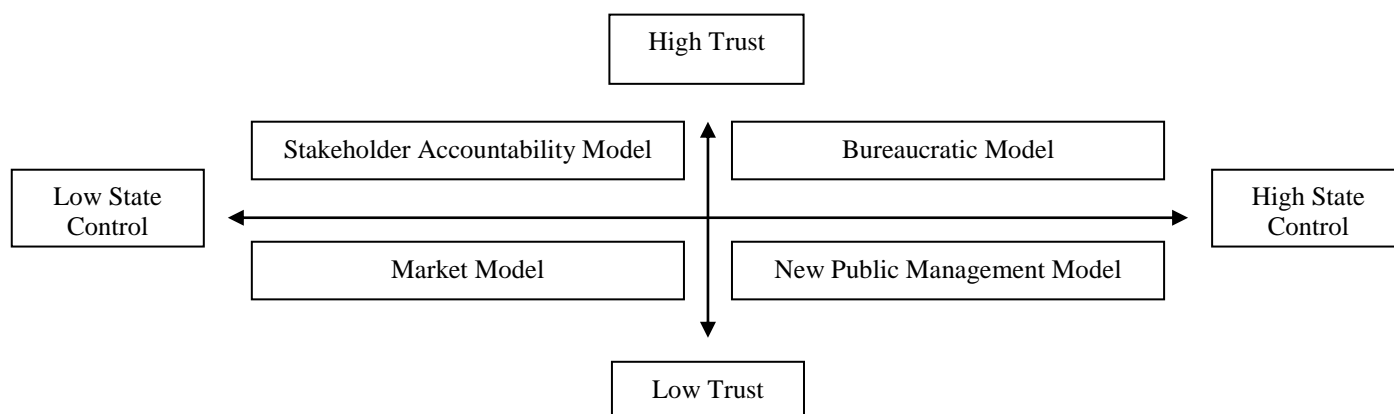
⁹⁵ Griffiths, R.,(1983)

⁹⁶ BMA Survey on Core Values for the Medical Profession in the 21st Century (1995).

through the establishment of a general management function which would “provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach.”⁹⁷

The New Public Management had huge impact not just on provision of services within the NHS but also on its organisational structure, in particular the necessary role management had to play in dismantling established, over-centralised, bureaucracy.

Models of Accountability



The diagram above shows the NHS’s move away from a Bureaucratic model style of management to the New Public Management model.⁹⁸ These management changes which began in 1983 had profound consequences, one of which altered the decision making process, while the autonomy of medical and nursing professionals as well as their representative bodies would be curtailed.

During this period the widely held assumption by cabinet politicians was that managers and professionals fell into two distinct groups, and similarly the work they undertook was also separate. Managers create and maintain bureaucracies, applying rules and concerning themselves with the minutiae of regulations ensuring that these are upheld; their knowledge increases as their experience of bureaucracies’ intricacies deepens. This world view is one where managers’ power and authority resides in their position in the wider organizational hierarchy and their ability to network, play the system, and be aware of the political manoeuvrings of all agents within their organization. Therefore, it is one which they look to maintain and are resistant to change, in particular change that involves structural reorganisation as it undermines their authority and is a threat to the status quo. Managers are thought of as conformist, self-interested and career-motivated. Compare

⁹⁷ Ham, C., (2004) p33

⁹⁸ Baggott, R., (2004), p56-57

this then to assumptions made about professionals. These creative, altruistic individuals are dedicated to offering expert services and advice. Their motivation lies in their ethical commitment to their expertise, or at least to their profession as a way of securing status and privilege and, most importantly, the power and authority derived from the specialist knowledge they hold is not confined to a specific organisation. They are seen as being more independent, championing those that they serve. The table below illustrates clearly the common distinctions made between managers and professionals. However, “we must be cautious about the assumptions of an inherent and inevitable contraction between bureaucratic authority and professional autonomy.”⁹⁹

Ideal type contradictions: managerial/ professional ¹⁰⁰

	Managerialism	Professionalism
Sources of legitimacy	Hierarchical authority	Expertise
Goals/objectives	Efficiency/ profit maximization	Effectiveness/ technical competence
Mode of control	Rules/compliance	Trust / dependency
Clients	Corporate	Individuals
Reference group	Bureaucratic superiors	Professional peers
Regulation	Hierarchical	Collegial/ self regulation

In the later chapter on stigma I will illustrate how these ideal types have been absorbed into the culture of the NHS and how language has been appropriated by performance management as means of both reinforcing and undermining these contradictions. From inside the NHS, the first step towards managerialisation was greeted with caution but there was an inherent belief that good and appropriate management would deliver real change. Medical and nursing professionals within the NHS had always been expected to carry out managerial tasks; to an extent this was one way in which they have furthered their careers and moved up the professional ladder. However, the idea of a new exclusive managerial layer was not seen as a threat but rather an opportunity. The new managers, it was hoped, would help lighten the workload of clinicians; there was a sense of compromise, a belief that collaborative working between the two groups would benefit medical professionals allowing them to learn new skills/ techniques within their field as well as spending more time with patients.

⁹⁹ Flynn, R., (1991) p41

¹⁰⁰ Exworthy, M., and Hal, S., ed. (1999) p25

2.8 Management as a new type of work

The public and central Thatcher government both censured public services, including the NHS, for being inflexible, unwieldy organizations unresponsive to the public needs. Only those who worked for these establishments appeared to receive any benefit. In discussions of managerialisation from the 1980s, it is apparent that participants made a clear distinction between old and new management. Old managers were characterized as bureaucratic pen-pushers, conformist and dogmatic in their approach. In contrast, new managers were seen as innovative, creative and empowering to organizations and crucially as ‘policy entrepreneurs’. The health sector reforms had the intended effect of making all staff entrepreneurs. This proved to be a far more effective form of control than is possible with explicit and open conflict, (as seen with disputes amongst teaching unions). The entrepreneurial spirit was a Thatcherite ideal as one might expect from a greengrocer’s daughter who had risen to become Prime Minister.

Throughout the scandals of the 1990s, the medical establishment continued to sustain high levels of respect from the public, higher than most professions, possibly because their job as a service has at its core the value of human life. By comparison, other professions deal with the material or seemingly mundane. In spite of this, doubts were beginning to be raised as to the role the medical establishment played in keeping its failings out of the public arena. “One of the major sources of inefficiency in the NHS is that the medical profession is not only exceptionally powerful but also internally divided, so that the provision of medical services is often decided by a power struggle between groupings whose representations hide their pursuit of vested interests behind what the outsider called ‘a mumbo jumbo about clinical acceptability.’”¹⁰¹

The medical profession maintains a privileged position; it retains its professional autonomy, that is, it has a degree of autonomy seen by few other professions, and it preserves professional dominance through controlling the activities of other healthcare staff.¹⁰² The birth of the NHS saw a bargain with the medical profession: it would retain its power and status; in exchange the State would gain a comprehensive health care system.¹⁰³ The medical profession’s influence has barely waned in the decades that have followed. Its influence also extends to public opinion and it can bring to bear tremendous pressure on government to the extent that the government could not afford to ignore it.

¹⁰¹ Ashmore, M., *et al*, (1989), p35

¹⁰² Flynn, R., (1991) p45

¹⁰³ Moran, M., (1999)

The government recognised that it was necessary to make a distinction between respect and authority if the NHS as a larger organisation was to maintain credibility and influence. It is against this background that the government published the NHS Plan in July 2000.

The NHS Plan was in many ways a radical document. It stated that the NHS had failed to keep pace with change in society and must modernise to meet public expectations, reshaping itself from patients' perspectives. The government set the NHS 5 challenges: partnership, performance, profession and workforce, patient care and prevention.¹⁰⁴ That performance should be on the agenda at all was surprising; that it should be so high up the agenda was shocking. This idea of performance was new to the NHS; it was one where, data, information and knowledge were freely available to both patients and the public. Moreover, the information was there for them to ascertain the performance of clinicians, Trusts and the NHS as a whole. The perception was that the medical establishment, the wider NHS and the government, were no longer authorities whose expertise could go unquestioned. No longer was information solely for internal NHS purposes. The public had been deemed fit to judge. They had ceased to play the child/pupil in a parent/child, pupil/teacher relationship.

2.9 Notions of Governance

The NHS does not have shareholders, in the way other businesses do. However, stakeholders, those with a vested interest (often patient groups), and government on behalf of taxpayers, have demanded that the NHS as an organisation provides more accountability and transparency. Measuring the effectiveness of an HR Department, for example, does not fall into traditional financial reporting. Nevertheless, there is a need to track its performance and actively measure the performance of such departments, in order to justify initiatives and provide confidence to the public. There is also a need to monitor and measure clinical outcomes in terms of quality and levels against set standards.

Traditionally, within PCTs, issues of quality (defined by Lord Ara Darzi, “as clinically effective, personal and safe”¹⁰⁵) have organisationally fallen under ‘Governance’, which is separate from performance, with the Chief Executive having lead responsibility. Governance is another area that has been pushed up the political agenda. New Labour sought a shift in culture which saw the replacement of anachronistic systems of governance based on trust and tacit agreements by modern modes of regulation which

¹⁰⁴ Department of Health (2000)

¹⁰⁵ Department of Health (2008) p8-9

included include standard setting and audit. “In light of the Shipman Inquiry, we will strengthen clinical governance in the NHS to ensure that professional activity is fully accountable to patients, their families and the wider public.”¹⁰⁶ Effective clinical governance refers to “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”¹⁰⁷ From 1997, clinical governance was central to modernisation within the NHS.¹⁰⁸ This concept is now embedded in all services across the Trusts to support continual quality improvement in new and existing services. For example in the PCT where I carried out my ethnographic research, an Integrated Governance Committee was set up to deliver the ‘*National Standards Local Action*’, which was a key planning framework from the Department of Health.

The document ‘*National Standards Local Action*,’ set out seven domains including: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. In each of these domains a range of quality standards must be achieved. Each PCT is assessed on the degree to which they have met these core standards: fully met, almost met, partly met and not met. The rating achieved directly affects the overall rating gained by each Trust. The introduction of *National Standards Local Action* had huge implications for performance, as it changed the performance management role. On an organisational chart, performance sat under finance, because of its historical roots with cost savings. However, with numerous targets looking at the quality of care patients receive, for example the introduction of counting the number of MRSA cases, there were discussions to move performance to the Quality and Governance directorate. Nevertheless, there is a difference between ‘measuring and monitoring’ and governing: governing implies a form of intervention. Performance management then ceases to be exclusively about efficiency, economy, and effectiveness; it is also about public accountability.

2.10 Performance management: a tool for increased accountability?

Performance management, New Labour hoped, would create a culture of openness where scientific research could flourish, where best practice would be celebrated and areas of

¹⁰⁶ Labour manifesto (2005) p60

¹⁰⁷ Scally G., Donaldson L.J., (1998) “Clinical Governance and the drive for quality improvement in the new NHS in England” *BMJ* 1998; 317:61-65

¹⁰⁸ Department of Health (1997)

concern highlighted.¹⁰⁹ How successful it has been is part of this discussion. The public are increasingly sceptical about those working in NHS management and accuse politicians of hiding behind numbers. Current public opinion is that the NHS has become target-driven¹¹⁰, with management creating a tick-box culture and where clinicians are prevented from doing real work through endless bureaucracy. This contrasts with health economists' view of the NHS as singularly inefficient, and therefore irrational, organization unduly weighted in favour of the medical provision at the expense of administrative services.¹¹¹ The following quotation is from a health economist in 1989, referring to Nigel Crisp, then the Chairman of a local health authority who became the head of the NHS from 2000 to 2006¹¹². "The NHS is grossly under-administrated. The government proudly says they only spend 4% on administration....there is no routine information that a firm would normally use in managing an enterprise. The chairman of the local health authority is a guy from Rowntree Mackintosh. He is absolutely appalled. He is used to knowing the price of a bag of Smarties and all that sort of thing. He rolls into this place; he has never done anything in the health service before, and is absolutely amazed that nobody knows anything. They have not got any cost data; they have not got much activity data; the planning is in its infancy".¹¹³ This illustrates how the man who would become Chief Executive of the NHS under New Labour, having previously worked in private industry, expected to have figures at his fingertips on all types of activity and felt at a loss in the NHS during the 1980s where this was scarce. He addressed this concern; his leadership of the NHS would be one where performance provided the State with data and the public with greater information.

Progress was made under New Labour in augmenting the NHS workforce, including a proliferation of professional managers who were appointed to fill the gaps in information and knowledge. Nonetheless, John Reid, MP, Secretary for Health (2003-2005) still sounded defensive when talking about non-clinical staff: "The 'snapshot' census figures exploded the myth that everyone working in NHS was a bureaucrat, with 84 per cent of NHS staff directly involved in patient care and managers only making up three percent of the workforce."¹¹⁴ The Labour manifesto went further, making a commitment to cut NHS

¹⁰⁹ Crisp, N., (2011)

¹¹⁰ Picker Institute Annual Review (2005/6) "Being treated like a person not a number, that's what counts for me."

¹¹¹ Ashmore, M., *et al*, (1989) p34

¹¹² Sir Nigel Crisp stood down, in March 2006, as chief executive of the National Health Service, taking early retirement.

¹¹³ Ashmore, M., *et al*, (1989) p32

¹¹⁴ Reid, J., 'The Times', 20/03/04

management and administrative costs by 2.5%: “By strengthening accountability and cutting bureaucracy we shall ensure that new investment is not squandered. We are decreasing the numbers of staff in the Department of Health by a third and are halving the number of quangos - freeing up £500 million for frontline staff.”¹¹⁵ The government was defensive owing to the low opinion held by NHS staff and the public of published information. Those working within the NHS are suspicious of statistics, having some idea of how they are formulated and being aware that the data does not always provide an accurate reflection of NHS life. As Michael Power points out, “The audit society is a society that endangers itself because it invests too heavily in the shallow rituals of verification at the expense of other forms of organisational intelligence.”¹¹⁶ In addition, the public has grown cynical as figures are constantly thrown about to bolster the government position.

The Labour government was proud of its financial investment in the NHS, particularly as most of that investment has gone on clinical staff, something that appeals to the public. “Spending on the NHS has more than doubled (from 1997) to £69 billion. The NHS now has 79,000 more nurses and over 27,000 more doctors.”¹¹⁷ Public perception was that services such as the NHS were safe under Labour in part because of their manifesto pledge: “We promised to revive the NHS; we have. In our third term we will make the NHS safe for a generation.”¹¹⁸ The sweeping success in the 1997 election was partly based on its strong support of public services particularly the NHS, but how accurate is this assessment? Is this a misguided belief based on historical tradition that is no longer valid? The last decade has seen the NHS under increasing pressure to function more efficiently, provide better services and operate in an economically sustainable manner, while ensuring any changes implemented do not detrimentally affect the overall clinical quality of care. Growing regulatory demands and stakeholder expectations add further financial pressure.

2.11 The role of regulatory bodies vs. performance management as a regulatory instrument

Regulation has been a feature of the state for far longer in the US than in Britain. In the US, the regulatory state was embedded in its structure in three phases: 1) the progressive economy 2) the New Deal and 3) social regulation in the 1960s, far earlier than anything

¹¹⁵ Labour (2005) p60

¹¹⁶ Power, M., (1997) p123

¹¹⁷ Labour manifesto (2005) p11

¹¹⁸ Labour manifesto (2005) p56

similar in Britain.¹¹⁹ Firstly, the progressive economy is ‘neutral state,’ that is it is sympathetic to business but guided by legal impartiality, for example the Food and Drugs Administration and Federal Reserve Board. Secondly, The New Deal’s purpose was to create an environment where competition could flourish, redressing market failures, particularly its failure to police entry ensuring fraudsters are excluded and guaranteeing honest and fair trade. Thirdly, the 1960s social regulation created agencies that were not specific to one industry but encompassed the whole economy, e.g. Environmental Protection Agency.¹²⁰ The introduction of these policies results in US risk assessment and management, which is both comprehensive and rigorous. This is further aided by the litigious US culture; it is an environment that promotes public discussion of an adversarial nature.¹²¹ The continuous internal questioning generates a system that is genuinely more robust.

The regulatory state in Europe has three key functions: redistribution, stabilization and regulation.¹²² However, its corresponding public bodies (e.g. HCC, NICE) in Britain have been unable to prevent or deal effectively with the repercussions of highly publicised crises. It is worth noting that funding towards regulatory bodies is neither continued nor sustained. The HCC and the National Audit Commission have, year on year, received less funding irrespective of increased calls by the public for independent regulators to have more power and authority. The regulatory state’s focus is on risk because of a heightened awareness in the public consciousness.¹²³ Risk has not increased, but public knowledge of its existence has. This awareness is based on increased discussion within the media - discussion that leads to a demand for action against possibly dire consequences. In an open society, traditional elites hold insufficient influence over the issues within risk debates and the agendas set are beyond their control. “Regulation is the response to the new instinctive reaction that ‘something ought to be done about it.’”¹²⁴ Panics, scares, alerts are not necessarily rational responses to the real risk posed, but rather a way in which government can demonstrate to the public that it is acting on their concerns. This change in response is more acutely felt in Britain because of the nature of government and the previous form of rule, which still makes its presence felt.

¹¹⁹ Moran, M., (2003) p14

¹²⁰ Moran, M., (2003) p15

¹²¹ Moran, M., (2003) p16

¹²² Moran, M., (2003) p17

¹²³ Power, M., (1994b) p5

¹²⁴ Moran, M., (2003) p26

In 19th century Britain, professional status had an element of social closure, particular features of which were the opposite of what is necessary to a regulatory state: openness, lack of secrecy and co-operation. These features persist to the current day and are not seen to the same degree within the American system. The proliferation of public panics within Britain is a possible symptom of the demise of club government¹²⁵, the shift from oligarchy to pluralist democracy, but that risk management often employs remanagerialisation as a technique to deal with these crises illustrates how crumbling old elites attempt to reassert their control.¹²⁶ Management appropriate professional clinicians such as doctors, making it more difficult for other doctors to challenge decisions made, as they would find themselves questioning the judgment of colleagues with the same knowledge and expertise. This explains why managers would seek to employ doctors in management positions but not why doctors would chose such a role. The answer lies in the fact that doctors are able to re-claim their lost authority and autonomy and re-assert their own agendas, their own morality. The importance of this is that professionals and public often express competing values with reference to accountability. Therefore, the history of performance management in the NHS is a story not just about monitoring, auditing and regulation; it is the story of how old medical elites have responded to and dealt with its introduction

Two major political upheavals have affected the British government and its wider institutions: firstly, Britain's entry into the European Union in 1973 and, secondly, the constitutional reforms made by the 1997 Labour government. These upheavals saw the two connected phases of stagnation and hyper-innovation, which were produced by a crisis in the governing order. The crisis came about because of the continued failures of economic policy but more importantly, yet less publicised, because of the failures of the system of rule. The degree to which these two failures are intertwined goes some way to explaining the force of the cultural change. The economic policy crisis occurred during the mid-1970s whereas the institutional crisis, which saw a clash between professional self-regulation and club government, occurred between the 1970s and 1990s. It was the regulatory state which triumphed: it was "immensely superior."¹²⁷ The regulatory state "by any of the standards by which we might expect to judge economic government in liberal democracy - accountability, transparency, plurality of representation -" ¹²⁸ appeared modern and open. Club government and self-regulation had come to be seen as

¹²⁵ Moran, M., (2003) p4

¹²⁶ Moran, M., (2003)

¹²⁷ Moran, M., (2003) p116

¹²⁸ Moran, M., (2003) p116

ineffective and inadequate, and, by the time New Labour assumed government, this perception allowed them to introduce new forms of regulation with relative ease. Within the health service an independent regulator for the NHS was established under the 1999 Health Act. It was initially known as Commission for Health Improvement (CHI) and came into being in 2001. This body would take on many names and guises, going on to become known as the Healthcare Commission (HCC) while its legal title was the Commission for Healthcare Audit and Inspection (CHAI) (2004-2009). The addition of the words ‘audit’ and ‘inspection’ were significant, as they highlighted the new mechanisms and techniques of regulation New Labour sought to apply to the NHS; they are discussed further when looking at the work of Michael Power in the following chapter. The most recent incarnation of the health regulator is as Care Quality Commission (CQC) (2009- present).

During the 1980s, Thatcher’s ideas - Efficiency, Economy, and Effectiveness - led to the creation of performance management and the mass production of performance indicators (PIs).¹²⁹ Performance indicators have been and continue to be a fundamental component in US healthcare; this is primarily because it is an insurance-based system. Information has been central to its working since its conception. Information has inevitably led to comparative judgements and the costing of every aspect of care has become an intrinsic part of that process. Earlier in this chapter the principles on which the NHS was formed were adduced, the most pertinent being that universal healthcare should be free at the point of delivery. Taxation is the basis for the funding the NHS; therefore ensuring value for money and minimum waste is the government’s responsibility, not that of private health insurance companies. It has been shown how the NHS changed through New Public Management under the Conservatives; we see there the precursor to performance management that would be further advanced under New Labour. The complete trust in the medical profession and the NHS which prevailed at its inception has declined; reforms to renew the NHS have to a degree curtailed the autonomy of the medical profession. There has been a transformation in the nature of work, as well as new types of work being undertaken by the NHS, including the introduction of clinical governance and the use of performance management as a means of strengthening public accountability. However, only after the election success of New Labour in 1997 was performance management pushed to the top of both the NHS and political agendas. Professionals in a true representative democracy undertake well-defined tasks within strictly defined objectives,

¹²⁹ Klein, R., (1995) p139

as is often demanded of employees within private industry. However, this was impossible to impose as the NHS still had significant areas of self-regulation. Nevertheless, the change in how the NHS was managed has been inevitable because of the parallel change in culture described earlier. Furthermore, the scandals of the 1990s provided Tony Blair with further justification for pushing this new performance strategy. While New Labour oversaw the introduction of regulatory bodies into healthcare, this happened simultaneously alongside the proliferation of performance as a regulatory instrument. The imperatives and drivers that saw performance become associated with ideas of modernisation and progress meant that it became central to New Labour's system of rule and style of management. This will be demonstrated in the following chapters.

Chapter 3

Theoretical Background

3.1 Overview

The previous chapter provided an overview of the NHS, the forces that led to its creation as well as key reforms under successive governments which pushed performance to the centre of management culture within the NHS. This is relevant to my discussion if a real understanding of how the NHS is now run is to be gained; it will provide context to the current changes and prevent me from falling into the trap of thinking I necessarily know better; “gaining some historical perspective should be sobering and enlightening experience. Such experience should turn us away from ‘quick fix strategies based solely upon an interpretation of current conditions.’”¹³⁰ I provided a brief history of the NHS in the previous chapters. In this chapter I build on this by discussing authors whose work was relevant to my research, though they may not have directly or explicitly spoken about the NHS. Here my expertise and experience in the NHS will provide the reader with clear links between their work and mine, how their thoughts on specific issues has informed my research. This background knowledge, this orienting theory, helps me recognise which particular phenomena are important and where I should focus the attention of my study.

3.2 Bureaucratic regimes and their effects

The NHS is a vast bureaucracy and performance management has become central to the operation of this bureaucracy (see Chapter Two) so it is necessary to understand the nature of bureaucracy itself. Bureaucratic organization is, according to Weber, what defines modernity and pervades the modern era. As a form of administration, it surpasses all that came before it. It is technically superior when compared with other forms of organisation in its “precision, despatch, clarity, familiarity with documents, continuity, discretion, uniformity, rigid subordination, savings in friction and in material and person costs.”¹³¹ Its

¹³⁰ Whyte, W.F., (1984) p161

¹³¹ Runciman, W.G., ed. (1996) p350

success is marked by its ability to generate large-scale results, while losses are avoided or at least minimized. Rationalisation is the process of achieving more for less effort.¹³² As will be evidenced throughout my research, this idea of rationalisation had huge appeal for both governments and senior management in the NHS.

Modernity sees the rise of rationalization in all aspects of society. This includes the political, administrative, and economic arenas. Thus, the bedrock to the rational State is the rationalisation of procedure.¹³³ One aspect of rationalisation is quantification. “The spread of quantification also corresponds to a reconfiguration of expert knowledge and stimulates projects of professionalization.”¹³⁴ Quantification counts and measures all variables. The statistician Karl Pearson exemplifies the idea that quantification can be applied to all aspects of life, including government and administration, providing rigour and a reasoned approach which had previously been missing in these areas.¹³⁵ Both the economy and technology are wheels in the engine of bureaucratisation. The rational State sees bureaucratic conditions take hold: organisations are large scale, there is a strict hierarchy and order in place, and rules govern actions, with decisions based on a rational set of principles. In this respect, a bureaucracy can be defined as a centrally-coordinated system where administration is rationalised. Within this, individuals work on specific structured areas gaining a specific expertise. Qualifications, rather than fulfilling a set criteria, are what lead to an appointment.¹³⁶ This bureaucratic coordination of the actions of large numbers of people has become the dominant structural feature of modern forms of organization.

However, bureaucracy as a system is not without its drawbacks. The aspects of it that make it successful, such as its size and scale, may also make it cumbersome. It can become a vast monolith. Those who work within it are small cogs in a large machine and outsiders who encounter bureaucracies can feel as if they are on a production line conveyor belt. The by-product of bureaucratization is the overwhelming sense of depersonalization, it “dehumanises itself...the exclusion from the conduct of official business ...of purely personal sentiment (and instead is) manned by the expert, who is all

¹³² “There apparently being no consensually identified textual sites to which all committed Weberians can turn in order to learn what he meant by the set of related events we call ‘rationalisation.’” Turner, S., (2000) p52

¹³³ Weber, M., (1983) p150

¹³⁴ Power, M., (1994) p10

¹³⁵ Porter, T. M., (1996) p20

¹³⁶ Runciman, W.G., ed. (1996) p351

the more indifferent in human terms, and so all the more completely objective.”¹³⁷ Rationalisation and bureaucratisation are linked; as one increases so too does the other. Weber argues that the more embedded the bureaucracy, the greater the level of depersonalisation.

Weber's views are not dissimilar to Marx's notion of alienation and the way in which this manifests itself through the process of commodification. Within Marxist literature, much has been written about the idea of commodification, the notion that monetary value can be allocated to a thing or process, previously not considered in such terms, which can therefore now be traded in a market economy. The good life, such as an individual's health, is one such area which now has a fiscal value attached to it. There is calculability to decision-making; illnesses are coded and costed and outcomes are measured not only in clinical terms but also on a financial basis. What cannot be measured, qualities such as compassion, caring and kindness, by their absence cease to be important. This lack of clear visibility in a list of performance indicators means these values are no longer viewed as an immediate priority. Marx recognised as equally important several other aspects of commodification, which is worth noting. Commodification leads to an abstraction, a generalisation in order to produce a product which holds universal appeal. The societal bonds that go to its creation are no longer clearly apparent.¹³⁸ The labour undertaken as part of commodification leads to the loss of ownership and accountability as relationships become more impersonal and take on a corporate identity. The NHS which has become the purveyor of services illustrates this, and also displays the corresponding shift to performance management business process where seeking patient/consumer satisfaction is paramount.

Marx and Weber recognize that depersonalised work is a tyranny in itself. The constant need for increased effectiveness and efficiency can be damaging not only to the individual but also to the society it seeks to further. Contrary to expectations, increasing rationalisation and the bureaucratisation of all aspects of life ceases to be a civilising force. My findings support this theory and are elucidated in the chapter on Stigma. This provides evidence that, contrary to intuition and mainstream viewpoint, on-going rationalisation of structures within organisations was not always the most appropriate way of running effective organisations. Rationalisation can be counterproductive as networks of relationships become narrower, insular, inflexible and sometimes collapse. Work in

¹³⁷ Runciman, W.G., ed. (1996) p351

¹³⁸ McLellan, D., ed. (1997) p435-436

modern society is becoming depersonalised as more recent studies focusing on the changing nature of work undertaken by professionals have shown.

Foucault, while not dealing with the idea of bureaucracy directly, covers many of its aspects in his book 'Discipline and Punish'.¹³⁹ It details the shift from death through torture to the establishment of prisons. Foucault does not favour one over the other. Rather his work shatters the myth that prisons are a means of deterrent. Prisons act as a form of both punishment and control and seeks to re-establish the law as sacrosanct. Discipline is "a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology."¹⁴⁰ Within prisons, a strict regime of discipline is imposed. Moreover, the panoptican approach of control and surveillance is an intrinsic part of modern management. As he states, "our society is one not of spectacle but of surveillance....We are neither in the amphitheatre, nor on the stage, but in the panoptic machine, invested by its effects of power, which we bring to ourselves since we are a part of its mechanism."¹⁴¹ Foucault widened the context of his work by applying the regulatory regimes of disciplinary power seen in prisons to schools, factories and hospitals. The prison, its structure, management and use of technologies is metaphor for how modern society is run. At the same time that hierarchical power has declined, local systemic power has increased.

When discussing the medical profession,¹⁴² Foucault's focus is on the clinic and what he refers to as the clinical gaze. Observation is the essence of the clinical gaze; it is a form of surveillance. It is silent, gestureless and uninterrupted, seeking out the essential as it records and totalises before reaching an impartial objective judgement.¹⁴³ As Foucault argues, "the clinical gaze has the paradoxical ability to hear a language as soon as it perceives a spectacle",¹⁴⁴ meaning that every symptom is considered a potential sign, a diagnostic.¹⁴⁵ The establishment of 'clinics' or hospitals advanced a new type of medical approach, one based around clinical systematic observation by doctors who were the experts and controlling agency. It saw them undertake physical examinations of docile and passive patients. This new way of knowing, clinical expertise, was only possible

¹³⁹ Foucault, M., (1991)

¹⁴⁰ Foucault, M., (1991) p215

¹⁴¹ Foucault, M., (1991) p217

¹⁴² Foucault, M., (1989)

¹⁴³ Foucault, M., (1898) pp107, 121

¹⁴⁴ Foucault, M., (1898) 108

¹⁴⁵ Foucault, M., (1898) 159

because of new technologies, tools, instruments and altered spaces. It aided and characterised this type of behaviour and saw persons become categorised to suit the emerging professions within medicine. Doctors compartmentalised disorders, experts diagnosed diseases and in so doing the body was disaggregated.¹⁴⁶ The ‘clinic’, hospital, engenders a new type of individual, ‘the active patient’. This is a person who understands and acknowledges the value of self-assessing and self-observing techniques. Moreover, this is the norm; as such, they monitor their body and lifestyle for signs and symptoms of abnormality without real conscious thought. Good health is no longer a personal affair but a societal duty. Individuals are not concerned with the salvation of their soul; this has been superseded by wellbeing. Health has greater status now than ever before. Therefore a responsible citizen is one who recognises the need to safeguard, control and care for one’s health.¹⁴⁷ Medicalisation of everyday life sees individual citizens complying with minimal outside intervention. This system of self-surveillance is internalised such that individuals become their own overseer. Originally discussed with reference to the disciplinary power and with regard to prisoners, the panopticon is now reproduced in a medical setting.

More recent interpretations of rationalisation and surveillance have been put forward by Scott and Ritzer. Scott in his book “Seeing like a State” describes different examples of rationalisation such as a forest in Germany and cities in India and Brazil. The book is concerned with efforts made to ‘read’ both nature and society. Statecraft is the process by which the state imposes a system of simplification of structure, in order to make circumstances and situations more legible.¹⁴⁸ In so doing administrations and bureaucratic processes mistakenly assume a map is not just a representation of a landscape but the terrain itself,¹⁴⁹ that is, holding as real only that which has been codified and counted. Parameters are created through the process of rationalising and standardising; anything which falls outside this is considered valueless. Scott begins “Seeing Like a State” with the example of German ‘scientific’ forestry as applied in the 18th and 19th Centuries. Scientific forestry established ordered and regimented planting systems, usually a single crop of Norway Spruce or Scotch pine. Other elements of the forest were considered worthless. Profit was the bottom-line and balance sheets make appropriate record of this. Monetary value assigned to commodity was reflected in the language defining what was

¹⁴⁶ McNay, L., (1994) p50

¹⁴⁷ Beck – Gernsheim, E., ‘Health & Responsibility: from Social Change to Technological Change and Vice Versa’ eds. Adam, B, Beck, U., & Van Loon J., (2000) p124

¹⁴⁸ Scott, J. C., (1998) p3

¹⁴⁹ Scott, J. C., (1998) p3

of worth and what was worthless. Hence valuable trees were regarded as ‘timber’ in contrast to ‘underbrush’; crops fought against weeds and pests.¹⁵⁰ At first easy money was to be had by the forest owners, as the more valuable trees were harvested.¹⁵¹ The focus on one commodity allowed codification, measurement and rigorous discipline that would have otherwise been impossible. However, over time the lack of biodiversity, the narrowing species and the loss of little understood symbiotic relationships, were an ecological catastrophe and had a huge negative impact on the overall productivity of the forest. All trees were the same age and same species and experienced weather threats such as severe snow or storms in a similar fashion. This was an environmental disaster as trees fell down like bowling pins. While the removal of underbrush simplified the working life of foresters, the disappearance of the forest floor weakened the overall forest. Moreover, particular pests and predators thrived in the newly created monocultures and reached epidemic proportions. Huge amounts were then spent on insecticides, fungicides and fertilisers in an attempt to make up for these failings. This whole process culminated in the death of the forest. Germans refer to this as *Waldsterben*.¹⁵² My case study of the health policy initiative “18 weeks” introduced by New Labour makes similar claims, of simplification and streamlining. This will be evidenced in the chapter on rationalisation, particularly in the section on tabularisation.

Scott goes on to examine what he refers to as ‘high modernism,’ an example of which is the utopian planned cities. Here large scale schemes of development placed value on rational design, social order and human improvement. Science and technology were employed to impose the state’s vision of a well-run and efficient city. This ideology is illustrated by the architectural work of Le Corbusier. Primarily, Le Corbusier saw the city as a workshop for production, a place where human needs were met in order for the city to be at its most productive.¹⁵³ One example cited by Scott is Le Corbusier’s design of Chandigarh. Chandigarh, the new capital of Punjab, was a city built from scratch, a planned city organised into separate sectors through the use of wide open spaces. The buildings within sectors were uniform with little variation. Order was considered a precondition to efficiency; therefore there was a greater use of geometric lines, grids and a simplification of structures. Vast squares were created for public space; however the sheer scale and size made it both impersonal and disorientating to individuals. The crossings and corners, meeting places where people gathered previously were not incorporated into

¹⁵⁰ Scott, J. C., (1998) p14

¹⁵¹ Scott, J. C., (1998) p19

¹⁵² Scott, J. C., (1998) p20

¹⁵³ Scott, J. C., (1998) p115

this new planned vision.¹⁵⁴ Older cities that had adapted and grown with their residents were often labyrinth-like, in which side streets and roads converged to create mini-mazes. This contrasts with the new simplified planned cities which were organised, streamlined and highly rigid.

Both examples of “seeing like a state” share a vision of central control where change is imposed from above; it is bureaucratic by nature, seeking to standardise objects, processes and procedures. Central control creates a culture through which to rule, regulate and manage effectively from afar. It is an administrative world view and therefore it is not surprising that planned cities such as Chandigarh are administrative capitals. These are places where administrators reside and hence their city reinforces their vision of the future.¹⁵⁵ To an inhabitant or insider it is easy to understand and navigate oneself through the traditional system, but to an outsider, taking the perspective of high modernism things appear chaotic, disorganised and therefore dysfunctional. As Theodore Porter in his book “Trust in Numbers” states: “to measure for public purposes is rarely so simple as to apply a meter stick casually to an object....Adequate measurement clearly means disciplining people as well as standardising instruments and processes.”¹⁵⁶ Similarly, Scott uses these examples to illustrate how the loss of local knowledge can be devaluing and the assumption that the external perspective is correct is often invalid.

Modelling, simplification and generalizing are only conceptual tools. Ecological and societal relations are infinitely more complex to model accurately. More often than not planners, managers and bureaucrats make no attempt to understand the local conditions, instead working on the premise that they know better. The practical implicit knowledge gained through experience is disregarded. Scott refers to this as *metis*. *Metis* is a type of knowledge that is of the moment, temporarily defined, highly spatial. It is learnt knowledge which is local to its conditions and context. It is not explicit and therefore difficult to write or prove in line with positivistic imperial science.¹⁵⁷ Modernists question the existence and value of such knowledge. However to ignore it leads ultimately to the failure of these new regimes. The reductionist vision of society engenders docile minds as people who were once autonomous are now reliant on the expert’s advice. Weber noted the modern state is a bureaucratic state run on principles of instrumental rationality. Within a bureaucracy, statistics and measures are a key technology of power. The state

¹⁵⁴ Scott, J. C., (1998) p131

¹⁵⁵ Scott, J. C., (1998) p132

¹⁵⁶ Porter, T. M., (1996) p20

¹⁵⁷ Scott, J. C., (1998) pp311, 313

“sees” society through numbers and statistics with decisions and interventions being made accordingly; this process is one which remakes society.

Zygmunt Bauman also discusses the effects of rationalisation and bureaucracy. His work is important to my research as it illustrates how bureaucracy diminishes personal responsibility and increases the risk of behaviour that would otherwise be considered unacceptable. His work sheds light on how the Holocaust happened, how individuals were co-opted into committing mass atrocities. His argument is that rather than an aberration of modernity, the Holocaust is a symptom and a product of modernity. The Holocaust, he contends, could not have happened without the infrastructure and technological mindset that is a central feature of modernity - rational, planned, scientifically informed, expert, efficiently managed and co-ordinated.¹⁵⁸ Bauman claims the Holocaust “could merely have uncovered another face of the same modern society whose other, more familiar, face we so admire. And that the two faces are perfectly, comfortably attached to the same body. What we perhaps fear the most is that each of the two faces can no more exist without the other than can two sides of a coin.”¹⁵⁹ According to Bauman, characteristics of bureaucracy such as the apparatus of the state, governing organisations, the constant drive towards progress, the elevation of scientific method with its focus on rational thinking and personal detachment are all aspects of modernity which made the Holocaust so effective as a killing machine. As Bauman states “though engaged in mass murder on a gigantic scale, this vast bureaucratic apparatus showed concern for correct bureaucratic procedure, for the niceties of precise definition, for the minutiae of bureaucratic regulation, and the compliance with the law.”¹⁶⁰

Professionalism, effective administration and comprehensive documentation were central elements to the Holocaust. While most individuals would shun the use of brutality and not condone the killing of individuals, the State can sanction its citizens to use violence. It has the authority to call upon its citizens who may feel compelled to do so where they consider their values to be threatened. The State legitimises killing; individuals are free from guilt in the belief that their actions are obligatory and necessary.¹⁶¹ The aversion the individuals have to violence is set aside. They are prepared to be complicit in behaviour that they would otherwise consider abhorrent. Individuals are able to abdicate the consequences of their actions as responsibility lies with the next person in the chain of

¹⁵⁸ Bauman, Z., (2001) pp88-9

¹⁵⁹ Bauman, Z., (2001) p7

¹⁶⁰ Bauman, Z., (2001) p14

¹⁶¹ Bauman, Z., (2001) p245

command. It is this obsession with bureaucracy, where citizens are obliged to obey and there is pressure on individuals to conform and comply, which creates a moral detachment. Bauman looks at how the death penalty is implemented. Individuals talk about taking a professional approach to their job and the team in which they work. Bauman notes “all those people partake in the act of killing but no one is (or, rather, needs to feel) a killer. At no point is there but one trigger to be pulled by one finger.”¹⁶² What becomes apparent is the team effort enables all those in the team to say with a clear conscience they did not do it. Moreover, the division of labour further aids the sense of mental detachment as individuals are concerned only with their part in specific processes, happy to remain unaware of others’ precise functions. This distancing allows personal morality to be suspended with greater ease than if individuals had to scrutinise the behaviour of all participants and their impact on those participants. “Responsibility as Hannah Arendt observed is floating. And a floating responsibility is nobody’s responsibility.”¹⁶³

For Bauman the nation-state’s role is pivotal in forming the conditions that led to the Holocaust. The state has a monopoly on force and in the Holocaust we see its most brutal application. While modernity is considered a civilising force, it also created a place where the only acceptable form of violence is that employed by the state. Citizens are less likely to challenge or confront the authority of state organisations such as the police and armed forces. As Bauman states, “somewhere in the wings physical violence is stored - in quantities that put it effectively out of the control of ordinary members of society and endow it with irresistible power to suppress unauthorised outbursts of violence.”¹⁶⁴ The bureaucratic machine ensured processes were carried out with scientific but lethal precision. State funding of scientists meant the government had a close cooperative relationship, “a government who stretches its helpful hand and offers just that can count on the scientists’ gratitude and co-operation.”¹⁶⁵ The Third Reich exercised a modern rational approach in exterminating those considered racially impure, and in executing the final solution they showed deadly efficiency. This detachment of emotion and conscience is still a fundamental part of organised, sanctioned and legitimate State violence. The State “far from calling for mobilisation of individuals’ moral code or any other convictions, demand on the contrary their suspension, obliteration and irrelevance.”¹⁶⁶

¹⁶² Bauman, Z., (2001) p146

¹⁶³ Bauman, Z., (2001) p146

¹⁶⁴ Bauman, Z., (2001) p107

¹⁶⁵ Bauman, Z., (2001) p109

¹⁶⁶ Bauman, Z., (2001) p250

While it is impossible to say categorically that the Holocaust would not have occurred without modernity, Bauman clearly illustrates how the power within hierarchical bureaucratic organisations engenders a moral abdication where individuals no longer feel culpable for dubious practices.

Scott's idea of surveillance is not a direct interpretation of Foucault but rather an adaptation which sees surveillance as part of State work. Governmentality is the term used by Foucault to describe the subtle creeping in the governing modes of thought; there is no master plan, no grand design, no conscious overarching scheme by the state. He differentiates between power as domination and that between individuals¹⁶⁷. All actors have varying degrees of power which increase and decrease dependent on the circumstances, and while power relations can be hierarchical they are not fixed. Examples given by Scott demonstrate that rationalisation is in the interests of those who hold power. Where the State lacks knowledge and capacity to understand specific local conditions it generates new rationalising systems; Statecraft is where the role of the state is as the all-seeing eye. The rationalising processes introduced involve measures that compare and contrast, include and exclude, as well as differentiate and homogenise all actors and actants. For Foucault these are all aspects of normalisation. Scott's examples note the trend is towards bureaucratic rigid planning, imposed practices and centralised inflexible systems. Thus practical local knowledge, which is valuable for its detail and expertise, is replaced and context is lost. This makes decision making at ground level ineffective, cumbersome and difficult. The introduction of rationalisation processes often involve claims to efficiency. In fact the new systems decrease overall efficiency but increase State intervention, surveillance and, more importantly, power.

In his book, *The McDonaldisation of Society*¹⁶⁸, Ritzer gives a critique of rationalisation in modern society. McDonaldisation is the term Ritzer uses to describe how any process can be broken down into its component parts and rationalised on the basis of efficiency.¹⁶⁹ This new process can be further broken down and rationalised again. Hence an ongoing process of rationalisation, which lends itself to Weber's belief that it is ubiquitous and unconquerable.¹⁷⁰ This is a wholly rational, logical development as all variables are now controlled and all elements can now be costed and accounted for. This sense of

¹⁶⁷ McNay, L., (1994) p85

¹⁶⁸ Ritzer, G., (1994)

¹⁶⁹ Ritzer, G., (1994) p12

¹⁷⁰ Turner, S., (2000) p42

calculability, that is a reduction to numbers,¹⁷¹ a quantifying of all elements and predictability, creating a culture of uniformity¹⁷² is paramount to the rationalisation process¹⁷³; measured outcomes are a fundamental performance management tool. Both calculability and predictability promote speed and routine repetitive work. Ritzer coined the term McDonaldisation, after the fast food chain McDonalds, a company skilled at adopting and deploying these work practices. However, these modes of behaviour have crept into all aspects of society including healthcare, with widespread cumulative effects. It creates a culture where speed, efficiency, and replicability have predominance over all other factors. While this may be superficially gratifying, it is neither life enhancing nor emotionally sustaining. Creativity, passion and human relationships are sidelined in the quest for ever greater standardisation and conformity. The McDonaldization theory combines ideas of rationalisation expounded by Weber and Scott while recognising how this impacts the individual in the workplace. The chapter on stigma picks up on how performance as a type of work has imposed standardisation on the NHS and how this affects the actions and activities of staff, particularly in decreasing the autonomy of performance managers.

McDonaldization also sees the consumer take on the role of the worker; consumers carry out tasks previously done by paid members of staff. Thus, the consumer is an unpaid employee. Within healthcare this can be seen in patients not only having rights but also responsibilities. These responsibilities involve undertaking small administrative tasks and simple care practices, such as booking further appointments and taking prescribed medicines. Another aspect of McDonaldization on the workforce is a general deskilling, which Weber describes in relation to bureaucracy. Within healthcare, there is a greater reliance on medical technologies. The role of doctors increasingly becomes that of a 'dispatcher,' referring patients to technical machines and specialists.¹⁷⁴ In so doing their understanding of their work lessens; so too does their control and autonomy. The fragmentation of complex skilled work into a series of simpler focused tasks means that staff can be easily replaced, as training is no longer cumbersome or costly. The use of casual, short term, contract labour for permanently temporary work is an effective strategy for corporate rationalisation. While this may reduce wage costs and overheads, and promote greater flexibility, this is not its true purpose. The value in the new pattern of

¹⁷¹ Ritzer, G., (1994) pp62, 78

¹⁷² Ritzer, G., (1994) pp83, 94

¹⁷³ Runciman, W.G., ed. (1996) p351

¹⁷⁴ Ritzer, G., (2000) p109

work is the workforce now carries the burden of risk.¹⁷⁵ Expertise and knowledge are no longer valued; performance is judged solely on the completion of a specified job. Another aspect of rationalisation and facet of deskilling is deprofessionalisationism. This is the loss of cultural authority, prestige and trust once enjoyed by a particular profession. This may be due to general social change, e.g. decrease in deference, an increase in the number of professional women both inside and outside the NHS, as well as an increase in information. There is now a wealth of available information on any given topic, easily accessible through the internet or various other forms of media. Over the last decade, the public has seen a huge increase in access as well as an increase in the mass of information available. Professional clinicians therefore now argue that they provide expertise, in that they can differentiate between good and bad information. They may no longer have a monopoly on knowledge; they argue instead that they have a monopoly on expertise.

The Proletarianisation thesis expounded by Oppenheimer¹⁷⁶ is the idea that professional labour is dependent on employment in bureaucracies. However, this dependency brings with it a loss of independence, subjection to rules and greater scrutiny, and increased management as in any other group. Critics have said this theory lacked specificity in process and consequence, stating that it was unable to show why the subjection of professionals to the same rules as other working groups was detrimental to their profession. Within the NHS, state regulation led to a formalisation of existing structures, explicit monitoring, an emphasis on procedures and quality assurance, with the expectation that all patients should receive a certain standard of care. All of this supposedly leads to a loss of professional independence and personal freedom.¹⁷⁷ But while both theories can be applied to clinical staff in the NHS, it is important to remember the primary focus of self-regulation is the autonomy placed on the self, whether that self takes the form of a market, a firm, or a profession. So while successive governments have encroached specifically on professional self-regulation, they have been careful to ensure that healthcare professionals believe that they have far more to gain than lose from the changes proposed.

3.3 The rise of the Public sphere

Public involvement was key to the Labour government's reforms in the NHS which means it is necessary to understand how the 'public' is being constructed and what role for the

¹⁷⁵ Beck, U., (2000) p89

¹⁷⁶ Martin Oppenheimer, "The proletarianization of the professional" in Halmos, Paul ed (1973)

¹⁷⁷ McDonnell, O., Lohan, M., Hyde, A., & Porter, S., (2009) p50

public is evolving within performance management. Habermas charts the rise of public discourse with the emergence and establishment of the middle class. He divides society into two spheres, the public and the private; both are constantly changing and developing in this highly complex relationship. The influence and rise of democracy corresponds to changes within both these spheres. Habermas states that the bourgeoisie, the middle class, grew through expansion in trade and industry. Their power was further strengthened through the use of literature, letters and the press. This voice was then asserted through the public sphere, a sphere where the middle class were particularly comfortable having helped in its creation, to become a significant challenge to state power. This ties in with Moran's conception of club government. It demonstrates that the middle class use aristocratic norms, emulating the aristocracy, creating connections through businesses. Democracy, independence and rational debate are central to the middle class' success and are necessary conditions for discussions to take place within the public sphere.

Debates and discussion of public policy give rise to a 'bourgeoisie public sphere', which consists of forums such as debating clubs, salons, coffee houses, newspapers and books. Moreover, 'public' is no longer a place, but rather a state in which discussion can occur freely, e.g. the press. The private reading culture becomes the medium of public expression. Therefore, the rise of the public sphere is linked to the rise of rational public interaction and the middle class. Public houses are those that are accessible to all; public buildings are those working on behalf of the public; public representation acts as an authority for the greater public and, crucially, public opinion is the function of the people to act as critical judge, providing checks on the public representations made. The bourgeoisie opposes aristocratic titles and privileges and rides against the 'publicity of representation', the visible ritualised representations of feudal structures. "While the early institutions of the bourgeoisie public sphere originally were closely bound up with the aristocratic society as it became disassociated from the court, the 'great' public that formed in the theatres, museums and concerts was bourgeoisie in its social origin." However, in today's society there is no single public sphere; rather there are many including counter-publics, competing publics, and alternative public spheres. Habermas refers to this as the marketisation of public discourse.

According to Habermas, the public sphere declined during the 19th century and atrophied during the 20th. He looks to the Enlightenment period for the ideal conception of public. Here discussion in the public sphere is not connected directly to action. Habermas sets out a moral philosophical framework where we are free and autonomous, and assumes the

ideal speech situation. This view holds reason and rationality as a liberating force; it is what binds humanity together, as it is a characteristic we all share. This contrasts with Foucault's position, where he argues that reason becomes a dominating force.

3.4 Historical examples of the State as a social engineer

Throughout this thesis I argue that the State has a transforming vision; in pushing forward ideas of progress it irrevocably alters society. As already described, the process of measuring, the creation of records and the formation of lists are an intrinsic aspect of statecraft providing an approximation of reality. Planning the corresponding by-product of measuring allows the state to see: it is a form of surveillance. It allows State officials to gain knowledge of a section of society that was previously hidden. The state works from a premise that if it is possible to reshape nature it must be equally possible to reshape society. This can be seen on numerous occasions where the state has attempted to break from the past, from fixed traditions and old conventions. Extreme examples include Cambodia under the Khmer Rouge with the introduction of year zero and Apartheid in South Africa. Bauman states that it took an efficient bureaucratic society to implement the Nazis' Final Solution.¹⁷⁸ In exterminating the Jews, German society was perversely celebrating its efforts as civilising force; the organisational machine and workforce that enabled such an accomplishment was a salutation to modernity. Such systems are complex, sophisticated and simultaneously deceptively simple, severe forms of social engineering. These regimes establish and develop intricate forms of classification and engage in a process of rationalisation as expounded by Weber. There are less extreme examples of rationalisation which allow the State to see. I argue, using both theories of Scott and Ritzer, that policies driven through in the NHS were such processes.

Ritzer articulated his belief that society is undergoing 'McDonaldisation'. By this he meant that four main qualities are being subscribed to by various organisations irrespective of their place in society. These four dimensions are efficiency, quantification and calculability, predictability and control. This was exemplified by the American businessman and restaurateur Ray Kroc when he "talked about uniformity, about a standardized menu, one size portions, same prices, same quality in every store" in relation to his McDonalds empire. Ritzer's work develops Weber's theory of formal rationality; this is the idea that people exist within a structured world where rules and regulation inform and to some degree coerce their thinking, choices and actions. The bureaucratic

¹⁷⁸ Bauman, Z., (2001)

machine that lies at the heart of modern organisations pushes the individual into certain positions on the basis of supposed rationality. Ritzer states that, “profit-making medical organisations are not the only ones pushing medicine in the direction of greater calculability; all medical bureaucracies are moving in that direction.”

3.5 Understanding various approaches to risk

An overview of the literature on risk will be provided because, as discussed in the previous chapter, high profile crises allowed New Labour to validate the need for performance in the NHS. Notions of risk have changed considerably. Appearing first in the Middle Ages in relation to maritime insurance, it meant the possibility of objective danger, the threat of a natural event, an act of God or an incident where blame could not be apportioned. This notion of risk negates the idea of human fault; as culpability is not an issue, censure or chastisement is inappropriate. With the rise of modernity, industrialisation and the establishment of public institutions in the seventeenth and eighteenth centuries, notions of risk change.¹⁷⁹ Risk became defined in terms of probabilities and statistics, as it continues to the present day where risk is concerned with calculating contingences and uncertainties. Unlike the earlier conception of risk, outcomes can be altered and/or influenced by human behaviour. Risk is synonymous with uncertainty as such is viewed as the same. While risk can be either good or bad, personal experience tends to equate it with bad. Risk moves to being fact and fact in turn moves to being absolute truth; nonetheless these are merely calculations provided by experts.¹⁸⁰ All risk analysis is context bound¹⁸¹ and the evaluation of risk is very much dependent on the present; there is a temporal dimension¹⁸² which is essential when attempting to understand and calculate risk.

Deborah Lupton gives one of the most comprehensive introductions and critiques of the three major theoretical approaches to risk: Cultural/Symbolic perspective as presented by Mary Douglas; the Risk Society/Reflexive Modernization perspective put forward by Ulrich Beck and Anthony Giddens, and ideas of Governmentality which emerged from the work of Michel Foucault. (Each will be looked at in more detail.) Lupton makes clear the distinction between the three perspectives, noting that all three approaches to risk recognise politicisation of the topic and how ideas of risk pervade both modern life and society. Lupton studied the relationship between risk and subjectivity. For her individuals

¹⁷⁹ Luhmann, N., (1993) p9

¹⁸⁰ Lupton, D., (1999) pp5-18

¹⁸¹ Lupton, D., (1999) p42

¹⁸² Lupton, D., (1999) p49

deal with risk differently in different forums; how they deal with risk in the public arena is different to their experience of risk in their personal life. How risk is constructed depends on context and circumstances of individuals on daily basis, where the everyday experience is essential in understanding risk. Previous analysis focused on the presentation of risk within the public forum, but neglected to understand how risk is dealt with in everyday life. Lupton focuses on the personal attempts to address this deficiency.

3.6 The work and function of risk

The cultural anthropologist Mary Douglas argues risk is a culturally constructed concept, reliant on and framed by knowledge of wider belief systems and moral positions. In “Purity and Danger,” Douglas attempted to understand the process by which something is labelled risky or dangerous. Things that did not fit easily into traditional classification systems were often regarded as impure. By crossing boundaries, or lying on a categorization border, things were considered polluted and hence dangers and threats as they defied the rules. These things, meaningless in themselves, are symbols, representations of cultural beliefs which can only be understood in the context of the communities in which they originate. Douglas concludes that danger acts as a trigger in creating social boundaries between individuals, groups and communities. “Danger is defined to protect the public... a common danger gives them (society) a handle to manipulation, the threat of a community-wide pollution is a weapon for mutual coercion. Who can resist using it who cares for the community?”¹⁸³ Danger provides a demarcation criterion for distinguishing between them and us. Risk is employed to construct notions of blame that serve to distance particular threats and blame. This is done by negatively associating specific characteristics with the other, and blame and perceived wrongdoing invariably influence ideas of justice and its enforcement.

Douglas gives a traditional description of risk: “risk is the probability of an event combined with the magnitude of the losses and gains it will entail,”¹⁸⁴ and she also provides a fuller description of risk. Perception and ideas of risk enable values to be produced and maintained. If culture is to be considered a set of values, then risk to that culture is that which endangers its values. Notions of risk are understood, reinforced and perpetuated through those cultural values. For Douglas the politicisation of certain risks serves a particular function. She believes it is impossible to reduce risk to the individual level, and that real understanding of the role of risk in society is lost. In this respect she

¹⁸³ Douglas, M., (1992) p6

¹⁸⁴ Douglas, M., (1992) p40

follows in the academic tradition of Émile Durkheim. According to Douglas “the idea of society is a powerful image. It is potent in its own right to control or stir men to action. This image has form; it has external boundaries, margins, internal structure. Its outlines contain power to reward conformity and repulse attack.”¹⁸⁵ Hence it is the defence of society and its attack on perceived risk that inevitably strengthens group identity, increases group cohesion and provides a sense of solidarity at times of decreasing social security and rising uncertainty.

3.7 Professional life in the Risk Society

Ulrich Beck elevated the concept of ‘risk society’¹⁸⁶ in the developmental period of modernity. To understand the risk society it is necessary to give a description of risk of which there are numerous definitions. For Beck risks are “uncontrollable scientific, technical, or social developments which were started long before their side-effects or long term consequences were known.”¹⁸⁷ Risk is concerned with potential catastrophe rather than its actual occurrence. “The concept of risk thus characterizes a peculiar intermediate state between security and destruction, where perception of threatening risks determines thought and action.”¹⁸⁸ A normative account of risk is one which involves probabilities, likelihoods and chances of specific events occurring. Where calculations lead to a loss, measures are sought to nullify the risk. This process is known as risk management.¹⁸⁹ A risky occurrence is one where the chances of it happening are high and the losses are equally high. There are various regulatory bodies and departments within organisations whose primary concern is understanding and assessing risk. They introduce systems to lessen the chance of the event occurring and/or the consequences of the event itself. Society’s concern with minimising and preventing these hazards is referred to by Beck as the Risk Society. This is the anxiety, response and manifestation to the hazards and threats faced by individuals. In an effort to diminish these perceived risks, different approaches and methodologies for risk assessment exist in which a combination of evaluatory tools, techniques and technologies are used. Yet questions remain as to how effective these methods are in dealing with risk.

¹⁸⁵ Douglas, M., (1999) p114

¹⁸⁶ Beck, U., (1992)

¹⁸⁷ Douglas, M., (1992) p44

¹⁸⁸ Beck, U., ‘Risk Society Revisited: Theory, Politics and Research Programmes’, eds Adam, B, Beck, U., & Van Loon J., (2000) p213

¹⁸⁹ “Risk management organises what cannot be organised...Historically, a public politics of risk management, particularly in the field of health, has been concerned with transparency and accountability of scientific expertise in decisions about risk acceptance” Power, M. (2004) pp10-11

With the collapse of the banking system, the value and effectiveness of financial risk systems is being scrutinised. Professionals in this area have been challenged to explain how risky events were allowed to happen based on the knowledge already available. Another profession which relies on risk systems to inform its decision-making, and is now under enquiry, is social care¹⁹⁰. Practices in this area have come to the public's attention after high profile cases such as that of Victoria Climbié¹⁹¹ and 'Baby P' hit the media. Social workers are under enormous pressure to explain how such huge failures in care, i.e. the abuse and death of two children could happen. Local knowledge needs to be acted upon, rather than ignored. These tragedies occurred irrespective of the audit and inspection systems in place in order to make practice transparent.¹⁹² Eileen Monroe argues that social work has become a risk assessment exercise at the expense of the child's needs and social justice.

Beck considers our preoccupation with identifying risk in every aspect of daily life. Risks are man-made and self-inflicted, caused by the very technologies that make society modern. They are side effects or by-products to technology. Risk has now moved on to a global scale. Once risks were perceived as localised or limited in nature; now new risks such as terrorism and climate change are globally encompassing threats. These risks are unmanageable but democratic, that is, there is no hierarchy as to who is affected. There is an increased reflexivity within society. Due to greater education, media coverage and scepticism, individuals no longer accept authority. Society is in a state of permanent high alert as disaster is always imminent. The crisis which society awaits creates a sense of constant tension, anxiety and impending doom. The doubt and uncertainty felt by society means that all risks are susceptible to being politicised. While for Foucault and Scott the sense of watchfulness is part of the state surveillance, for Beck this is another aspect of anticipation. This tension experienced prior to a catastrophe, this state of flux, is essentially the marker of the risk society. However, others counter that the rise of the risk society is due to a blame and compensation culture and risk features highly when politicians seek justification for their policies. "Command and control" policies, where accountability is both constantly sought and imposed, becomes an essential element of statework.¹⁹³

¹⁹⁰ Munro, E., (2002)

¹⁹¹ Munro, E., (1999)

¹⁹² 'Eileen Munro: Lessons learnt, boxes ticked, families ignored,' The Independent on Sunday, 16th November 2008.

¹⁹³ For further discussion, see the work of Foucault and Scott.

3.8 Trust within the Risk society

Discussion of risk happens within the private and public spheres. However, in the Risk Society the public sphere is consumed by perceived threats and possible risks. “The discourse of risk begins where trust in our security and belief in progress end.”¹⁹⁴ It is clear the clash between security and danger or even trust and risk is not as unambiguous as it would first appear. These traditional divides can no longer be called upon in discussions; a consequence of modernity is that these distinct areas have collapsed. To talk about one as if it is in conflict with the other is nonsensical; today’s society sees persons entering situations where security and danger, trust and risk are two sides of the same coin and nowhere is this more apparent than in healthcare relations. The word of the health professional is not a guarantee; at best, they present patients and public with the most reliable information and evidence to date. However, their expertise, like much of science, is uncertain. This is because, as new evidence arises, so do the prevailing views and understandings. Antony Giddens states, “Many people, as it were, make a “bargain with modernity” in terms of the trust they rest in symbolic tokens and expert systems. The nature of the bargain is governed by specific admixtures of deference and scepticism, comfort and fear.”¹⁹⁵ This implies that the degree of trust an outsider places in abstract systems is dependent on their experience at access points, i.e. the moment in which interaction can occur between a lay and expert person. Access points within any sector of industry are often places of great tension because of the conflict between public and professional knowledge.

According to Giddens, interaction with abstract systems leads to a basic understanding of the system itself, but interaction with the NHS predominantly occurs when an individual has a health concern which means it is a time when they are vulnerable and personal fears are magnified. “We may end up claiming not to trust and yet, for practical purposes place trust in the very sources we claim not to trust.”¹⁹⁶ A distinction must be made between the patient’s and public’s stated and revealed trust; that is the response given when asked and what their actions actually tell us. It is necessary to differentiate between the motivation to trust and the competency of the individual in whom trust is being placed. Earle and Cretkovich argue that trust placement is irrational.¹⁹⁷ This may frequently be because the

¹⁹⁴ Beck, U., ‘Risk Society Revisited: Theory, Politics and Research Programmes’, eds Adam, B, Beck, U., & Van Loon J. (2000) p213

¹⁹⁵ Giddens, A., (1990) p90

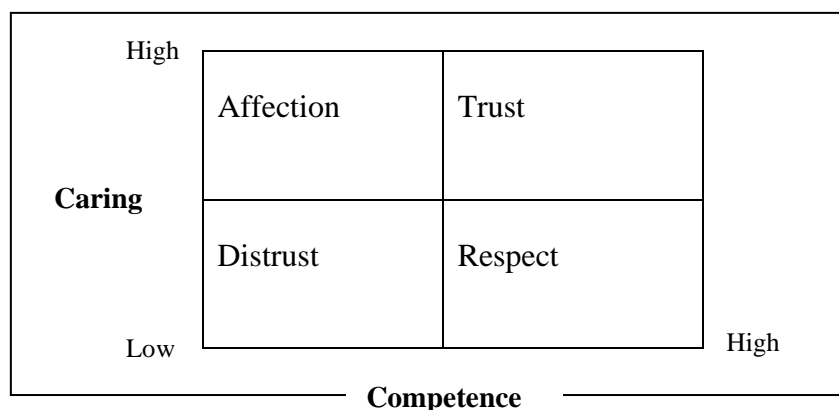
¹⁹⁶ Onora O’Neil 2002 Reith lectures. <http://www.bbc.co.uk/radio4/reith2002/>

¹⁹⁷ Earle T.E., & Cvetkovich, G., (1999) Social trust and culture in risk management. In Cvetkovich, G., Lofstedt, R.E., eds. (1999)

necessary scepticism, understanding of risks, potential failures and other possible outcomes, obligatory in modern life, are relinquished as a lack of trust in the medical expertise provided proves too emotionally draining.

To understand the rise of risk awareness in the NHS it is necessary to understand how relationships exist and work and the role trust plays within those relationships. Trust has many facets: as an emotion, a social contract and its relationship with rationality. It can be characterised as an alternative means of control, or a form of dependency that is the acceptance and reliance on another. Trust is bound up in feelings of expectations and safe dependency. It is a feeling of confidence in another’s future actions and also confidence concerning one’s own judgement.

Competence and Caring in relation to building trust.¹⁹⁸



Trust can be placed in the absence of pertinent knowledge or as a bridge between the present and future events as it anticipates outcomes. Trust can be unintentionally transitive: an example of transitivity is if A trusts B, and B trusts C, then A will trust C. Trust is contextual as well as conditional. Trust is based on expectations and not fixed calculations; nonetheless it still appears rational to trust trust.

3.9 Accountability and Trust

There have been dramatic changes occurring within public sector bodies in terms of internal accountability; the nature of traditional relationships between patients and doctors has also evolved. Debates within society changed focus due to a shift from the manufacturing of material goods to a focus on information. This marked a move from modernity to a transition society, one based around information and consumer culture. This was also reflected in the patient-doctor relationship where patients insisted on more

¹⁹⁸ Paling, J., “Strategies to help patients understand risk.” BMJ 27 September 2003;327;745.

detailed information about their treatment. Previously science, of which medicine and those involved in its practice are part, made certain claims to knowledge, authority and power. This privileged position is no longer assured. “Challenge to authority, including the authority of science should be expected in a healthy democracy,”¹⁹⁹ Patients now expect to be kept fully informed.²⁰⁰ This loss of assurance is due to a plurality of heterogeneous claims in modern society as well as a decrease in personal relations and a simultaneous increase in abstract systems and regimes. This sees a move from individual accountability, to faith, a form of trust in disembedding mechanisms²⁰¹ relying on expert knowledge and trust placed in the entirety of the NHS rather than solely on the local family doctor.

According to Giddens, how patients experience trust can now be divided into ‘event types’ of two sorts: firstly, as interpersonal, an individual doctor; secondly, role-based which incorporates doctors. Modern society provides order and a sense of security, possibly falsely, by organizing the world in which we live. It does this through the use of expert systems,²⁰² that is through individuals who hold technical or specialist expertise, e.g. NHS professionals. Expert systems eliminate social relations from narrow precise situations, a characteristic that is shared with disembedding mechanisms. They provide instead a guarantee in the expertise offered irrespective of when or where, thereby encouraging confidence in the system. “Trust is therefore involved in a fundamental way with the institutions of modernity. Trust here is vested, not in individuals, but in abstract capacities.”²⁰³ Giddens refers to the ‘time-space distinction’ as one way in which the system is maintained; trust is placed in the whole system rather a select individual. Within the NHS, trust is placed in the system to deliver good efficient care. Trust in the organisation is essentially about effectiveness and legitimacy which differs from individual trust relations. Thus, public trust is closely linked to public satisfaction towards the NHS and the particular personality traits of clinicians are supposedly immaterial.

Trust relations are changing throughout society and within the NHS²⁰⁴; policy initiatives have been introduced to increase levels of trusts in different trust relationships: trust and performance management, trust and patient care, trust and participation in disease

¹⁹⁹ Bellaby P., “Communication and miscommunication of risk: understanding UK parents’ attitudes to combined MMR vaccination.” *BMJ* 2003;327;727

²⁰⁰ Coulter A., (2002)

²⁰¹ Giddens, A., (1990) p21

²⁰² Giddens, A., (1990) pp21-29

²⁰³ Giddens, A., (1990) p26

²⁰⁴ (Beck 1992;Giddens 1991;O’Neil 2002)

management.²⁰⁵ Under Sir Ian Kennedy, Chairman of the Healthcare Commission, the publication of patient survival rates of individual consultants has been introduced. In so doing this illustrates the shift to operationalise trust relations of which performance management is a significant part.

Forms of Trust Relations

Old	New
Embodied	Informed
Peer	Earned
Status	Performance

3.10 Audit as form of accountability and a tool for risk management

Michael Power argues that “The Audit Society” is based on the political desire for greater accountability and control. Power sees audit as central in the functioning of modern society, as audit acts in the absence of trust, both in the public and private sectors. Employees become auditees and make auditability a central characteristic of their work. In the public sector, there is a greater emphasis on internal control systems with the performance of individuals and organizations assessed through an official and auditable process. There are financial audits, environmental audits, value for money audits, management audits, quality audits, forensic audits, data audits, intellectual property audits, medical audits and many others besides.²⁰⁶ These audits are an attempt at “restoring credibility”.²⁰⁷ Power argues audits do not deliver greater accountability, as the assurance provided is superficial and largely ineffective. There may be adverse repercussions from trusting such systems.

Power gives a historical account of audit culture showing how it arose from financial audit compensating for the intrinsic mistrust at the heart of the relationship between investors and managers.²⁰⁸ The audit society “trusts auditors before operatives”²⁰⁹ and so the audit framework grew to foster the full functioning of financial markets. As mentioned in the previous chapter, financial audit was exported to the public sector via new public

²⁰⁵ Davies, H. 1999, "Falling public trust in health services: implications for accountability", *Journal Health Services Policy*, vol. 4, no. 4, pp. 193-194.

²⁰⁶ Power, M., (1994a) p299

²⁰⁷ Power, M., (1994a) p301

²⁰⁸ Power, M., (1994b) p9

²⁰⁹ Power, (1994a) p301

management²¹⁰ which Power states saw “the diffusion and generalization of the financial accountability model, particularly in the public sector.”²¹¹ Public sector organisations in theory were devolved from central control but in practice government still required mechanisms for management; it is in this vacuum audit flourished. It was deployed to resolve the disparity of these two incongruous ideals acting as “the shadow of hierarchy which saves the appearance of central control.”²¹² Thus, audit is a “political technology”²¹³ acting on behalf of a centre unprepared to relinquish power and control, in this case the state, within the public sector. This description of audit is one that makes organisations within the public sector auditable rather than genuinely accountable. Audit as a technology replaced other methods of accountability including both inspection and quality control²¹⁴ because it “has a special versatility in which submission to audit establishes legitimacy regardless of the operational substance of audit”.²¹⁵

Power identifies a gap in expectations but this is not considered detrimental to audit, rather a political resource. The public assumes audit will provide assurance yet it is ineffectual in its delivery.²¹⁶ Instead, there is an appearance of high levels of assurance which legitimates regulatory programmes and bodies.²¹⁷ The public are aware something is askew, the consequence being “the audit society is the anxious society”²¹⁸ Commissioning further audits is the only recourse that the public can take. “The ‘fact of audit’ reduces anxiety, or more positively, produces comfort.”²¹⁹ The public’s only “hope for control in the face of increasing evidence of its absence”²²⁰ is pretending audit improves the situation, but it deludes itself with ease as “audit success or failure is never a public fact.”²²¹ Whether audit has failed or succeeded remains ambiguous to the public. Moreover, discussion about audit practices is prohibited - “criteria of success are withdrawn from public discourse.”²²² Thus audit failures remain hidden due to “durability

²¹⁰ See the previous chapter under the subheading “The NHS under the Conservatives: the formative performance years” for a more detailed account of New Public Management.

²¹¹ Power, M., (1994a) p302

²¹² Power, M., (1994a) p302

²¹³ Power, M., (1994a) p302

²¹⁴ Power, M., (1994a) p303

²¹⁵ Power, M., (1994a) p304

²¹⁶ Power, M., (1994b) p19

²¹⁷ Power, M., (1994a) p305

²¹⁸ Power, M., (1994a) p307

²¹⁹ Power, M., (1994a) p307

²²⁰ Power, M., (1994a) p307

²²¹ Power, M., (1994a) p307

²²² Power, M., (1994a) p308

as a ‘political rationality’²²³; the public is forced to accept audit because it is professed to be a better technology.

Audit generates rules and procedures with which auditees have to comply. Moreover, audit over the years has moved away from inspection, towards systems audit, “whereby it is the auditee’s own system for self-monitoring that is subject to inspection, rather than the real-time practices of the auditee.”²²⁴ Power claims that, with the arrival of audit, self-monitoring systems such as inspection were discarded,²²⁵ yet this is misleading. Power himself recognises that audit thrives on paradoxes, stating audit is a process, “in which newly perceived difficulties and dangers can be ritually purified and reconciled to existing managerial and economic practice.”²²⁶ The auditor is likened to a priest, undertaking rituals of purification and reconciliation within religious ceremonies. The auditor as priest engenders a sense of security to managers, giving them ease and comfort against new threats and possible dangers. This is one of the most important roles audit performs. The sense of authority it promotes, its ability to transcend failure and its adaptability make audit pervasive. The notion that there may be fewer audits becomes unthinkable; the audit society no longer envisages organisations or individuals left to their own devices.²²⁷ Power’s summation of audit culture is that “we are all auditees now.”²²⁸

3.11 Language as work

Later in my research I illustrate how New Labour’s political rhetoric is given meaning through those who work in the NHS. New Labour talks about ideas of open government and appeals to traditional notions of public involvement in decision-making but is effective in controlling public discussions; accusations of spin have been rife. The literature (documents) produced are promotional, resembling forms of propaganda. The NHS Plan, discussed in Chapter Two, is not a document for dialogue but a statement of intent. As Foucault states, “multifunctionality of language in texts can be used to operationalise theoretical claims about the socially constructed properties of discourse and texts.”²²⁹ Language produces a shift in ideology and changes and controls public perception. Yet, lack of real discussion hinders public understanding of the scientific process. The public are unable to assess evidence and judge risk appropriately, democratic

²²³ Power, M., (1994a) p308

²²⁴ Power, M., (1994a) p310

²²⁵ Power, M., (1994a) p303

²²⁶ Power, M., (1994a) p313

²²⁷ Power, M., (1994a) p314

²²⁸ Power, M., (1999)

²²⁹ Foucault, M., (2002)

decision-making regarding prioritisation and rationing is impossible, and there is nothing on the broader issue of the future direction of the NHS. However, criticism of the language used by New Labour is difficult to make; it is not merely a campaign for ‘plain English’. People within the NHS took the language and made it their own; performance managers, as described in the chapter on stigma, have their own vocabulary. They give meaning to the political rhetoric so that it has depth and substance. It is an example of administration as work, staff putting language to work. Conventionally culture, of which language is a part, sits within the superstructure along with non-economic institutions. This is unlike ‘work’ which as a form of productive labour is positioned within the base. Traditional approaches assume that productive work involves the manufacturing of objects. State work in contrast is immaterial labour. However, I argue that it is no less a form of productive work.

Talk is how people create values and within institutions, such as the NHS and performance management, helps formulate these values in individual organisations. Habermas calls this ‘communicative action’, that is talk or interaction which creates relations and consensus and provides understanding and meaning.²³⁰ He asks us to move towards “the paradigm of mutual understanding between subjects capable of speech and action.”²³¹ This differs from strategic action which is focused on achieving success, on its practicalities and realities. Theodore Adorno claimed that instrumental rationality or strategic action was the most efficient way of achieving a goal, and when comparing both instrumental and communicative action, instrumental rationality is conventionally thought superior to communicative action. However, it is not so straightforward; performance management draws on the strengths of both forms of rationality and their application within the NHS can be seen at different points. Communicative action is about the process, not just the product. Previously considered the sphere of politicians or performing artists whose work requires an audience, communicative action as a type of labour is both immeasurable and measurable. It cannot be broken down into set units, yet time acts as the overarching unit of measurement. It challenges the idea that talk is cheap. It is the recognition that values evolve, and therefore the process is as important as the end result. As Virno states, “enunciation is simultaneously means and end, instrument and final product.”²³²

²³⁰ Habermas, J., (1984)

²³¹ Habermas, J., (1992) p295-6

²³² Virno, P., “Labour and Language” trans. Bove, A.,

In a bureaucracy, language helps create an organization. In fact bureaucracies are networks of action of which the NHS is an exemplar. Latour advocates a move away from the narrow concept of the laboratory and a recognition that social constructions are created in a variety of settings.²³³ I would argue that the NHS acts as a laboratory for performance managers, a place where social constructs are created, fashioned and sometimes renegotiated; it is a place of co-production where facts emerge.²³⁴ Latour showed how the transformation of statements into facts is done through the use of technological devices and human devices. These technological devices can take a variety of forms: diagrams, dashboards and documents. Science depersonalizes, that is, it makes the author anonymous in order to provide a greater sense of truth. To confer objectivity on processes other spheres of work seek to emulate, imitate and replicate this idealized version of the scientific method. Latour states: “processes operate to remove the social and historical circumstances on which the construction of a fact depends.”²³⁵ Moreover, the history of a fact has by definition lost all historical reference.²³⁶ The importance of facts is their ability to provide credibility to accounts, driving forward and making acceptance of new political and policy agendas more likely. Latour examined the process of systemisation, how gathered facts become irrefutable and how facts act as a rhetorical tool, an instrument of both negotiation and persuasion.

3.12 The language of illness, its role in healthcare

Marx, Weber, and Ritzer all understood that by its nature bureaucracy, rationalisation and surveillance lead to dehumanising relationships. Certain patterns of behaviour are considered normal, and while, for Foucault, dominant cultural notions and labels are mere by-products generated through a system of order within society, they are nevertheless important. This is not an area of research I had expected to discuss. However, while undertaking research into the nature of performance management what became immediately apparent was the acutely-felt effect of rationalisation on individuals. Hence it is a central aspect in understanding how the State operates at a distance. Erving Goffman’s work on stigma has provided concepts on both individual and group identity which I have drawn upon to better understand my findings; these are set out at length in the chapter on stigma.

²³³ Latour, B., and Woolgar S., (1986)

²³⁴ Latour, B., and Woolgar S., (1986) p106

²³⁵ Latour, B., and Woolgar S., (1986) p105

²³⁶ Latour, B., and Woolgar S., (1986) p106

In his book “Stigma: Notes on the Management of Spoiled Identity,” Goffman describes how society judges what is normal and who is ascribed as falling behind this imaginary line. Stigma then consists of the mechanisms used by individuals and groups to cope with their realities. Stigma according to Goffman is “an attribute that is deeply discrediting within a particular social interaction.”²³⁷ Stigma originates when individuals are deemed deficient when compared to the norm. A stigmatized person is one who is “reduced in our minds from a whole and usual person to a tainted, discounted one.”²³⁸ Stigma leads to a devaluation and constriction of personal identity and a sense of being different and discriminated against, based purely on a particular attribute. Highly stigmatised individuals are those whose illness is self-inflicted or self-induced, where there is no clear treatment suggesting that the condition is permanent, where society has an inadequate grasp of the disease and where the symptoms cannot be effectively concealed. Stigma can arise as a response to an individual’s own fears and this is no less real. Moreover, Goffman puts forward the concept of frontstage and backstage, drawing from the theatre, to describe the acting of a role.²³⁹ A stigmatised person or group does this in order to meet the expectations of an audience.

Goffman divided stigma into three further categories: physical deformities, character faults and tribal stigma. My focus is on the last, “stigma that can be transmitted through lineages and equally contaminate all members of the family.”²⁴⁰ Here, stigma touches more than the single individual concerned. Stigma indirectly affects a wider group of people. “The individual’s real group, then, is the aggregate of persons who are likely to suffer the same deprivations as he suffers because of having the same stigma; his real “group,” in fact, is the category which can serve as his discrediting.”²⁴¹ This Goffman refers to as in-group alignment, individuals who share his interests and yet can at anytime be revealed as a fraud. Another way in which a non-stigmatised person can be linked to a stigmatised person is through a “wise person”. This is someone who is aware of the concealing actions of those who are stigmatized. Wise persons are sympathetic to the stigmatised “and who find themselves accorded a measure of acceptance, a measure of courtesy membership in the clan. Wise persons are marginal men before whom the individual with a fault need feel no shame nor exert self-control, knowing that in spite of

²³⁷ Goffman, E., (1976) p13

²³⁸ Goffman, E., (1976) p12

²³⁹ Goffman, E., (1990)

²⁴⁰ Goffman, E., (1976) p14

²⁴¹ Goffman, E., (1976) p137

his failing he will be seen as an ordinary other.”²⁴² A wise person is connected through family, kinship groups, or other kinds of social structure. Stigma can arise for a number of reasons, but what it does is to place the individual into a new or different peer group. Here the social rules must be re-learned; the rules of engagement are re-drawn and it becomes increasingly difficult to associate with friends, colleagues and those outside the stigmatised group.

Goffman used the concept of stigma to describe people’s attitudes to illness but I have broadened its scope to understand the effect of homogenisation in work as well as of organisational change on individuals in the PCT and SHA. Goffman’s writings on stigma are an instrument which helps shed light on coping mechanisms, strategies and the role of rationalisation on human relationships in the NHS. Goffman himself cautioned against the over-extending of his concept of stigma. However, my motive for using his concept and applying it to the discourse in the NHS on organisational change and policy implementation is that the concept of stigma is so pertinent that it seems unnecessary to reinvent the wheel.

Illness can be considered a form of deviance; moreover I will suggest it is not just individuals that become ill but organisations that take on aspects of deviant behaviour. Until the work of Talcott Parsons, deviance had primarily been associated with criminal activity. However, Parsons widened its use applying deviance to illness. He provided a Functionalist notion of the sick role. “According to Parsons, the sick role consists of two rights and two obligations. The rights are that sick people are exempted 1) from performing their normal social roles and 2) from responsibility for their own state. Sick people are at the same time obligated 3) to want to get well as soon as possible and 4) to consult and co-operate with medical experts whenever the severity of their condition warrants it.”

Metaphor is a major cognitive mechanism by which the mind establishes connections. It allows individuals to move between meanings, as the ambiguity in the language allows inferences to be made.²⁴³ Good metaphors affect parts of the mind that other cognitive mechanisms cannot reach; moreover they influence other minds and establish social connections providing significance and meaning to an individual’s world view. Metaphor functions not only at the cognitive level but also serves a social purpose. It “sees the

²⁴² Goffman, E., (1976) p41

²⁴³ Nerlich, B., & Clarke, D. D., (2001)

social function of metaphorical talk presupposing and reinforcing ‘intimacy’ between speaker and hearer.”²⁴⁴ Susan Sontag presents a comprehensive study of how metaphors are applied to illness. She focuses on this aspect of language because a metaphor crystallises and gives grounding to a complex idea which would otherwise remain out of reach to the masses. A metaphor takes an abstract idea and provides a framework for general understanding. Within “Illness as Metaphor” and “AIDS and its Metaphors,” Sontag illustrates how the description around specific illnesses became mainstream. Her work looked at the narratives surrounding TB, syphilis, cancer and AIDS. She tries to understand the myths, imagery and representations of illness. France in the 1870s saw modern bacteriology come into being, with which emerged the germ theory of disease. It developed during a time of Prussian militarization which would culminate, in the invasion of France. The germ theory grew in a cultural context where germs were considered to have both motivation and harmful intent. This way of seeing illness become predominant and as such three military metaphors have been engaged in the discourse surrounding cancer: the disease as the enemy, invasive, foreign and deadly; the body likened to a battlefield, and the sufferer seen as the hero, valiantly fighting a fatal disease. “Military metaphors contribute to the stigmatizing of certain illness and, by extension of those who are ill.”²⁴⁵ Originally, AIDS and cancer shared similar language as AIDS was thought to be a ‘gay cancer’. However, as knowledge of AIDS grew, it drew upon other imagery of its time; it focused primarily on surveillance metaphors. Performance managers drew used military and surveillance language, in part as a defence mechanism, and my findings are elucidated in the chapter on stigma.

In her book “Illness as Metaphor,”²⁴⁶ Susan Sontag looks at the language surrounding illness, in particular the words used in both text and dialogue by doctors and the wider public. Her particular focus is how metaphors are applied and the images they seek to convey. In using metaphors to describe illness, illness ceases to be just a biological deterioration; instead, it takes on wider meaning. Illness becomes a way of explaining society’s tribulations, disorders and malfunctions²⁴⁷. Sontag gives the example of how AIDS was seen as a punishment for supposedly morally deviant behaviour. There is a moral undertone in the language employed to describe those who are diagnosed with particular illnesses. Certain illnesses are defined by the negative characteristics of the associated ‘risk groups’. Yet, these risk groups are little more than bureaucratic

²⁴⁴ Nerlich, B., & Clarke, D. D., (2001) p14

²⁴⁵ Sontag, S., (1990) p99

²⁴⁶ Sontag, S., (1990)

²⁴⁷ Sontag, S., (1990) p72

subdivisions of the total affected by disease. Moral judgements are made about people with specific illnesses.²⁴⁸ For example to have TB was once considered a positive characteristic, while syphilis-induced dementia was thought to inspire creativity. In contrast, those affected by cancer and AIDS find negative imagery associated with their illnesses. Dominant representations of illness generate counter-representations, but both sets can be inaccurate in their depictions of the actual disease. It is worth remembering that societal assumptions are not neutral, but value-laden. This process creates a sense of separate identities and engenders feelings of shame and guilt in individuals. Neither of these emotions are beneficial in understanding the illness, helpful in providing appropriate treatment or in eradicating the disease. Sontag is not suggesting that we should do away with metaphors, but rather that metaphors should be used more appropriately and chosen by society with more care. There should be an understanding and recognition of the potential harm wrought by the use of wrongly applied metaphors. Metaphors are useful only when they help to describe a patient's reality, not when they create a false one. For my research Sontag's work was relevant in illustrating how performance staff co-opted military and surveillance metaphors.

3.13 Conclusion

My thesis centres around literature on theories of rationalisation. Rationalisation as explained by Weber forms the basis of bureaucracies which are, contrary to expectation, self-sustaining systems. The NHS is a massive bureaucracy where rationalising is prevalent in various guises. The government's 18 weeks policy, I argue in later chapters, is a clear example of McDonaldisation within a public service. It illustrates the growing desire for quantification and calculability into all aspects of life, including healthcare provision. Ritzer and Scott surmise that bureaucracies are created and perpetuated by methods of surveillance. Techniques of control and monitoring are numerous but observation is a core component to all. The breakdown of trust relations, according to Foucault, necessitates a surveillance mentality. For Foucault performance management would be a panoptic exercise of power, it is about making visible what is done within the NHS. It is not necessary to choose one over the other, Foucault over Habermas; the two theories are not mutually exclusive. Applying Habermas' thought to performance management sheds light on issues of normativity within the NHS. Performance management then is not just an exercise in power, but also about goals and value consensus. Deliberation is required in a normative sense; consensus within the NHS may

²⁴⁸ Sontag, S., (1990) p46

be assumed, but all stable practices need to be justified to the wider public in order to appear legitimate. Hence, performance management makes a latent argument about how things are done and what gives it legitimacy. Public values, I argue, are represented and embedded in institutions like the NHS through performance.

The later chapter on rationalisation will illustrate how different types of tools and techniques, including targets, were employed within the NHS so that central government knew compliance with its approach was all but guaranteed. Its ideology had been incorporated and absorbed into local organisational culture. As will be detailed later, though power filtered downwards, this did not increase individual autonomy or local decision-making. The deployment of punishment was not always necessary in the NHS as the threat of its use served to control organisations into compliance. Failure led to punishment in the form of greater surveillance and an adherence to a greater number of targets to be achieved in shorter deadlines. As detailed in the chapter on risk, the role of the performance manager is about organisational self-surveillance, about providing the eyes of the state within local NHS organisations without direct intervention. It is an example of the clinical gaze transferring from doctors to managers. This chapter also shows how success in the mandatory framework, the Balanced Scorecard, confers supposed autonomy on organisations, a supposed relaxing and lessening of state control. However, what happened was that success generated greater self surveillance, as organisations tightened their internal monitoring regimes thereby lessening individual autonomy. Thus one form of surveillance was merely replaced by another. Expertise and authority are no longer a given; professionals and politicians are no longer exempt from questioning. The voice of the establishment cannot be relied upon, society can offer no guarantee, no certainty and as such nothing is taken at face value. Beck's risk society is risk-averse; individuals go through life assessing the nature of conflicting risks. Risky behaviour creates potential crises, political catastrophes and global disasters. Giddens' risk society produces an atmosphere where individuals are forced to place their trust in external actors; to trust what reason tells them is the untrustworthy. This gives rise to a sense of apprehension and impending doom which permeates thinking.

The rationale for providing a brief outline of literature on risk is that it was this account which was used by New Labour to justify the need for performance in the NHS. As discussed in the previous chapter, the performance manager's role was established and developed in response to Shipman, Alder Hey and Bristol. It was against this background that the narrative from the New Labour government was formulated. Quantifying,

measuring and monitoring, it was argued, would mitigate potential risk. However, as will be illustrated in the chapter on risk, the increase in data, facts and information has not resulted in a decrease in risk. The then government sought to measure the previously unmeasurable on the premise that patients and public would be safer and the quality of service they received would be better. Performance was a command and control culture that sought continuous assurance that everything had been assessed to be 'satisfactory'. It was a response to the need to be seen to be taking immediate action against potential dangers, a process by which conformity, consistency and standardisation were valued, though this in itself led to a loss of genuine local insight, thereby maintaining and increasing the very risk it sought to diminish. It was an illusion; it provided a false sense of security to senior management that risks had been averted.

Understanding the nature of risk is an industry in itself as poor risk communication can turn the threat of risk into a reality. However, the increase in bureaucratic measures further decreases accountability and trust. The introduction of markets in healthcare, where none had previously existed, is transforming the relationship between clinicians, patients and technologies and, in some cases, this can be detrimental to patient care. For example, accusations have been made against the nursing staff that bureaucracy and a box-ticking culture has replaced care and compassion both on NHS wards and in the profession. The doctor and journalist Max Pemberton typifies this view, "The type of hands-on nursing that involves caring for patients day to day on the ward has been undermined and stripped of value and respect.....The pressure to hit targets means it is all too easy for the needs of patients to be lost, obscured amid piles of paperwork and the need to appease managers."²⁴⁹ As discussed by Moran and Power in the previous chapter, (Reform in the NHS), surveillance techniques fulfil a need to show that action is being taken, but these measures are merely procedure. The real examples given by Scott provide detail on how measuring, quantifying and monitoring are all aspects of rationalisation. They highlight how the State sees, how it attempts to rid areas from metis; I will demonstrate how this reductionist endeavour is replicated in NHS organisations. The demand for greater efficiency from the public and the drive for increased productivity by the government meant that nationally there was a move to standardise levels of care through the services delivered by the NHS; this had a transforming effect on work. The essence of performance in both Primary Care Trusts and Strategic Health Authorities was enforcing both the introduction and adherence to protocols, processes and procedures; this

²⁴⁹ Dr Max Pemberton 'Let nurses get back to nursing', 28th August 2009
<http://telegraph.co.uk/health/6104217/Let-nurses-get-back-to-nursing.html#>

changed the very fabric of the NHS, fundamentally altering its culture, structure and priorities forever. This standardisation provided no real verification or accountability; individuals were simply going through the motions of compliance.²⁵⁰ Any issue can “be problematized by a diverse and heterogeneous group of consultants, politicians, managers, experts and commentators of varying kind, who pronounce on the deficiencies of existing ways of making things and call for new ways to be invented.”²⁵¹

The introduction of monitoring measures is due to a sense of necessity; there is an imperative to change because of a supposed problem. “All uncertainty about legitimacy of the values of the constants may be divided into two categories: 1) random error and 2) systematic error, which correspond to the modern distinction made between ‘precision’ and accuracy to their true value.”²⁵² Regulatory regimes are concerned primarily with the latter. Preference goes to measures that are quantifiable, replicable and standardised. ‘Scientific’ models and practices are imitated in order to present a professional and objective approach.²⁵³ Yet this does not lessen the risk; instead it provides a false sense of security. There is a tension between development of trust and empowerment and in this respect regulation. The need to measure and monitor can be counterproductive; audit mechanisms can be self-defeating as they may maintain or increase levels of personal trust while also decreasing levels of trust in the organisation. New forms of trust relations are emerging in the NHS which appears to have different aspects from other welfare and public sector services, as shown by the public perception of differences between risk and uncertainty and trust and trustworthiness. Unfortunately these differences were not considered when introducing new performance management policies and systems. This means that from their inception they are already programmed to fail, as they do not fully reflect the users’ needs and expectations. Moreover intervention and monitoring systems are concerned with old risks and with preventing the reoccurrence of past crises. They offer no value in assessing new challenges or potential problems. Only now, with the colossal failure of the financial regulatory regime, are these systems and those like it being reconsidered in terms of their application and effectiveness.

The notion articulated by both Bauman and Arendt²⁵⁴, that bureaucracy promotes moral detachment from labour, in that responsibility no longer rests with a single individual was

²⁵⁰ Power, M., (1994b) p20

²⁵¹ Power., M., ed. (1994) p123

²⁵² Power., M., ed. (1994) p229

²⁵³ Power., M., ed. (1994) p86

²⁵⁴ Arendt, H., (1994)

given further credence by the serious shortcomings in care seen within the NHS. While of course not directly comparing the Holocaust to NHS mismanagement, it is clear that organisations have continued to be struck by severe and systematic failings which have led to needless suffering for patients and avoidable deaths. The bureaucracy, discussed further in the chapter on risk, has added to, not reduced or eliminated, the likelihood of such incidents occurring. Performance management, the preventative tool identified as necessary to averting episodes such as those seen at Bristol and Alder Hey, has in fact allowed such incidents to persist. The chapter on risk provides supporting evidence from my ethnographic research of how performance regimes, whether through the use of frameworks, dashboards or scorecards, has made answerability more difficult to assign. Where all the facts were visible to everyone, there was a corresponding widening in the distribution of responsibility. Everyone was now responsible to ensure success and stop unsafe events from happening, but this sharing led to a dilution of accountability; contrary to perception, responsibility ceased to be everyone's concern; it became no one's. The chapter on sigma illustrates how this effect was compounded by the breakdown in community and the disenfranchisement brought upon staff by on-going organisational change, where roles were made redundant and jobs were shifting. I will argue that performance managers took on this frontstage/backstage role to meet the expectations of those outside performance management, including other NHS staff and the public. Stigmatised groups use and apply concealing behaviours, which enable them to pass off in wider society; this includes development of their own terminology, language and forum in which to communicate freely amongst themselves.

While bureaucracy is a form of work, other forms of work also exist. Habermas and Latour contend that language is a form of work: when studying labour it is necessary to understand both what is done and what is communicated. The nature of bureaucracies means that rationalisation affects not only physical labour, systems and processes but also human relationships and interactions between colleagues. How staff talk, discuss and frame their work is as important as the artefacts and end products of their work. If opposition parties dismiss the language of New Labour they invariably dismiss the work of the NHS; this they do at their peril.²⁵⁵ People orientate themselves through language, and this is clearly evident in the NHS. It also helps in understanding how the nature of work has altered (the move from productive material work to immaterial work, i.e. emotional labour which is central to bureaucracy). Giddens has been quick to dismiss

²⁵⁵ Lord Heseltine attacks Conservatives for their dismissive approach towards six million public servants, which he says jeopardizes their electoral prospects. <http://www.timesonline.co.uk/article/0,,2-2138624.html>

suggestions by Luhmann that power or language is on par with money as disembedding mechanisms. Yet, when an institution as large and influential as the NHS provides meaning to political rhetoric, the government of the day unexpectedly has a language which holds enormous currency with the wider public. The fact that the language of New Labour has become the language of institutions and performance management is the clearest example of this phenomenon.

Stigma as defined by Goffman is discussed with reference to the changing quality of these work-related relationships and Sontag's study of how the metaphor of illness is deployed to articulate wider problems in society is also considered. So, while the sick role lacks permanency, it can be applied to anyone and appropriated by anyone irrespective of their status or position. Doctors judge and apply universal criteria to individuals deemed sick; there is an objective set of definitions in assessing who is sick, the extent of their illness and what types of illness they are suffering from.²⁵⁶ The doctor acts as the 'gatekeeper', separating the sick from the healthy, the genuine sufferers from the fraudulent. The doctor's role in this sense has many of the characteristics of an auditor. By widening this definition to the macro-level of organisations it becomes apparent that the Healthcare Commission plays a similar role. It decides which NHS organisations are healthy and which are failing; it has demarcation criteria in the form of targets and assessments. The role of the doctor differs from the HCC in relation to the remedial solutions it offers. While doctors in the majority of cases provide some sort of advice to patients and possibly the greatest advice to the most sick, the same is not true of the HCC. Organisations which they define as failing, 'unfit for purpose,' receive no direct advice on a way forward. Individuals suffering from specific symptoms often feel reassured by having their illness accurately diagnosed. The diagnosis is thought of as the first step to recovery; in diagnosing the illness, there are several possible paths of treatment. An organisation, being defined as under par, does not share this sense of relief: diagnosis confers no immediate solution.

The work of both Goffman and Sontag illustrate the complex role illness plays in society, how prevalent attitudes not only shape but limit our understanding. Sontag's examination of how military and surveillance metaphors have become ubiquitous in narratives on disease is central in highlighting that no part of life is exempt from rationalisation. In the chapter on stigma I elaborate on this theme providing '18 weeks' vocabulary as a case

²⁵⁶ Freidson, E., (1970)

study. Within my research, the focus of my interest was both the military and surveillance metaphors and how these have once again been co-opted by performance staff. I will show what purposes they now serve, bearing in mind that the focus is no longer on a biological disease.

“Large modern capitalist enterprises are themselves in most cases unrivalled models of strict bureaucratic organisation. Their commercial relationships are completely dependent on increasing precision, reliability and above all speed of operation.”²⁵⁷ The NHS, even as a public sector organisation, in this sense is no different; if anything the focus on these qualities has become more apparent as the NHS has grown and developed. Aneurin Bevan, the founder of the NHS, foresaw the pressures that would face the NHS when he said, “We shall never have all we need. Expectations will always exceed capacity.” From the inception of the NHS, this rhetoric served as a predictor to rationalisation and gave impetus and credence to change. There is an assumption that ongoing rationalisation will bring about radical change in how work is undertaken and yet there is little change in the concepts, categories and nature of work.²⁵⁸ Nevertheless, rationalisation is happening at several levels throughout the NHS: in the organisational structure, and on material and immaterial work. The original panopticon transformed the way people acted, but more significantly changed the way they thought. One example would be the establishment of a performance manager position within a PCT by a new Chief Executive, where previously there had been none. By having someone dealing solely with performance issues in the organisation, the Chief Exec subtly challenges the way people think; he challenges their idea of what is important and visibly consolidates his priorities. He also reasserts his authority by demonstrating that traditional organisational structures are no longer secure. Power operates within organisations and face-to-face relations. Foucault refers to this as micro power; hence, performance management is primarily about micro power relations. My thesis recognises that the facts in the NHS are co-constructed, socially engineered artefacts and that the role that performance management has within the NHS can be compared to a laboratory, in that laboratories sort, process, abstract and rationalize information. My thesis draws upon the wide range of existing literature on the various aspects of rationalisation and applies work already done to newer aspects of healthcare, in particular performance management. Previously people have focused on rationalisation in a clinical setting and on medical treatments. Rationalisation in the NHS is not new, but

²⁵⁷ Runciman, W.G., ed. (1996) p350

²⁵⁸ Beck, U., (2000) p67

the extent, pace and means by which this is happening, through performance management, is largely unstudied. My thesis goes some way to rectifying this.

Chapter 4

Methods

4.1 Introduction and overview to methods

The choice of my methodological approach is informed by my main objectives which are to understand how performance management policy impacts the workplace experience and to understand what is it that performance management seeks to achieve. This chapter will describe the rationale behind the final methods chosen. It gives an outline of the methods employed within this research, which are working as an institutional ethnographer in NHS organisations, using the New Labour health policy ‘18 weeks’ as a case study, the use of in-depth interviews and discourse analysis of major Department of Health documents. I give the reasons for choosing an ethnographic approach. I detail how the method was chosen, a qualitative method that would provide legitimacy, reliability and sufficient reflexivity within the research. The thesis is based on Institutional Ethnography of performance management in the NHS. It is based on the premise, that at the beginning of this research, there was no clear understanding of what performance management work entailed. The focus of the research is to understand the role of performance management within the NHS, through the work of those involved in its creation and sustenance: primarily performance managers and those whose work comes into direct contact with performance managers and the current performance agenda. The research is undertaken with an understanding that performance management in the NHS has evolved since its introduction into the NHS, and moreover that recent politics in the form of the last Labour government elevated and enlarged its role in the NHS further.

New Labour placed an emphasis on being a modern party; one way in which it sought to achieve this modern approach in the NHS was to place an emphasis on science and

scientific practices. Medicine and other sciences had always been at the heart of healthcare, but NHS management was now encouraged to base its decisions on evidence, taking a more scientific approach to decision making. Glancing back at history, the debate between Hobbes and Boyle illustrates how modern scientific knowledge came to be considered as objective, demarcating it from other forms of knowledge²⁵⁹. However, this division between science and sociocultural factors is, according to Bruno Latour, artificial, as the boundaries are constantly shifting and far from fixed.²⁶⁰ Only by stripping away specific aspects of knowledge, though a process of purification and transformation can this reified knowledge exist.²⁶¹ For Latour, we should not stand in awe of the stated results, rather we should seek out ways of understanding the production process behind this knowledge, to go inside the laboratory and see how scientific facts are created. In a similar fashion, performance management can be considered a laboratory for the production of facts. These facts however are not confined to the NHS: they also permeate politics, fashioning ideas of self and national identity. As illustrated in the previous chapter, in the section on language as work, science laboratories are not the sole areas where the purification and transformation of knowledge occurs. Laboratories take on many different guises; performance management in the NHS is one such guise. One aspect of performance management is how the requirement of measurement aids the metamorphosis of data into facts. Data appears from its chrysalis as facts, just as the caterpillar emerges from its cocoon as a butterfly. The whole process remains hidden and out of sight. The nature of performance management work is to act both as a catalyst and a veil to this process. My role as a researcher is to understand what goes on behind the veil.

My primary research tool was institutional ethnography, which includes focused interviews, a case study and my experiences and notes gathered during a period based as a participant in NHS organisations. The interviews were with those whose work comes into contact with performance management and a case study of the implementation of the '18 weeks' policy, which was a New Labour initiative to reduce waiting times and ensure treatment commenced within 18 weeks. In addition, principal documents that inform the research are Department of Health publications that address performance managers directly, such as '*The New NHS; Modern Dependable*.'²⁶² The methodology was chosen primarily because of its ability to capture the reality of those who work within performance management in the NHS. It allows the voices of those who are working

²⁵⁹ Shapin, S., and Schaffer, S., (1985)

²⁶⁰ Latour, B., and Woolgar S., (1986) p152

²⁶¹ Latour, B., and Woolgar S., (1986) p106

²⁶² Department of Health (1997)

within there to speak for themselves about what their roles entail, their purpose and function. The research format allows me to gain access to the individual voice, the personal experience, inner thoughts and feelings which would otherwise remain hidden.²⁶³ However, quotations are neither data nor statistically representative. They provided a way of representing certain behaviours based on my experiences as an ethnographer where I act as the sociological technique. What this generates is a process whereby individual voices layer together to provide a more complete and complex picture of working life. This compiled and analysed research allows the distinct voices to speak collectively with a compound and cumulative effect. Furthermore, “ethnography is valuable to healthcare because it can be used to rethink current policies and working practices.”²⁶⁴

I took a standard approach to reviewing and analysing my experiences, that is: 1) following orienting theory and methodological strategy to theoretical conclusions, 2) case analysis asking questions and challenging given answers and 3) learning theory through action. Though aspects of methodology were centred on a single organization, I hoped by combining several qualitative methods to provide a more complete picture of performance management. My aim in applying this methodology was to produce a comprehensive appraisal of institutional discourse, social institutions and social formations.

4.2 Rationale for Chosen Method

I decided to focus on qualitative types of research methods as I believed it would give me a fuller understanding of the issues in performance management. While quantitative research is concerned with the numbers generated, using statistics to interrogate the data, the primary concern of qualitative research, interpreting social realities, which was more pertinent to me.²⁶⁵ Furthermore, those who work in performance management are very adept at using and providing numbers. As a researcher, I recognised that, had I chosen the quantitative approach, participants would be constantly trying to influence the outcome of the research by manipulating answers and possibly figures as well as attempting to second-guess my motives. My research therefore focused on institutional ethnographic methods: analysis of primary documents and interviews with participant observation providing wider background knowledge. There is no clearly defined ethnographic method; rather ethnography covers a wide range of investigative tools, of which I utilised

²⁶³ Campbell, M.L., Institutional Ethnography and Experience as Data, March 1998, Qualitative Sociology, p82

²⁶⁴ Ross, T. (2012) p93

²⁶⁵ Denscombe, M., (2010) p304

several.²⁶⁶ While the advantage of ethnography is its ability to produce rich, deep, holistic data, the disadvantage is that it is time-consuming and hugely labour intensive.²⁶⁷ Moreover, “infiltrating a culture requires trust and intimacy and these take time to develop.”²⁶⁸ It may appear unhelpful that there is no directive or specified approach in how ethnographic research should be undertaken, but this would be a misjudgement. Rather, this open format allowed me, the researcher, to choose the most appropriate design method.

I chose institutional ethnography over autoethnography as I was looking to gain an insight into how others, working in the field of performance management, experience it. Autoethnography is a self-reflexive approach to research. It aims to explain through, personal experience and systematic analysis, wider cultural phenomena.²⁶⁹ In contrast to institutional ethnography, the researcher’s subjective experience, rather than the experiences of others, is the focus. The approach overturns traditional, well-established, ways of conducting research and representing others. Instead, research is seen as a political, socially-just and socially-conscious act.²⁷⁰ Researchers employing this methodology use aspects of autobiography and ethnography to describe and write an autoethnographic account. Autoethnography incorporates personal narratives in the form of prose, poetry and performances to comment on wider societal realities and reveal hidden truths,²⁷¹ thus being seen as both process and product. While autoethnography has its merits, I opted for institutional ethnography as the basis of my research; I wanted a wider picture of performance management than my own experience of it.

Institutional Ethnography (IE) is focused on discovering ‘how it happens’, exploring people’s relations with others inside an institution. IE has a strong tradition in healthcare research, i.e. doctors, hospitals, pharmacies, community clinics.^{272, 273} Ethnographic methods have been employed in public sector research, and studies in certain aspects of clinical healthcare have been studied in detail.²⁷⁴ These methods have also been used in research into business management. However, having undertaken a literature review, I found that research using ethnographic methods in non-clinical areas of healthcare such as

²⁶⁶ Silverman, D. (2011) pp113-118

²⁶⁷ Ross, T. (2012) p93-94

²⁶⁸ Ross, T. (2012) p93

²⁶⁹ Chang, H., (2008)

²⁷⁰ Ellis, C. (2009)

²⁷¹ Ellis, C., (2004)

²⁷² Silverman, D. (1970)

²⁷³ Silverman, D. (1987)

²⁷⁴ Silverman, D., (1997)

management and particularly performance management was non-existent. The reason for this may be because, within British healthcare, the key players have always been considered to be the patient and the clinician, and as such it is their opinions and their world view which have been sought.

IE combines theory with a practical workplace method, which is why it was an ideal tool for me. It unmask the relations of ruling elites that shape and form everyday life. Its history is based on professionals concerned with forces shaping their work, and activists looking to understand the institutions they confront and seek to change, giving a voice to the silent majority.²⁷⁵ The methods employed in IE include interviewing, ‘talking with people,’ which can take the form of field observation or informal and planned interviews. The purpose of IE is to look at seemingly ordinary conversations or everyday events to reveal deeper truths, to discover and shed light on the practices of everyday life.²⁷⁶ People talk about their work using the language of the institution. There was an institutional language within the NHS and one I argue particular to Performance Management. The following quotation illustrates how IE is central to enabling the researcher to understand the values of the world in which they are located both working and observing.²⁷⁷ “IE is interested in text mediated discourse that frames issues, establishes terms, concepts, and in various ways serves as resources that people draw into the everyday work processes.”²⁷⁸

4.3 My role as an institutional ethnographer

Throughout the NHS during the late 1990s, Trusts were creating Performance posts and many newly appointed Chief Executives introduced the post of Head of Performance and Information. It was in this role that I worked for six months as an institutional ethnographer in a Primary Care Trust. The function and responsibilities of a PCT were described in Chapter Two. In this section, in an effort to retain the organisation’s anonymity, I will keep description to a minimum. I will say is that it was a medium-sized PCT, employing approximately four hundred staff, over half of whom were based in management. The headquarters of the PCT was where the majority of my fieldwork was undertaken. This piece of research was encouraged by the PCT as it touched on some of the organisation’s core values, principally those of openness and innovation. As a three

²⁷⁵ Campbell, M.L., Institutional Ethnography and Experience as Data, March 1998, Qualitative Sociology, p57

²⁷⁶ Denscombe, M., (2010) p80

²⁷⁷ Denscombe, M., (2010) p90

²⁷⁸ DeVault, M.L, McCoy, L., Institutional Ethnography: Using Interviews to Investigate Ruling Relations in Holstein, J. A, Gubruim, J.F., eds. (2003) p382

star Trust for two consecutive years, it appeared that in terms of performance management the organisation was ahead of the game. However, with the move away from the 'star' system to the four point scale for annual performance ratings, in order to stay at the top, the PCT was looking for new ways of improving its service while meeting the expectations of its staff, patients and local population.

The position of Head of Performance and Information for a PCT had important strategic and operational responsibilities in a defined service area whilst making a significant contribution to the Trust's modernisation agenda. I was asked to lead projects both internal to the Trust and on a collaborative basis. The senior management aspect of my role was to provide strategic and management leadership, direction and support of directorate services, ensuring that teams and departments provide a high quality service to the patients and staff of the Trust. Heads of Performance and Information were supposed to become the physical representation of the public; the role was to hold Trusts to account on behalf of the public. However, as a Head of Performance and Information, I had many lines of accountability within the PCT: to the Chief Executive, Director of Finance, the Strategic Health Authority, Department of Health and MPs, with the least importance given to the public. Heads of Performance provided an internal layer of scrutiny, keeping the promise "Management will be held to account for performance levels."²⁷⁹ I contributed significantly to the development, determination and implementation of appropriate policies and strategies relative to their services. I also had the opportunity to influence the development of strategies, policies and operational procedures of the Trust. This role, as described in greater detail in Chapter Two, was about putting New Labour's idea of performance at the heart of an organisation as articulated in the NHS plan; it was about making it a part of the NHS culture, moving away from centralised government and top down management and, most importantly, about reaffirming the change from Labour to New Labour as described previously in Chapter Two.

The job's purpose was: to ensure that the PCT achieves local and national performance targets and that all relevant parties receive performance management information; to work with the PCT's public relations and advise/assist the Chief Executive on internal trust-wide communications; to modernise services to achieve the best services for patients, working closely with the Director of Modernisation. The remit of the role saw me develop the Performance Management framework for Directorates and Departments

²⁷⁹ Labour Party (1997) manifesto

across the Trust, including Implementation of Balanced Scorecard. The Head of Performance and Information was expected to contribute to the corporate agenda, leading on Trust-wide issues as agreed with the Director of Modernisation and Director of Public Health and managing project work arising. In this position I was expected to work in collaboration with internal and external stakeholders, in order to achieve improvements across organisations. This is set out more clearly in the table below.

Key Working Relationships for Heads of Performance

Internal (within the Trust)	External (Outside the Trust)
Chief Executive Trust Executive Directors: <ul style="list-style-type: none"> • Director of Modernisation • Director Finance & Performance • Director of Public Health • Director Nursing & Community Services • (Head) Director of HR & Governance Professional Executive Committee (PEC) members <ul style="list-style-type: none"> - Assistant Directors of Operations - Assistant Directors of Finance - Head of Analysis - Head of Systems Delivery and Integration - Head of Patient Administration - Head of Service Planning & Commissioning - Service Improvement Managers - Head of Clinical Governance - Head of Risk 	<ul style="list-style-type: none"> - Department of Health - Strategic Health Authority - Primary Care Trusts - Local Authorities - (Modernisation Agency) - Third party System/Information Providers (BSS) - Information Colleagues in other Trusts

As the Head of Performance and Information I worked with the Director of Finance and Performance to oversee the operational, day to day management of Trust Performance Management Framework. The role required me to maximise the use of financial resources and ensure all staff were involved and able to contribute to their full potential within a supportive environment, with a focus on service delivery. This aspect of the job follows Margaret Thatcher's three E principles, those of Economy, Efficiency and Effectiveness (as described in Chapter Two). The role was not just to provide strong leadership for setting direction and delivering excellent service results but to act as a role model for all departmental staff, providing a positive 'can do' approach. I was expected to participate in the trust modernisation agenda required by the chief executive or Director of Modernisation leading specific projects as appropriate. As Head of Performance and Information my role was to actively support executive directors in the exercise of their roles or responsibilities, to bring the necessary 'clout' to the performance agenda when this was required. I was expected to participate in projects and programmes of work

across the trust as required by the chief executive. This style of working was actively encouraged and promoted by Chief Executives as their jobs, through star ratings - a performance rating mechanism - were at stake if the organisations they led were assessed as failing.²⁸⁰

I held two roles simultaneously: as an employed member of staff, I was the Head of Performance and Information, and by my own choice I was an institutional ethnographer, a researcher. Reflexivity required me to operate on multiple levels, recognising as a researcher I was intimately involved in both the process and product of the research project.²⁸¹ Therefore, having a critical reflexive awareness, understanding the role I played as researcher within the research project was paramount. In the role of an ethnographer I “learn to speak the language that I wish to interpret.”²⁸² As an ethnographer some basic questions were redundant as these were answered by my day to day observations. The interviews gave me the opportunity to check whether the assumptions and inferences were accurate and to clarify areas of ambiguity. Part of triangulating my research included keeping field notes and reflective diaries during the research period. This provided a medium in which I commented on significant events that occurred as well as jotting down informal remarks and my immediate reactions to what I heard. It was not practical to record every conversation because of the sheer volume of recordings, transcriptions and analysis that would be created. Moreover, some would no doubt be mundane conversation irrelevant to the focus of my research. Writing my reflections on a more ad hoc basis allowed a judgement to be made at the time as to what was significant and what was not. Habermas’ concept of *Verstehen*²⁸³/ understanding was helpful here in explaining what I was attempting to achieve: seeking to recognise the link between one’s own life experience and the tradition to which one belongs, and the sphere of communication between different individuals, groups and traditions.²⁸⁴ Thus a reflexive diary acted as aid in providing context to the other parts of my research, particularly in-depth interviews. The process gave me greater confidence that my attention was focused on what was relevant. As an institutional ethnographer both what I observed in the interview setting and outside it was as important as what was actually said. By noting the reflections made by myself and participants in real time, I gained a deeper understanding of performance management as it was experienced and was clear about the issues faced by participants.

²⁸⁰ Setting Targets for Health Care Performance: Lessons from a Case Study of the English NHS. Gwyn Bevan *National Institute Economic Review*. 2006; 197: 67-79

²⁸¹ Denscombe, M., (2010), pp86-87

²⁸² Bauer, M.W., and Gaskell, G., eds. (2000) p14

²⁸³ Habermas, J., (1984)

²⁸⁴ Bauer, M.W., and Gaskell, G., eds. (2000) p14

Actions do often speak louder than words. Gestures and actions informed my knowledge of who held genuine influence and the informal and formal hierarchies that existed within the organization. In terms of accountability, the organisational chart structure was of limited use, especially in the PCT, which, along with other PCTs in the country, underwent a merger. The merger began during 2006 and took place while I was located in the PCT. Observation did not provide me with the answers as to the ‘whys’ of certain behaviours but it acted as a prompt to new themes I had not previously considered. Whyte said, “Social scientists may assume that people in organizations we study do not have any theories to guide them. In fact people cannot make sense of the world around them and act in any coherent way without some theory. The problem is that practitioners seldom explicitly articulate local theory. They do not tell us, ‘I will do X because the ABC theory tells me to do so’. We have to discover the nature of the local theory from observing what people do and getting them to explain their actions and beliefs.”²⁸⁵ One of the early triggers to my research was noticing how clinical and managerial professionals often interpret and make sense of vague public health commitments proposed by the government.

4.4 The use of in-depth focused interviews

I also carried out a total of seventeen semi-structured interviews with individuals working in performance management or having direct links to performance outcomes.²⁸⁶ One of the reasons for choosing this approach was because my working knowledge of what is involved in NHS performance helped me in asking specific, pertinent and direct questions. Questions were posed around themes, which included trust, leadership, regulation, performance management and NHS development. This followed Whyte’s methodology where conversation is centred on themes and questions are intentionally open to allow the respondent to frame their understandings and world views.²⁸⁷

Schedule of Interview Questions:

1. Could you tell me about your role in the PCT?
2. How does that link in with performance management?
3. What does performance mean to you?

²⁸⁵ Whyte, W. F., (1984) p190

²⁸⁶ See p 269 Appendix A for a general list roles of staff identified and interviewed.

²⁸⁷ Whyte, W. F., (1984)

4. What do you think it means to the public or patients?
5. How well do you think performance management works?
(What day to day problems, if any, do you experience while doing your job?)
6. What has changed in your role over the last (10?) years?
7. How have information requirements changed?
8. What is it like working for the NHS?
9. Talk me through the reorganisation.
(What has that been like for you?)
10. What makes an effective organisation?

According to Malinowsky, “it is impossible for outsiders who come from a dramatically different culture to participate fully in the lives of people they study.”²⁸⁸ This statement has enormous truth to it. This impression has been reinforced through my working knowledge of NHS. Staff often view outside research consultants with scepticism for several reasons: they have no real understanding of health service provision; their main concern is to increase productivity but they rarely take into account the lack of real market forces; successful management structures from within industry seldom transfer effectively to the public sector; the knowledge that their jobs or those of their colleagues could be at risk. When I employed this approach, I did not face the accusation of being an outsider or someone ‘who doesn’t really know what is going on.’ I had other issues to deal with.

One of the initial problems I anticipated in being a participant was that others would see me as part of the organisation and possibly part of the problem, and thus be unwilling to talk freely. However, I noticed early on that PCT staff took on board with apparent ease the fact that I had two roles: that of an institutional ethnographer and the other, as member of the organisation. Since the start of this project, staff to whom I otherwise would not have spoken shared their experience of performance with me. They seized the opportunity to voice their opinions, finding this in some ways cathartic. In the NHS this was a period,

²⁸⁸ Whyte, W. F., (1984) p28

2006-7, of great uncertainty: there were organisational mergers occurring (currently there are 303 PCTs; in the future approximately only a hundred will exist²⁸⁹), large-scale redundancies were being made and management posts, including my own, were most at risk as Trusts struggled financially. This feeling of uncertainty that individuals experience is a theme which I address, particularly as this feeling was intensified and brought to the fore by the threat of redundancy. My dual role as participant and researcher was an asset rather than a problem as my professional background enabled me to recognise where to probe more deeply.

4.5 Sampling and data collection

The interviews took place with those who were involved in performance management. They included: information analysts, public health data specialists, performance managers, service heads and commissioning managers. It was a one-off interview for each of the interviewees, with the intention that each interview last a maximum of one hour. However, when a couple of interviews went over this limit I allowed the interviewees to continue as they were providing valuable data. The order of the interviews depended largely on the availability of the individuals as the interviews took place around their work schedule. I had no wish for a more formal process, as I did not want those being interviewed to feel that there was a hierarchy in the process, or that greater weight was given to certain opinions. Ashmore *et al* scrutinised the practices and discourse of health economists to understand how they rationalised NHS policy and decision making, doing this through interviews and focusing on key reforms. I picked up where Ashmore *et al* left off but, rather than focusing on health economists, my attention was on the NHS workforce. Those who are openly sceptical about performance agendas were also interviewed, for example Public Health Managers. Their contribution was useful in terms of giving an insider outsider perspective; that is, someone who works within the NHS but is not directly involved with performance management. The differences, similarities and points of contention they raised in contrast to the other interviewees highlighted deeper issues. I conducted semi structured interviews around themes, e.g. trust, leadership, regulation, performance and NHS development, rather than a closed questionnaire. This I felt would be more productive as it allowed me to pick up on any new point that needed further clarification, rather than having to write down a series of questions.²⁹⁰ Without the constraints of a formal questionnaire, staff were less likely to give a normative account of

²⁸⁹ The number of Strategic Health Authorities was slashed from 28 to 10 in July 2006. This was in line with the 2001 Labour Manifesto pledge to “cut the number of health authorities by two-thirds”, p13

²⁹⁰ Denscombe, M., (2010) p175

what occurs within the organisation.²⁹¹ This format was less regimented and left the interviewee free to give a fuller response.

I tape-recorded all the interviews I conducted. This way I could actively listen, ensuring my personal views were not directly or indirectly expressed, concentrating on what was said and checking to make sure the interviewee was clear about what s/he had stated. I guarded against needless interruptions which would break the interviewee's train of thought. This approach meant that I did not need to worry about taking detailed notes during the interview. Nor was I relying solely on my memory, as my focus in the write up was on what I considered important at the time. It was only after all the interviews were complete that a real assessment of what was valuable was made. When writing up I used the subjects' description to explain their specific experience, while my own perspective provided clarification and a general summation of the situation.

4.6 Coding and Interpretation

With regard to the indexing and evaluating data produced from the interviews, I considered using the Atlas tool to link themes, events and individuals, though I had concerns about research that has an over-reliance on the use of this tool, as analysis could easily slip into a coding exercise and little else.²⁹² In the end I kept software use to a basic minimum, using a series of themed tabs which I cross-referenced in an Excel spreadsheet. This provided me with a modern version of index/file cards which were both mobile and easily accessible to me during the working day. The aim of my analysis was to provide some structure and coherence to the mass of information gathered. While it was important to have a clear methodology, it was equally important that my data did not swamp the research and that real analysis took place. On this issue I was very firm. This resolution stems from working in the NHS and realising that it holds huge amounts of data in various forms and locations, but does not have the resources to understand or use the data it holds. Whyte states that "it is useful to think in terms of two issues: breadth versus depth and description versus analysis."²⁹³ Finding the appropriate balance was essential for me, but it is the last word of each two phrases which will prove valuable, as the NHS rarely has the resources to undertake this type of non-clinical, non-patient focused study.

²⁹¹ Denscombe, M., (2010) p188

²⁹² Denscombe, M., (2010) p278

²⁹³ Whyte, W. F. (1984) p226

4.7 Using the 18 weeks policy as a case study

4.7.1 Introduction to 18 weeks initiative

A case study was undertaken of ‘18 weeks.’ This was a term used within the NHS, shorthand for referring to the time taken from GP referral to hospital treatment. Eighteen weeks was the maximum time allowed; it acted as a standard against which other aspects of the patient’s treatment were measured. More importantly ‘18 weeks’ was a New Labour manifesto pledge. The phrase was first used in 2004 by the Department of Health in the document *The NHS Improvement Plan* where a commitment was made that all patients would be seen in this timeframe by December 2008. During 2008, as the deadline approached, ‘18 weeks’ had regained prominence in the NHS so that its delivery had become the central aspect of performance managers’ work.

Case studies are an excellent way of gaining understanding of complex issues and strengthening what may already be known through previous research. Case studies focus on providing detailed contextual analysis of events, situations, conditions and relationships.²⁹⁴ However, the criticisms of case studies are that owing to their scale they cannot establish reliability nor can generalisations be made of findings.²⁹⁵ Nevertheless, researchers continue to employ this approach as phenomena can be studied in its entirety within a real life, natural, context.²⁹⁶ The aim of this case study was to understand how the introduction of a government target 1) changed the way in which old processes were viewed and 2) allowed us to see the way in which the target created a new way of seeing. The research centred on how the actors, in this case performance managers, conceptualised the ‘18 weeks’ policy; how it operated both as an epistemology and a technology. The focus of this research was specific to one policy and was done within the constraints of NHS. However, the results would be of wider benefit, illustrating how a small change in policy by the State can completely alter a world view for organisations and thus for the wider population.

4.7.2 Political background and detail to the ‘18 weeks’ policy

In this section I provide the political background and the detail of the ‘18 weeks’ policy in order to illustrate why it became a priority for the Strategic Health Authority SHA. Details of the role of an SHA were described in Chapter Two; it was here that the case

²⁹⁴ Denscombe, M., (2010) p52, 62

²⁹⁵ Denscombe, M., (2010) p61-62

²⁹⁶ Denscombe, M., (2010) p53-54

study was located and where I was based. This background also helps to set the context to my research questions.

'The NHS Improvement Plan' published in June 2004 introduced the Government's ambition that "by 2008 no-one will wait longer than 18 weeks from GP referral to hospital treatment."²⁹⁷ The reason for this figure was that previously the average length of time from GP referral to hospital treatment was 18 months. The move to 18 weeks was seen by New Labour as a memorable way of highlighting progress within the NHS to the wider public. Its success was seen as being as much of an achievement of the NHS as of the Labour government. The 18 weeks pathway strategy appeared as a central reform in modernizing the NHS, and in this respect was part of the "civilising mission," dragging the NHS infrastructure into the 21st century. As Scott states, "The builders of the modern nation state do not merely describe, observe and map, they strive to shape a people and landscape that will fit their techniques of observations."²⁹⁸ Nowhere was this more clearly demonstrated within healthcare than in the 18 weeks pathway. I wanted to understand what it meant to be a patient going through processes of transformation, reclassification and rationalisation.

The 18 week pathway focused on delivery of an efficient, effective and safe patient journey from initial GP consultation and referral to the start of treatment and included the previously hidden waits within diagnostics and patient follow-up. The scope of the target included waits for GP referrals, consultant-led services including consultant-to-consultant referrals, A&E and Walk-in Centre referrals and any therapies that form part of the patient's treatment in secondary care. PCTs were held to be fully accountable for the achievement of the 18 week Referral to Treatment (RTT) pathway for all patients. They assumed responsibility, in line with the NHS Contract, for the performance of any providers and ensured that the commissioning of any activity delivered achievement of the target for each patient. RTT times were assessed using clock start and stop times; a fuller description of what this entails is given in the later chapter on stigma under the section 'A dictionary of terms'. The PCT was required to identify and capture this information from all providers along the pathway ensuring performance was managed. All patient pathways needed to be identified, analysed, redesigned where necessary and then measured. This required significant engagement from clinicians and management across the whole of the

²⁹⁷ Department of Health (2004)

²⁹⁸ Scott, J.C., (1998) p82

SHA, both within each organisation and across those organisations that shared responsibility for delivery of the end-to-end patient journey.

Key targets and milestones had been identified by the Department of Health to enable organisations to manage the changes in working practice. PCTs failing to achieve the targets at the December 2008 deadline were to be penalised according to the degree of failure. It was therefore imperative that actions were taken to ensure achievement of the target and the SHA had established a programme of work to support and help manage the delivery of the changes required across the health economy. This programme built on the structure and focus areas identified in the National Implementation Programme i.e.: Engagement (clinicians, management and patients), Communications, Policy and System Reform; Planning and Strategy; Measurement; Performance Management; Navigation (Monitoring, knowledge sharing); Service Transformation and Commissioning; Intensive Support.

The LDP and contracting process for 2007/08 were concluded and plans put in place by all PCTs and Trusts to achieve the following requirements as set out in the Operating Framework by March 2008:

- 85% of pathways where patients are admitted for hospital, and 90% of pathways not ending in admission, are completed within 18 weeks
- Stage of Treatment milestones of a maximum of 5 weeks for a first outpatient appointment, 6 weeks for diagnostic test and a maximum of 11 weeks for elective inpatient treatment are achieved

The SHA where I undertook the case study managed approximately 25 NHS organisations, including PCTs, hospital Trusts, ambulance Trusts and mental health Trusts. It was one of ten SHAs that were established across England whose role was to regulate commissioning and the delivery of healthcare across the region. My role in the SHA was to performance manage local organisations against government targets including 18 weeks, and this gave me both the opportunity and direct access to see how a single target was implemented. Within the SHA which was to be my focus, most organisations were using Stage of Treatment milestones of a maximum of four weeks for outpatients and diagnostics and ten weeks for inpatients for their capacity plans in order to ensure delivery of the 85% and 90% targets. These plans had been reviewed against national and local capacity assumptions and local demand management plans. Monitoring was

continued on a weekly and monthly basis with the use of dashboards, which gave a visual representation of performance.

The SHA had committed itself to achieving the 18 week target, from referral to first definitive treatment, nine months ahead of the December 2008 deadline and within the SHA this project was referred to as 'Further Faster'. The scope of the programme covered the SHA and its associated PCTs. Achieving the target ahead of the national schedule was accomplished through two mechanisms: firstly, provision of additional resources to reduce the existing backlog, and, secondly, provision of support to PCTs to redesign and implement sustainable improvements to patient pathways which ensured that waiting times remained below 18 weeks in the long term.

Work to redesign and improve patient pathways across the SHA was coordinated through the "End Waiting, Change Lives - Transforming Care" Programme, a joint initiative between the SHA and the PCTs²⁹⁹. The main goal of the Programme was to equip personnel within PCTs with the service improvement skills and motivation to continuously improve patient pathways (in terms of waiting times, overall patient experience and quality, efficiency and staff morale).

In attempting to attain the overall target, mini-milestones had been identified by the SHA in order to assess progress.

By End Dec 2008:

- 100% of all patients treated within 18 weeks but likely to include tolerances to take into account patient-initiated delays and clinical exceptions i.e. 10% admitted and 5% non-admitted. This was later confirmed in the Operating Framework.

- Good results from patient's feedback survey.

- The SHA Shadow Early Achiever

•By December 2007:

- 90% of admitted – in 4 specialities for patients in a particular county from a specific hospital.

²⁹⁹ Information about the programme of work, 'End Waiting, Change Lives - Transforming Care' was initially set out through several stakeholder meetings between SHA and PCTs. Here the remit of what the programme would cover was discussed and formalised so that all parties were in agreement.

•95% of non-admitted – in 4 specialities for patients in a particular county from a specific hospital

The SHA Accelerated Delivery (Further, Faster...)

By March 2008:

•90% of admitted

•95% of non-admitted

In recent times, the SHA and the organisations which reported to it have found themselves responding to the criticism that they are “hitting the target but missing the point” and, as Scott puts it, there was “a strong incentive to prefer precise and standardizable measures to highly accurate ones.”³⁰⁰ In response to this argument they tried to identify what good looked like. This was an attempt to show that not only was the target achieved but that the original spirit in which the target was set was also being adhered to. The list below sets out what achieving the target in a good and appropriate manner would look like:

•RTT admitted and non-admitted achievement of 90% and 95% but coverage needed to be at 90% level

•Zero unknown clock starts

•No patients waiting over 20 weeks for in-patients

•No patients waiting over 11 weeks for out-patients

•No patients waiting over 6 weeks for diagnostics

•Incomplete – Reduction in length of wait month on month

•Patient Tracking List (PTL) – ability TO report last week’s RTT activity, completeness of data, low or zero unknown clock starts. The total number of patients waiting on the PTL was reduced; the stock of patients who had breached 18 weeks and were still awaiting treatment was reducing. The number of patients passing breach date each week reduced to a level which was consistent with the tolerance.

•Good results from patient surveys

³⁰⁰ Scott, J.C., (1998) p81

The list illustrates Ritzer's claim that "The performance of the incumbents of positions within bureaucracies is reduced to a series of quantifiable tasks"³⁰¹, such that volume becomes the main measure of success rather as on an assembly line. To counteract this within the SHA the project around '18 weeks' was to be completed and considered successful when all project activities had been undertaken and an agreed methodology for pathway redesign were available to all PCTs. PCTs and hospital Trusts were expected to redesign efficient, patient centred care pathways for agreed high priority conditions that consistently delivered minimal patient waiting times. PCTs had redesigned and implemented agreed pathways over the nine month period. A Knowledge Management infrastructure was in place to ensure PCTs were able to share the outputs of interventions across the SHA, to consist of both electronic document search-and-retrieval tools and formal networking mechanisms. Embedded skills and experience in the application of the agreed Lean Thinking³⁰² methodology, such that individuals were comfortable that they could replicate the work completed with little or no external support, could be measured and reported by the PCTs.

The main objectives for the Further Faster programme were fourfold:

1. Support and monitor the development of redesigned care pathways in PCTs and Trusts across Strategic Health Authority to ensure that achievement of the target of 18 weeks from referral to treatment was sustainable;
2. Ensure effective programme and project management structures, disciplines and resources were in place to deliver the changes required;
3. Support effective communications, involvement and engagement activity across the SHA to ensure clinical and patient representatives were supportive and active in delivering new patient pathways;
4. Ensure PCTs and Trusts took appropriate steps to develop a workforce with the right skills and behaviour to change ways of working for the benefit of patients and healthcare colleagues.

³⁰¹ Ritzer, G., (1993) p21

³⁰² Lean is a management technique, initially proposed by Toyota, in order to reduce waste within their organisation. This approach has since been picked up by other organisations that are trying to increase efficiency and to keep waste to a minimum. The SHA has 'encouraged' the organisations it manages to take part in Lean workshops.

It was hoped the 'Further Faster' programme would ensure that, for the participating PCTs, their chosen pathways became efficient and effective and were designed, implemented and utilised by clinicians and commissioners, and shared across organisations where appropriate and safe to do so. It would also help to develop experienced and skilled Lean practitioners within the programme, and provide a shared repository of knowledge for subsequent use by the PCTs and the SHA. The primary benefits to the stakeholders would be realised from achievement on each of the re-engineered pathways. The SHA and PCTs intended to achieve the 18 week RTT trajectories for their selected pathways in a sustainable way that contributed to financial balance and high quality patient care, thereby avoiding financial penalties for non-achievement. Patients would receive treatment quickly, in the most appropriate setting, potentially leading to better clinical outcomes. Patients and carers would be highly satisfied with the services provided, enhancing the reputation of high quality service providers. Following development and implementation of new pathways, patients would have equal access to services (based on clinical need). There would be high levels of staff satisfaction through structured learning and the knowledge that patient care was of a high standard. Cooperation and partnership working across the social and health care sector would lead to joined-up, effective patient care planning. Moreover PCTs were equipped to continue Lean pathway development for the future.

The 'Further Faster' programme of work was focused on the measurements supporting Scott's theory. According to Scott the five principal characteristics of state simplifications are utilitarian facts, written documentary evidence, static facts, aggregate facts and standardised facts³⁰³. The measurements around the patient pathway were poor at first but become more detailed, with the introduction of tables, charts and registers. Patients took on qualities similar to inanimate items and therefore were disposed to being organised. It was then possible to measure and standardise parts of the patient journey within the health system. The employment of tables leads to systemisation, a focus and precision previously unseen. While local knowledge and local standards were at best informed approximations of what happens to a patient, the introduction of the 18 weeks pathway had deconstructed this experience only to rebuild it. The patient undergoes quantification, a process similar to Weber's rationalisation which strips away the local context, removing any situation-specific knowledge and historical account. "Particular customs of measurements were

³⁰³ Scott, J.C., (1998) p80

thus situationally, temporarily and geographically bound”³⁰⁴ with many of these measurements dependent on the skills of the individuals and the interest groups to which they belonged. The insight into a wider history that they provided was disregarded in the rush to quantify that which was under scrutiny, in this case the individual’s treatment pathway.

As discussed in the previous chapter, in Theoretical Background, Scott calls upon the example of forestry in the 19th century and notes that it was seen primarily in economic terms and discussed in terms of revenue. The language used is similar to that employed by an accountant, that of “minimum diversity” “balance sheet” “sustain yield.”³⁰⁵ The discussion was based on utilitarianism in relation to the state: nothing outside revenue production has value and is therefore of no interest. In this context the forest is considered principally in fiscal terms. The language reclassifies the world into a world of the valuable - in this case crops and livestock, and the other, the worthless, which are weeds, pests, predators and vermin. This is relevant to the case study as the 18 weeks programme had seen new language come into being, new ways of defining the patient’s experience unbeknownst to the individuals themselves. The research questions I posed tried to uncover and understand this process.

4.7.3 Research Questions

Within performance management, judgements are instinctive and formed both rapidly and frequently on the basis of group norms which are rarely queried.³⁰⁶ Practitioners and managers must invoke a range of rationalities to justify, explain, excuse or exonerate their actions.³⁰⁷ There is a sensemaking process occurring.³⁰⁸ Those working within the 18 weeks project would have learnt in a relatively short space of time to reason in an institutional context. 18 weeks was an artificially constructed reality; Habermas would refer to the ‘lifeworld’ of the patient being intrinsically altered. It was a lifeworld that had become simulated and codified in order to undergo measurement. I wanted to understand the technical heuristics that lead to this conformity, standardization and homogenisation of pathways, because the final measured product had more reality and meaning in the eyes of the State.

³⁰⁴ Scott, J.C., (1998) p26

³⁰⁵ Scott, J.C., (1998) p15

³⁰⁶ Weick, K.E (1995) p79

³⁰⁷ Weick, K.E (1995) p15

³⁰⁸ Weick, K.E (1995) p14

My empirical research focused on asking actors '18 weeks' work the following questions:

1. How has the notion of 18 weeks come about?

What historical context do those working with the 18 weeks give to the policy? How does this frame their understanding of how the policy came into being? Does setting '18 weeks' into a wider framework of health policy help in their delivery of the target?

2. How had the idea of the 18 week pathway been constructed within the NHS and SHA?

How has the 18 weeks policy become a pathway? How do the dashboards work as visual representations of the 18 weeks pathway? In what way is this similar to the wider national debate on achieving the '18 weeks' target and how is this different locally at the SHA level?

3. How are these constructions prioritised?

Which measurements are given priority? How do performance managers choose between priorities? How does this process work?

4. What post ad hoc reasoning do individuals give to normalise their actions, in particular to emergent errors or miscalculations?

What rhetoric do individuals use to justify their actions? How are performance managers rationalising their behaviours?

5. How was the 18 week construction relevant to the public?

Do performance managers think the public know what 18 weeks is? What is the purpose, the goal of 18 weeks?

4.7.4 Sources and Methods behind '18 weeks' case study

The intention then was to gain a real understanding of the 18 weeks policy, as a specific example of performance management, how the patient pathway had been redefined and in particular the 'Further Faster' project being undertaken by SHA. Frederick W. Taylor (1856-1915), the founder of scientific management, devised methods to improve industrial efficiency through maximizing the organisational working structures and environment. "Taylor believed that the most important part of the work world was not the workers, or even the managers but rather organisations that must be constructed to plan, oversee and control their work.....it was the task of management to study the knowledge and skills of workers and to tabulate that knowledge and skill to laws, rules and even mathematical

formulas.”³⁰⁹ This could be a clear description of the role of the SHA, and particularly its part in the implementation of the 18 weeks policy. I had originally thought to do a vertical study, taking a single record and following its journey through the system, looking at one patient’s experiences of the NHS. However, the time constraints, together with not knowing when the patient journey would end, made this option less feasible.

I was nevertheless ideally placed to get a thorough understanding of how the patient had been reclassified though a horizontal study; the focus was on one layer of the organisation, in this case the work and perceptions of performance managers at the SHA. Unlike a PCT where only one performance manager exists, in a SHA there are a number of performance managers. The SHA consists of several regional areas, each one with its own corresponding performance manager. I undertook interviews with all eight performance managers in the SHA, with each interview lasting between sixty and ninety minutes. This was the organisation that implemented and gave grounding to the Department of Health’s vision. As such its focus was on the rules and regulations that lead to the standardisation of measurements. It managed a number of organisations, so by talking to those involved in this target I gained a clear picture of the challenges each organisation faced and the strategies they employed to deal with difficulties arising from these new ways of measuring.

Scott states that “control co-ordinating schemes do work effectively under conditions where the talk environment is known and unchanging, where it can be treated as a closed system. The more static, standardised and uniform a population or social space is, the more legible it is, and the more amenable it is to techniques of state officials.”³¹⁰ However, this was contrary to the current position of the NHS; the last ten years had seen it in constant flux. I was curious to know whether high levels of dissatisfaction felt by the staff had affected its ability to implement such schemes efficiently and if there was a sense of ambivalence to the inevitable changes which the actors faced. Bauman³¹¹ argued that it would be reasonable to expect rational workers, confronted by lack of transparency and clarity in modern bureaucracies, to adopt a position of ambivalence. I assumed that the language used throughout the interviews would be indicative of interviewees’ wider feelings about work satisfaction and as such would not be directly questioning on this subject.

³⁰⁹ Ritzer, G., (1993) p118

³¹⁰ Scott, J.C., (1998) p82

³¹¹ Bauman. Z., (1993)

My research questions arose from simple preparatory work as an ethnographer in this area and were developed in each of the interviews. The ethnographic work consisted of my involvement in monthly performance meetings to monitor progress made by PCTs on 18 weeks over a period of six months at the start of 2008, attendance at six 18 weeks workshops led by the SHA for PCTs and Trusts, as well as regular reviews of the information published by the DH on its national '18 weeks' website. During this time I also kept extensive informal notes of team meetings, conversations and phrases of interest I heard.

The research for the case study was primarily in the form of qualitative interviews with eight performance managers. Each interview was taped and lasted approximately 45 minutes. The only recordings taken were those of the interviews; there were no other media recordings as I felt this would have been overly intrusive.³¹² I chose to undertake qualitative interviews because this allowed me as the interviewer and ethnographer to understand what others in similar situations to mine were thinking and feeling.³¹³ The feedback contained dense description; it gives the opportunity to the researcher to see how individuals are making sense of their worlds, while giving them the opportunity to describe their experiences freely in their own language.³¹⁴ Following the interviews with participants, transcriptions were made and analysed alongside my field notes. The analysis, coding and interpretation were undertaken in the same manner as the earlier interviews, within the framework that helped me to derive greater meaning and understanding of what I had observed.

4.8 Discourse Analysis of Department of Health policy documents

I initially considered employing critical discourse analysis (CDA), but instead chose to use the broader approach of discourse analysis (DA). DA was applied to my research in two ways; firstly to focus on key Department of Health documents that shaped performance management and secondly to influence and inform my ethnographic research.

Discourse happens at several levels including political and institutional. Institutions like the NHS hold immense power by providing social cohesion. This latent power becomes apparent in how it disseminates information, engages in discussions with the public and conducts dialogue with its staff. DA focuses on language, not on its linguistic nature, but

³¹² Blaxter, L., Hughes, C., Tight, M., (2008) p172

³¹³ Denscombe, M., (2010) p180

³¹⁴ Denscombe, M., (2010) p173

rather on both written and spoken discourse while critical discourse analysis provides a ‘3-dimensional picture’ through 1) the analysis of language texts 2) the analysis of discourse practices and 3) the analysis of discursive events³¹⁵. What DA and CDA have in common is that they are both methodological approaches that highlight the relationship between language, ideology and power, as well as the relationship between discourse and sociocultural change. Language can not only define the discourse but also set the political agenda. The documents I focused on provided a history and helped set the context. A brief analysis of documents provided an insight into political discourse while interviews provided an insight into institutional discourse. There was of course an overlap between the two spheres and employing DA on both primary documents and interviews highlighted where this occurred.

In contrast to discourse analysis, CDA necessitates text being broken down in terms of argumentation, rhetorical figures, lexical styles, storytelling, structural emphasis, credible writers and expert quotation. When studying the text, genres that are usually considered are communicative acts and social meaning, participant positions and roles, speech acts, macro semantics (topic), superstructures (text schemata)³¹⁶. Within text and talk both local meaning and coherence should be uncovered, including levels of specificity and degree of completeness, perspective, implicitness³¹⁷. I did not apply this level of detail to my analysis, but, while conducting textual analysis, I was alert to the different levels at which text works, that is both the structure of the text on the page and how that text relates to an organisation such as PCT as well as, more widely, to an institution like the NHS. I restricted the scope of the research, excluding media texts as their inclusion would have limited the time spent on analysing the data from the interviews.

NHS staff have a significant shared knowledge base which has its own language codes and abbreviations. There is also the knowledge of principles and norms of language use, knowledge of situations as well as knowledge of the wider world.³¹⁸ I incorporated and applied three of Fairclough’s definitions - subject, client and public -³¹⁹ to both the PCT and the NHS. I used the term ‘subject’ to refer to individuals in the institution, institutional roles and identities. ‘Client’ is used in relation to outsiders and in an NHS context this was the patient. The concept of ‘public’ refers to the larger audience to which

³¹⁵ Fairclough, N. (1997) p2

³¹⁶ van Dijk, T (1993) pp271-273

³¹⁷ van Dijk, T (1993) pp275-277

³¹⁸ Fairclough, N. (1997) p33

³¹⁹ Fairclough, N. (1997) pp38-39

institutions such as the NHS address their communication. Institutional ethnographers often suppress personal information, identifying speakers instead by location in the institutional work process, for example nurse, client, teacher, administrator. This is something I replicated in my research to maintain a degree of separateness.

I utilised the same methodology as Norman Fairclough (2000), in that I was not exhaustive in my use of published NHS documents, concentrating rather on those with a key impact on shaping performance management. As Fairclough states “CDA should focus its attention upon discourse data within the history of the present.”³²⁰ Therefore, I focused on the period from 1997, when Tony Blair’s New Labour took office. There were a great number of documents written by numerous agencies within government, but, I directed my research to high level policy documents published by the Department of Health, because these address both the public and NHS staff, as well as stating the primary audience is ‘professionals’. Furthermore, in major policy documents, there is usually a foreword by the Prime Minister and a preface by the Secretary of State for Health. The documents under study were as follows:

- The New NHS: Modern, Dependable (1997),
- The NHS Plan: A plan for investment, a plan for reform (2000),
- Shifting the Balance of Power: Securing delivery (2001),
- Delivering the NHS Plan: next steps on investment, next steps on reform (2002),
- NHS Improvement Plan: Putting people at the heart of public services (2004),
- Creating a Patient Led NHS: Delivering the NHS Improvement Plan (2005),
- Our health, our care, our say: a new direction for community services (2006).

By focusing on the text within these documents I am acknowledging that text had a greater meaning than that which was on the page. Policy text has several levels of meaning: 1) its intended political meaning and the meaning ascribed to it, 2) management level, how text is handled and employed, 3) day to day interaction, the way in which text is put into action by staff. Looking at the texts in this manner helped inform and frame my ethnographic observations as all three levels contribute to explaining how people give language meaning.

³²⁰ Fairclough, N. (1997) p19

4.9 Summary of Ethical considerations

I concentrated on qualitative research methods in order to gain a fuller understanding of the issues in performance management. There were, however, ethical considerations that came with choosing this approach. As with any type of observational work, institutional ethnography requires more than an element of self-awareness as in effect you are an embedded participant-observer. Observation is not a passive act as selection and interpretation occur in mind of the researcher.³²¹ I was aware of the problem of imposition, that I could pollute my research with my own beliefs and values, possibly skewing the findings. I recognised early on, when considering the methodology for this study, that while undertaking interviews with NHS staff I would be supplementing, authenticating and validating what I heard with my own experiences. This being the case, it seemed that for me to write off my own experiences would be a waste of the valuable knowledge I had gained over years in the NHS. I believed and still do, that it was better to take those experiences and analyse them in the same way as those that had been interviewed and observed. This process allowed me to reflect on all observations and experiences in their totality while also providing me with a sense of detachment.

My role as institutional ethnographer was fundamental to my research. The reason why it proved to be invaluable is summed up nicely by the researcher and sociologist William Foote Whyte: “As I sat and listened, I learned answers to questions that I would not even have the sense to ask if I had been getting my information solely on an interview basis.”³²² However, one of the problems of being a participant was that others would see me as part of the organisation and possibly part of the problem, and as such might be unwilling to talk freely. I had worried that keeping the diary might act as a distraction, making those with whom I worked cautious in their behaviour. However this was not the case. My work colleagues with were aware of my reasons for keeping notes. This practice was taken as the norm and my behaviours were accepted by participants and those around me. Moreover, I noticed that staff took on board with apparent ease the fact that I had two roles: that of an institutional ethnographer as well as a member of the organisation. Since starting this project, I found staff, whom otherwise I would not have spoken to, sharing their experience of performance with me. They seized the opportunity to voice their opinion and some reported that they found the interview process cathartic.

³²¹ Ross, T. (2012) p107

³²² Hammersley, M. and Atkinson, P. (1983) p 303

As an institutional ethnographer I involved myself in everyday work situations taking on board all that I encountered, trying to make sense of the routine interactions. The period during which I undertook my research was one of great uncertainty for the NHS: there were organisational mergers occurring (of the 303 PCTs, in the future only approximately a hundred would still exist), large-scale redundancies were being made; the people most at risk were management, including myself, as Trusts struggled to break even financially. This feeling of uncertainty that individuals experienced was a theme I address, particularly as it was intensified and foregrounded by current circumstances. As both a participant and researcher I inhabited two worlds, seeing this as an asset rather than a problem. It could be said that as an insider I was biased, or that my views would unconsciously corrupt what I heard³²³. However, as the interviewer I had a professional background to assess what was valuable, what to disregard and more importantly what issues needed further discussion. There were minor difficulties, but being part of the organization gave me opportunities and access which made this method worthwhile.

4.9.1 Gaining informed consent

Informed consent was gained from those who chose to participate in my research. On being selected, individuals were given a participant information sheet.³²⁴ The final participant information sheet was comprehensive and covered the following areas:

- what the research was about, why it is being conducted and its importance,
- the purpose of the study and how the results would be shared;
- what was expected of them if they agreed to participate and much time they would be committing to;
- participants could expect anonymity and confidentiality:
- they had the option not to participate, that their involvement was voluntary;
- if they agreed to participate could withdraw at any time without any penalty or effect our professional relationship.

However, rather than simply giving participants information sheets before the start of each interview, I checked to see that they fully understood what they were taking part in, addressing any questions or concerns they had, and going over issues of anonymity and confidentiality³²⁵ before asking them to sign the consent form. It was made clear that the identities of participants would be concealed, names excluded and locations where

³²³ Denscombe, M., (2010), p178

³²⁴ See page 270 Appendix B: Participant Information Sheet

³²⁵ Ross, T. (2012) p153

identities could be inferred removed from the published research. I reiterated that confidentiality would be maintained and made clear the raw data would be protected and access to it restricted. The consent document ³²⁶ covered both being interviewed and being observed; participants could opt into either or both parts of the research. All participants opted into both parts of the study.

4.10 Applying for and achieving ethics approval

Ethics approval was granted finally on the third application. My initial application was denied because there were concerns about the political nature of my research. The ethics committee felt that participants might say something that would later be harmful to their careers. They were also concerned about the impact that undertaking such research could have on my own career. This concern was alleviated by ensuring that the anonymity of both NHS organisations and the participants would be maintained at all times, and by producing a more explanatory consent form, detailing what would be required of participants.

The second rejection was because there was no clear understanding of institutional ethnography by the ethics committee. Providing a historical context, explaining how the methodology has been adopted from the discipline of social anthropology helped me over this hurdle. Silverman quotes Agar when defining ethnography as “the social research style that emphasises encountering alien worlds and making sense of them... called ethnography, or ‘folk description’. Ethnographers set out to show how social action in one world makes sense from the point of view of another.”³²⁷ However, providing an example of an ethnographic study within a medical setting that had recently gained approval ensured success on the third application.

I was supported by my employers, both the PCT and the SHA, to undertake this research. Both organisations were keen to encourage research into this area and wanted to show the day-to-day life within performance management. Their expectation was that I shared my findings with the organizations. I thought this was appropriate and envisaged no problems as they did not push an agenda or require certain results. I used the (ASR-2) applied social research approach; I was fully in charge of the process, including methodology design, and though I was officially accountable to my organization, I was largely independent in what I did. The only area in which this freedom was curtailed was in

³²⁶ See page 271 Appendix C: Consent Document

³²⁷ Silverman, D., (1993) p24

respect to my job. My research must not negatively affect my day-to-day ability to do the work: deadlines were not to be missed and meetings where my input was necessary had to be attended.

In this research there are multiple voices. Performance culture is reflected in the voices of the participants and my own as the institutional ethnographer; a picture emerges individually and collectively of performance management work under New Labour. Though there was no obligation to my colleagues, I felt it was my responsibility to represent their views accurately and fairly. This was not just an issue about conducting good and useful research but also about being able to face myself and those with whom I worked with confidence.

Chapter 5

Risk: Solely State Rhetoric

5.1 The introduction of Performance to eliminate risk

Performance management, as discussed in Chapter Two, had been in place under Thatcher's and Major's Conservative governments; however, it was developed more fully in the early years of Tony Blair's first term in office. Several high profile scandals had hit the NHS and the rhetoric around the introduction of performance management was one way of preventing incidents such as organ removal at Alder Hey Hospital, the large number of baby deaths seen at Bristol Royal Infirmary and the hundreds of murders carried out by Harold Shipman. The perceived sense of the New Labour government was that the NHS was facing increased risk from a number of fronts that threatened to overwhelm the image of an effective and trustworthy health service. A more comprehensive and robust performance management framework as will be detailed, they believed, would eliminate the threat of further occurrences which put patient care at risk.

“Technology is fundamentally a system of knowledge, but a knowledge that is readily comprehensible in one setting may be great mystery in another. Making a new kind of knowledge both understandable and useful often requires the services of a translator- a person capable of functioning in both settings so that information can be transferred from one to another.”³²⁸ The introduction of the position of Head of Performance and Information into the NHS workforce was in effect to provide a translator who could move between disparate areas of healthcare. The holders of this role were the visible representation of increased accountability for the NHS, not to the public, as they rarely came in contact with them, their job more behind the scenes, but to the NHS employees.

³²⁸ Volti, R., (1992) p77

This role, the responsibilities it held and its ineffective relationship to reducing risk, will be discussed in this chapter in more detail.

Performance management had a number of tools at its disposal to decrease risk: the Balanced Scorecard (BSC) which connects a company's current activities to its long-term goals and is a means of priority setting; Star Ratings, a classification system assessing how successful an organisation has been in achieving set targets; and increased planning, monitoring measures, collaborative working, audit reviews and maximising the use of information technology. All these techniques were employed at the government's behest and this chapter considers the overall effectiveness this had in reducing risk. I will argue that as a means of reducing risk these tools were inadequate. The performance tools and technologies employed were not the panacea for risk. New Labour tried to imbue performance management with powers it did not have, and saw this as the answer to all that ailed the NHS. These technologies were chosen above others because they were visible symbols to which New Labour could point in order to show that change was happening, progress was being made and, more importantly, that their approach to the health service was vastly different to that of their political predecessors.

In this chapter I argue that those working in performance management do not choose the rhetoric of risk to give meaning to their work; rather this was the voice of the State, of the New Labour government. In order to demonstrate this, within this chapter a complete description of the work and activities undertaken by a performance manager, gained through my experience as an institutional ethnographer within a PCT, will be given. It illustrates how Beck's notion of the risk society has been interpreted by the NHS and how this has been applied at a local level. Performance management draws on science not only to uncover and identify possible risks but also to provide solutions. Yet new risks are continuously emerging within the NHS, and requiring immediate action in order to prevent the next oncoming crisis or catastrophe. The predictive nature of science gave the NHS the opportunity to lessen potential risks and impending threats; performance management was considered to be the application of this knowledge to avoid further crises. However, as will be demonstrated the same technology that provides solutions to emerging risks also adds to the burden of risk, as performance management does not always have the desired effect. Instead, what appeared to happen was the opposite: where measures were introduced to lessen risk, problems increased. The reason was two-fold. Firstly, attention given to a designated risk area strengthens individuals, departments and organisations so that failure cannot be allowed: success is the only option. Hence the

likelihood of ‘gaming the system’ increases as staff feel under greater pressure to succeed. Secondly, in focusing attention on one area, other areas suffered through lack of financial and physical resource.

5.2 Performance managers as risk minimisers

My experience as an embedded performance manager within the PCT revealed that performance managers were supposed to be the eyes and ears of an organisation, or more specifically the eyes and ears of the Chief Executives, providing an omnipresence in their physical absence. This style of working was actively encouraged and promoted by Chief Executives as it was their jobs, through Star Ratings - a performance-rating mechanism, that were at stake if the organisations they led were assessed failing.³²⁹ Previously, a Chief Executive was often the last person to know when a crisis was brewing in the organisation; the introduction of Heads of Performance was supposed to lessen this risk and thus make their long-term tenure more secure. The role would provide greater security to individual Chief Execs and greater stability to the organisation, a win-win situation.

One of the key functions of a performance manager was to maintain an in-depth understanding of the local and national performance indicators and targets that the Trust was expected to achieve and disseminate this information to relevant senior managers within the Trust, discussing ways of improving performance as necessary. This was done through a regular slot at Directors’ Brief. This session was closed to all members of staff except the Directors, though other members of staff might be asked to present a briefing paper on a specific topic. At these weekly sessions a quick progress report of the Balanced Scorecard, the specifics of which will be explained in the next section, was expected. Though the NHS in recent decades has tried to move away from hierarchical forms of management, they continue to exist, a fact only apparent to staff in a PCT over a period of time. I observed through being located in the headquarters that, though there were few levels of management within the PCT, there was nonetheless a clearly defined hierarchy; this one weekly meeting made visible who was making the decisions within the organisation. It demarcated those who made the decisions and those who could influence the decision making process. There was a divide between those in the loop and those outside it; being wise meant having access to privileged and often restricted information. Moreover, through attendance at these meetings I noted the maintenance of power

³²⁹ Setting Targets for Health Care Performance: Lessons from a Case Study of the English NHS. Gwyn Bevan *National Institute Economic Review*.2006; 197: 67-79

relations and attempts to legitimise old ways of working. Over a period of months I noticed those not invited to Directors' Brief complained to others similarly excluded about feeling disempowered because their voice was not heard. Informal networks that share information exist between staff; these are equally important to the formal structures of bureaucracies, but such connections broke down during organizational restructuring within the PCT. This will be discussed in greater detail in the chapter on stigma.

5.3 The Balanced Scorecard: strategy into action

The idea of the Balanced Scorecard was first put forward by two business academics Robert Kaplan and David Norton³³⁰ in the early 1990s as a way of measuring delivery. Their initial aim was to produce a more holistic and balanced view of a company's performance. The Balanced Scorecard was devised to enable anyone, but especially senior management, to know at a glance the performance status of their organisation. It was a way of providing a marker, a signpost to which areas needed managerial attention and were likely to be classed high risk if no further action was taken. Performance Indicators (PIs) had been employed from the mid-1980s as an internal control scheme for managers to assess the efficiency of their organisations. This was somewhat different to the outcome-related performance indicators (ORPIs) which were incorporated into the Balanced Scorecard as they were about providing external accountability, increasing citizen awareness and public trust, providing evidence that the government was keeping its election pledges.³³¹

New Labour published '*A First Class Service*'³³², a consultation document within a year of its first term in office. It emphasized the need for a performance framework which would promote high quality standards and assess matters that were important to both patients and the public. As Frank Dobson, MP, Secretary for State for Health, wrote in its foreword, "A national Performance Framework will measure the things that really matter...All these measures will complement and reinforce each other to ensure that high quality care becomes the norm everywhere to patients."³³³ Less than a year later "The NHS Performance Assessment Framework" (PAF)³³⁴ was published, as a response to the consultation. The NHS (PAF)³³⁵ introduced a new approach to assessing performance in

³³⁰*The Balanced Scorecard: Measures That Drive Performance*, with Norton, D. P., *Harvard Business Review*, January-February 1992.

³³¹ Holloway, JA., Lewis, JM., Mallory, G.R.. eds. (1995) p193-5

³³² Department of Health (1998)

³³³ Department of Health (1998) p4

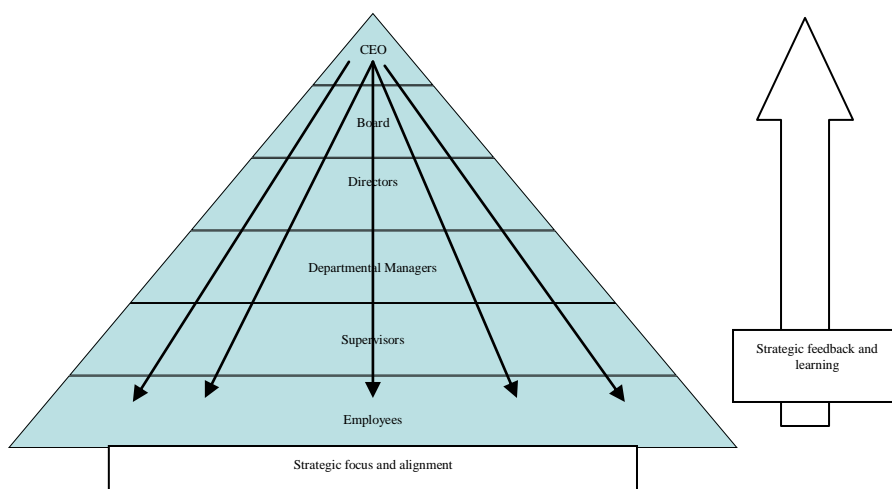
³³⁴ Department of Health (1999)

³³⁵ Department of Health (1999)

the NHS. It focused on six areas (Health improvement; Fair access; Effective delivery of appropriate health care; Efficiency; Patient/carer experience; and Health outcomes of NHS care). Alongside this was a set of High Level Performance Indicators (HLPs) and Clinical Indicators (CIs) for both Health Authorities and NHS Trusts. This was the first full range of indicators on which national comparisons of NHS hospital Trusts' overall performance could be made. The PAF was based on the Balanced Scorecard and established a more comprehensive style of evaluating performance in the NHS. While the framework was originally aimed at health authorities, it was later developed to meet the requirements laid out in 'The NHS Plan'³³⁶ and as such applied to all NHS organisations.

The Balanced Scorecard was supposed to create a framework for business planning, a tool to help organisations measure success and a method of involving all staff. Blair was keen to introduce ideas that had been used in private industry.³³⁷ As explained in chapter two, it was part of the 'New Labour' philosophy where public services would learn from the private sector, as they were focused on delivery, on tailoring their product to the customer. Part of this customer focus is the idea of translating a corporate vision, a strategy, into action. The strategy becomes a part of each individual job through the HR appraisal process and Personal Development Plans (PDP) and provides a strategic focus and alignment throughout the entire organisation from the Chief Executive, Board, directors, managers and the rest of the staff. The diagram below shows the flow of information being two directional. It is based on a democratic premise: all staff influence the targets by which they are measured.

Translation of strategy into action



The diagram illustrates Kaplan and Norton's vision of translating strategy into action

³³⁶ Department of Health (2000)

³³⁷ Giddens, A., (1998) p99-100

The Balanced Scorecard as presented by Kaplan and Norton consists of four perspectives: financial, internal business processes, customer and learning and growth. Its application as a strategic management tool provides a more comprehensive understanding of the direction an organisation is taking, than that of its predecessors. The Balanced Scorecard can be seen as example of what Giddens refers to as an expert system which operated at micro level. An expert system is a type of disembedding mechanisms, this is “the ‘lifting out’ of social relations from local contexts of interaction and their restructuring across indefinite spans of time-space.”³³⁸ Hence, the Balanced Scorecard is an expert system because local knowledge previously held only by specific clinical staff now became accessible to a wider audience without the same professional expertise. The much publicised scandals to hit the NHS had led to a breakdown in trust between the public and professionals which the State believed could hinder both treatment and care. The government sought to address this risk by removing trust from individuals by creating confidence in the whole system. It believed this was a more effective method of ensuring greater transparency as it enforced a process of abstraction, stripping away the specifics, which unlike standard risk analysis was context bound. The Balanced Scorecard was also supposed to act as a form of risk communication, as within minutes of staff seeing it they were able to ascertain poor performing, high risk, areas. However, the Balanced Scorecard, as will be demonstrated in this chapter, was not always effective in this respect. What became apparent was the inadequacy of communicating risk unless it was followed through with appropriate action. Risks must be confronted; to do otherwise was to increase the risk itself.

The use of the Balanced Scorecard within the NHS consisted of key targets and indicators monitored by the Healthcare Commission. The 2004-5 PCT Balanced Scorecard in the NHS was made up of 41 targets divided into four areas: 8 key target indicators, 12 targets on access to quality services, 11 targets on improving health and 10 targets on service provision.³³⁹ The weighting between areas highlights which area has supremacy, namely access to quality services. This is because election pledges were centred on reducing waiting times e.g. cut NHS waiting lists by treating an extra 100000 patients, end waiting for cancer surgery,³⁴⁰ and cut maximum waiting times by the end of 2005 for outpatient

³³⁸ Giddens, A., (1990) p21

³³⁹ See pages 272 & 273 - Appendix D: Balanced Scorecard - Indicator listings for Primary Care Trusts

³⁴⁰ Labour Party (1997) manifesto

appointments from six to three months and inpatient from 18 to six, and end waiting times for cancer treatment.³⁴¹

In the early years of the Blair government, success was measured by the decreasing of the length of waiting times for outpatients and inpatient appointments, and the lessening of the huge volume of patients on waiting lists. New Labour was keen to focus on the quality and success of treatments and move away from the 'Efficiency Index' employed by the Conservatives which counted the numbers of patient 'episodes,' believing this to serve as incentive for greater efficiency.³⁴² And yet by 2005 the financial position of a PCT would be the key measure of whether a Trust was successful or not. This outlook was articulated by the Director of Finance at regional SHA as follows: "The positive financial position is the successful expression of the status of the NHS. A surplus acts as buffer and we should not think in term of savings, instead refer to this as financial improvement."³⁴³ Initially discussed in Chapter Three, this quantification seen in performance management was based upon two false premises held by those in government: firstly, that by assigning a number to an issue there is greater understanding, hence a lessening of financial risk; secondly, quantification leads to facts and facts are difficult to refute. This erroneous sense of rationality in the process was a form of scientism and, while it provided a superficial reassurance to participants, was merely misplaced faith. The consequences of overzealous quantification culminated in a financial crisis for the NHS during 2005-6³⁴⁴, where many Trusts saw budgets cut, services slashed and jobs axed.

5.4 Star ratings: encouraging success, marking out failure

A short history of the introduction of Star Ratings into the NHS to provide context now follows. John Major's Conservative Government instituted school League Tables in education through the 1998 Education Reform Act to foster a climate of competition and choice. Schools were expected to publish key stages of educational outcomes, public examinations and truancy rates. This would enable parents to be more fully informed in their decision-making on their choice of their children's schools. As parents were likely to choose good schools, these would flourish, while failing schools would fold. Thus the role of the market would be to incentivise improvement.³⁴⁵ By 2001 New Labour had recognised its value and deployed a similar system in the NHS: Star Ratings. So, in spite

³⁴¹ Labour Party (2001) manifesto

³⁴² Labour Party (1997) manifesto

³⁴³ Director of Finance- Strategic Health Authority, 16 May 2007

³⁴⁴ NHS faces job cuts as financial crisis deepens Michael Day BMJ 2006;332:743, 1 April.

³⁴⁵ Travers, T., Next Risk Please: Metrics, Incentivisation and Risk Management in Schools.

of claims around the known negative aspects of educational league tables,³⁴⁶ the comparative quality that was inherent in the education system was replicated in Star Ratings. Star Ratings were intended to recreate the sense of competition seen in education between health professionals and NHS organisations, thereby pushing up quality. The achievement of all key target indicators was essential if PCTs were to achieve the highest rating of three stars. Star Ratings were a retrospective assessment of performance over a financial year within a Trust; they were introduced to acute Trusts in 2001, and 2002 for Primary Care Trusts. An independent regulator, the Healthcare Commission, assessed and evaluated the performance of each organisation and awarded an appropriate Star Rating. There were four levels of achievement, three stars, two, stars, one star and zero stars.³⁴⁷ Three stars was the highest level of attainment for any organisation; a Trust with zero stars was classified as failing.

Like the Balanced Scorecard, Star Ratings could be constructed as another example of Giddens' expert system. However, unlike the Balanced Scorecard, as a type of disembedding mechanism it functioned at a macro rather than the micro level. Its focus was to create a framework by which organisations could be judged nationally by the public. Local context and attributes specific to single organisations were removed in order to allow the process to be managed and administered from afar, that is by an independent regulator. In the case of the NHS the independent regulator was the Health Care Commission (later the Care Quality Commission). The Star Ratings format presented the state with a high level perspective of performance, marking out both successful and failing organisations. The government said this process brought transparency to organisational performance enabling the public to judge how their local Trust was performing. However, like the educational league tables, this process was intended to introduce market forces such as choice and competition into the public arena. In terms of risk, attention focused on failing organisations, as these were deemed high risk, but as will be shown this was a false premise: even the most successful organisations were partaking of high risk behaviour. A high star rating was not a guarantee of high quality patient care or safety.

The PCT where I was located, undertaking empirical research, scored one star in the first year, and then three stars in the following two years. It is because of the poor performance shown by the PCT in 2001-2 that a performance manager was appointed. In terms of the financial reward, the justification was that a person dedicated to the PCT achieving three

³⁴⁶ Goldstein, H. and Spiegelhalter, D. J., (1996) pp385-443

³⁴⁷ <http://www.performance.doh.gov.uk/performance/2001/index.html>

star status would be worth more to the PCT than their salary. The level Trusts scored within Star Ratings was dependent on the results gained in the Balanced Scorecard and Key Targets. A Balanced Scorecard existed for each of the different types of organisations in the NHS: acute, specialist, ambulance, mental health as well as PCTs. It was supposed to present a rounded view of performance within an organisation.

The briefing session of the Balanced Scorecard was in place to help the PCT understand what drives good performance, helping to anticipate possible future problems, enabling directors to take corrective action early and enabling me, the then Head of Performance, to centre staff activity on what really mattered. There were however problems with this idea when applied to an organisation as large as the NHS. I observed that when targets do not remain constant, individuals do not know what they are working towards. Trusts have been vocal in their requests for full specifications of the Balanced Scorecard targets before the start of each financial year in order to know the criteria by which they are being assessed, claiming there was a lack of transparency in the process. However, this uncertainty was maintained on the principle that by countering predictability, playing the system was less effective, and thus the assessment more credible.³⁴⁸ As in many British companies, the NHS financial calendar year starts in April, and the performance of a PCT is on a twelve month period from one April to the next. However, a Trust's performance was not officially assessed until July, when the 'Star Ratings' were published by the HCC. Revisions to the Balanced Scorecard targets then occurred during late December, early January. This delay of eight months left staff whose work had a direct impact on the success of a target playing 'catch up.' What was designed to increase participation in the formation of targets, failed magnificently.

A performance manager had to ensure that all relevant members of staff and management were aware of the Trust's targets and standards, to monitor and communicate progress against these to relevant personnel and assist in developing improvement programmes where required. Therefore, communication was essential around the key targets within Balanced Scorecard. Through my ethnographic observations I saw the benefits of implementing a national Balanced Scorecard in that it brings clarity and a systematic approach when setting the priorities of an organisation. It also brings greater awareness of performance because of the communication about targets. However one of the key pitfalls in making the Balanced Scorecard effective is that there can be a lack of senior

³⁴⁸ Targets, inspections, and transparency? Gwyn Bevan, Christopher Hood *BMJ* 2004; 328:598, 13 March.

management commitment so that the scorecards are not cascaded, not communicated throughout the organisation. In an attempt to avoid both these pitfalls the use of simplistic 'smiley faces' was introduced at the beginning of my time at the PCT as its performance manager. However it agreed with the PCT management's ethos of ensuring staff knew what was happening within their own organisation, making sure they felt a part of that organisation and conveying ideas of success and failure. Senior management felt that in areas where performance was poor, there was a possibility that, if staff were made aware of this, they would find new ways to improve the situation. Highlighting underperforming was not about blaming certain individuals; it was not a 'name and shame campaign.' My field notes during my time as an institutional ethnographer comment on how smiley faces created a more cooperative culture between staff; they promoted a sense of community and a sense of ownership of organisational targets as they were a talking point for staff from different work streams. It engendered an atmosphere in which everyone felt they could contribute to the success of the PCT, to the ongoing good performance and to the improvement of underperforming areas. The technique of smiley faces was later discarded when the PCT merged; this approach to performance was considered unprofessional by the new organisation. Field notes show morale suffered; staff became less aware of PCT priorities and organisational cohesion was adversely affected. Staff engagement in performance would now be conducted through the formal channels of board papers. The effect of organisational change on staff will be discussed at greater length in the chapter on stigma.

Monitoring and managing the Trust's levels of achievement against local and national targets and disseminating relevant monitoring information to local PCTs and local Strategic Health Authorities was a core component of the performance manager's role. It was necessary to be aware of the Trust's position against any of the targets at any time and to present on-going plans to keep the situation under control. Moreover, it was essential to be well informed on national and local developments in associated services, ensuring implementation of best practice. This is referred to as benchmarking and was one of the central components of performance management in the PCT. There was a sense within big business that uncertainty, risk and complexity were fundamentals of a globalised economy, a recognition leading to the development of the benchmarking tool to provide the competitive advantage necessary to be the 'best-in-class.'³⁴⁹ It was this motivation that New Labour sought to replicate.

³⁴⁹ Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995) p128

Although theory behind benchmarking suggests it provides quality improvements in service which may lead to parallel financial savings, monetary gain was not the prime motivator for introducing it. Benchmarking can be a driver of change, offering compelling evidence and justification for a new policy direction as it provides an outward-looking perspective.³⁵⁰ However this was not the motivation for New Labour, rather it was all about showing ‘value for money’ as it introduced benchmarking at the start of its term in office: “Particular emphasis will be put on benchmarking and the sharing of good practice,”³⁵¹ and again: “The requirement for benchmarking will encourage rigorous scrutiny of NHS Trusts’ costs and performance.”³⁵² Performance managers were expected to look across the county or Strategic Health Authority and see how other Trusts were performing on targets within the Balanced Scorecard. There are two significant aspects of benchmarking: firstly, measures are supposedly objective and therefore tracking progress on performance should be a transparent process; secondly, this process is a form of rationalisation as expounded by Weber, the idea of applying scientific approaches to aspects of society. There was little value in benchmarking in 1997, when New Labour took office, as information available within the NHS was patchy and often incomplete. However, benchmarking has produced data that now holds credibility. The consequence of the process of doing is that what is done now takes on real value. Meaningless work has become meaningful; it has gained authority.

One example of close monitoring is of the ambulance targets which measure the time it takes for the ambulance to reach the patient after the initial call. The PCT commissioned the service from the Ambulance Trust; the performance manager worked with the Assistant Director of Commissioning to improve three targets: Category A calls meeting the eight minutes target, category A calls meeting the 19 minutes target and category B calls meeting the 19 minute target. A category A is classified as urgent, that is responding to life-threatening emergencies, with category B calls less urgent than A. Within my PCT where meeting the first of these three targets had been a near impossibility for the Ambulance Trust, performance meetings, as my field notes describe, were often heated affairs. This is because the PCT, (unlike the neighbouring PCTs), covered a mainly rural area, and this, together with the fact that the main hospital was located within that PCT, meant that they always failed to reach this target. On a national level the Ambulance Trust’s performance was measured not by PCT but rather by a patch basis, in this case X,

³⁵⁰Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995)pp149-151

³⁵¹ Department of Health (1997) section 4.22

³⁵² Department of Health (1997) section 6.23

Y and Z PCTs. As far as the Ambulance Trusts were concerned, if they achieved the patch targets, then they were performing well.

The disparity between PCTs' performances was not a high priority for the Ambulance Trust, but the PCT commissioning the service had a duty to provide the best possible service to its population. Moreover, the local population was affluent and articulate, with high expectations that both the NHS and the PCT should at least hit the target, and its frustration was expressed in the local press. The board agreed additional investment to improve time, but there was no significant improvement. The PCT found it difficult to make the distinction between the PCT and the Ambulance Trust clear to the consciousness of the public, who viewed poor performance in this area as much a fault of the PCT as of the Ambulance Trust. Field notes taken during board meetings show they saw no separation between the provider of service and the commissioner who was buying it. The government policy of empowering local people failed in this case. Comments made in the NHS Plan: "The patient's voice does not sufficiently influence the provision of services. Local communities are poorly represented within NHS decision-making structures" are still relevant. The Health Select Committee on Patient and Public Involvement, a committee established by Parliament to promote public involvement in health matters, states: "If NHS bodies are to involve the public effectively, they need to do so at an early stage and before any options are drawn up or decisions are made."³⁵³ For the public to have any real understanding, the local community should have been involved in discussions with the Ambulance Trust from the beginning. Seeing merely the consequences to decisions already taken made the public feel that lip service to the idea of public engagement was replacing genuine or real participation.

The ambulance targets had been on the Balanced Scorecard since its introduction into the NHS. This was significant because it shows that it had been a constant priority during this time. In fact the ambulance target was seen as one of the Labour government's successes. In 2000 only one Ambulance Trust was able to meet at least 75% of category A calls within eight minutes. This was then set as a target in 2002 and by 2005 four fifths of Ambulance Trusts were meeting the target.³⁵⁴ Nevertheless, there have been issues around reporting. Since this target was introduced there have been accusations that those

³⁵³Health Select Committee "Patient and Public Involvement in the NHS", 20 April 2007. section 289 <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/27809.htm>

³⁵⁴ Department of Health, 2005, *Chief Executive's Report to the NHS: December 2005*. London: Department of Health.

who achieve the target have been ‘gaming.’³⁵⁵ Gaming is one of seven distorting effects produced by outcome related performance indicators. Others include “tunnel vision: concentration on areas included in the ORPIs (outcome related performance indicators), to the exclusion of other important areas; suboptimization: the pursuit by managers of their own narrow objectives, at the expense of strategic coordination; myopia: concentration on short term issues; convergence: an emphasis on not being exposed as an outlier on any ORPI, rather than a desire to be outstanding; ossification: a disinclination to experiment and misinterpretation: including creative accounting.”³⁵⁶ Gaming is explained by Bevan and Hood as playing the system in order to meet the target while failing to deliver the service. Different ambulance services had different reporting structures in place which inevitably led to different start times. While variations of thirty seconds may seem irrelevant on an 8 minute target, such variations make the difference between success and failure. It was due to the variable start times that the idea of ‘call connect’ was implemented in 2007. ‘Call connect’ refers to the clock starting from the moment the call connects to the ambulance service. So, irrespective of whether the member of staff has all the necessary information from the caller at the beginning of the call, they must be ready to dispatch an ambulance. This change in how times are measured was supposed to bring equity to the process of measuring and lessen areas of disparity between the ways used by Ambulance Trusts to measure the time it takes to reach patients.

5.5 Planning: forecasting the future

In this section I examine the proliferation of planning in the NHS as a means of reducing risk. Politicians across the political spectrum like to propose a simplistic view of science when talking to the public. The rhetoric is of science’s ability to predict outcomes, thereby allowing the NHS to both foresee and foretell the future; New Labour in this respect was typical. NHS organisations are seen to have the opportunity to lessen risk and avert disaster through planning, an important aspect of NHS work. Planning was seen by the DH at that time as one way of providing greater security against potential or impending risks through the deployment of specific actions, thereby bringing risk to a level which is deemed acceptable. However this relies on trust both in the initial assessment and in the subsequent actions. As Giddens summarises, “The experience of security usually rests upon a balance of trust and acceptable risk.”³⁵⁷ Observations made while working in performance management have shown that NHS organisations place high value on the

³⁵⁵ Have targets improved performance in the English NHS? Gwyn Bevan, Christopher Hood, *BMJ*, 18 February 2006

³⁵⁶ Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995) p200

³⁵⁷ Giddens, A., (1990) p35

planning process as evidenced by the recruitment of external management consultants. As consultants are financially costly, their advice was given considerable credence by the principal personnel, including the Chief Executive and leadership team within the PCT. While embedded in the PCT I noted that staff were obliged to listen to guidance given and were told to act on it; resistance was not allowed. Here is one such example of advice, taken from my fieldwork diary, listing what a plan within healthcare should contain: 1) it assesses needs and current services, 2) describes services and GAP analysis, 3) decides priorities, 4) includes risk management 5) provides strategic options³⁵⁸. Yet how constructive were these plans? It was necessary to prepare strategic and operational plans that support the achievement of short, medium and long-term objectives for the defined service area in order to deliver high quality services within available resources. The physical form which this takes is in the construction of the Local Delivery Plan (LDP), a three year plan revised each year updating planned data with actual/real data.

To a performance manager, taking the lead on negotiating local targets with the Strategic Health Authority and drawing up the LDP was central to the annual planning process. Parts of the LDP were then monitored on a quarterly basis in the form of the LDPr. It also contained several measures by which the PCT was monitored, including targets measured by the Healthcare Commission as well as other targets that have been part of the LDPr for years and are only measured in this document. Completing this form was a hugely time-consuming process. Shared Services (SS) provided data on its surrounding inpatient numbers. However, other measures, where data was collected by individual members in the PCT, were collated by the performance manager. Ideally, the same lines would have been requested by the DH each quarter, but this was not the case. In my fieldwork notes a recurrent comment is “Much of today has been spent on the LDP and LDPr.” Late January was one of the hectic times of the year because the updated LDP was required by the DH and SHA as well as the LDPr. However I soon came to realize that no amount of preparation and organisation eased the process of completion of the LDP or increased its accuracy, but I did recognize that the requirement to submit plans was a latent form of surveillance.

Blair pledged to “keep the planning and provision of healthcare separate, but put planning on a longer-term, decentralised and more co-operative basis. The key is to root out unnecessary administrative cost, and to spend money on the right things - frontline

³⁵⁸ Dr Tim Wilson Senior Adviser at PriceWaterhouseCoppers discussing World Class Commissioning, 16 May 2007

care.”³⁵⁹ Yet this ideal approach to planning was a near impossibility as “Although almost everyone can make accurate short-range forecasts, no one can predict accurately beyond a few months ahead. When it comes to foretelling the future, there are no true experts.”³⁶⁰ This flies in the face of the initial political rhetoric concerning both science and planning. The manifest function of planning is to reduce risk, both perceived and real; the underlying function however in the PCTs is cultural reproduction. Producing, updating and maintaining the LDP continues to be one of the most time consuming and inefficient aspects of performance management and yet it is the one ritual by which performance management is most readily identified with in the NHS. Many different types of images, objects and beliefs can be transmitted as traditions. This is in contrast to action which exists only in the moment. It is the images of action that are transmitted and, to give them life they must be reenacted.³⁶¹

By taking part in its creation and sustenance new staff become a part of old cultures, indoctrinated in old customs; keeping the ingrained tribal traditions of bureaucratic management alive. “Managers keep forgetting that is what they do, not what they plan, that explains their success. They keep giving credit to the wrong thing namely the plan and having made this error, they spend more time planning and less time acting. They are astonished when more planning improves nothing.”³⁶² Within a ten year period, from Blair coming to power in 1997 to the handover to Gordon Brown in 2007, there were seven main documents setting out the agenda of the NHS, four of which contained the word ‘plan’ in the title. Thus what is seen in the NHS is a fetishism of planning, where the plan becomes reified. The ritual of planning leads those working in the process to become disciplined in its structure and finally disciples of the plan itself. This replicates notions that paradigm and exemplars, as first proposed by Kuhn³⁶³, both exist and infer advantage on staff in times of political upheaval; a necessity due to the constant change and reorganisation in the NHS. (This is discussed further in the chapter on organizational change in the PCT.)

Being based within NHS organisations has allowed me to see firsthand how management within the NHS are often treated with disdain by clinical staff, who are sceptical about the

³⁵⁹ Labour Party (1997) manifesto

³⁶⁰ Starbuck, W. H., (1992) 'Strategizing in the real world,' *International Journal of Technology Management, Special Publication on Technological Foundations of Strategic Management*, 1992, 8(1/2): 77-85. (<http://pages.stern.nyu.edu/~wstarbuc/mob/strategizg.html>)

³⁶¹ Weick, K.E., (1995) p125

³⁶² Weick, K.E., (1995) p55

³⁶³ Kuhn, T.S., (1970) pp144-159

work they do. General Management as it currently exists only came into the NHS after the publication of the 1983 Griffiths Report³⁶⁴ and yet there is still a pervasive idea that they add to the existing bureaucracy of the NHS, preventing clinical staff from doing their job. Through my fieldwork the belief that managers do not know what they are talking about as they have no dealings with patients has been highlighted not so much by what is said by clinical staff but through the tone, untimely interjections and readiness to talk over management. This can come across as dismissive. By contrast, another significant latent function of the LDP is that it confers expertise on performance managers. It provides them with detailed knowledge which is neither known to other non-clinical staff or management to the same extent. They are the main authority and the main gatekeepers to this knowledge. To those working in the field it provides security, and given the newness of the profession in comparison to both other professions in healthcare and managerial approaches, this monopoly is vital. There are no set entry requirements for the role and no specific qualifications as a prerequisite to working in performance management. Staff come from a variety of backgrounds including finance and IMT, many having fallen into performance management. While the majority have degrees and years of experience, there remains a perception by those with a medical background that they are playing at management. Such precise knowledge then lends itself to providing a powerbase within the organisation as well as offering a sense of stability; the size of the LDP acts as a boundary, a barrier, stopping the encroachment of other managerial departments into this area. The role of planning in the NHS does not in itself lead to reducing risk; plans often repeat the mistakes of previous years as they deal with the same constraints, thus options and choices are narrow because specific variables cannot be negotiated. However, what planning does effectively, through its cyclical process, is to strengthen the position of performance as an ideal and embed it into an organisation.

5.6 Do performance managers increase accountability?

Monthly performance reports were produced and submitted to the PCT Board and the Professional Executive Committee (PEC), on behalf of the Director of Finance and Performance, in an effort to increase local accountability. This exemplified New Labour's ideas of openness between the public and public institutions. It contrasted with popular notions of sleaze which in 1997 had tainted the Conservative Party and from which New Labour were keen to distance themselves. Restoring trust was one of the central themes of election rhetoric; it was also an area with which Old Labour was comfortable, though

³⁶⁴ Pollock, A.M., (2004) p102

under a different banner, that of legitimisation.³⁶⁵ Blair pledged to modernize not just government but the institutions of the state; in the NHS this was not solely about ending secrecy but also offering transparency rather than paternalistic management.

Performance reports, moreover, provided external accountability, as Board meetings now included members of the public so these were taking place in the public forum. “In the new NHS, all NHS Trusts will be required to open their board meeting to the public.... Openness and public involvement will be key features of all parts of the new NHS.”³⁶⁶ However during the reorganisation within the PCT there were fewer public Board meetings: other Board meetings were held but were closed to the public. One of the principles to which Foundation Trust Hospitals were expected to adhere are Public Board meetings. Even though they have greater freedom and independence from central government they are obliged to provide greater local accountability. However, my time as an institutional ethnographer at the PCT showed that this was not the case; here too local Foundation Trust hospitals had fewer public meetings than before they had gained independent status. It seems that transparency and accountability are not embedded in NHS culture and where, it is possible to move away from open management, organisations take this route. Within the PCT it appeared that, when all was going well, the public could be involved, but when there was a crisis they were asked to leave. Doctors in the past did not tell patients the severity of their illness, believing that the patients could not cope. This style of management is similar; it assumes that the public cannot deal with difficulties.

However, while Board reports from performance managers are supposed to increase accountability there are often huge swathes of information that are unavailable due to a variety of reasons: only annual data is available, the PCT does not hold the information, only an approximate figure is known and this is not suitable for public consumption. Some of the available information originated from the quarterly LPDr as well as the monthly monitoring returns; where neither returns were suitable, the comment “data currently unavailable” appeared. The role of performance manager requires that all national and local monitoring requirements are met to high quality standards, in accordance with DH and NHS guidance, making certain that all data submitted are valid, reliable and consistent. Furthermore, all data produced or used within the department must be managed in accordance with the Data Protection Act and relevant Trust policies and

³⁶⁵ Driver, S. and Martell, L., (1999) p156

³⁶⁶ Department of Health (1997) section 2.23

procedures, and that statutory weekly, monthly and quarterly reporting requirements of the Department of Health against performance measures must be met. The reason for this was to ensure that no information showing the PCT in an unfavourable light left the PCT without acknowledgement from senior management. Many of the reporting structures within the NHS fell into what Moran refers to as “shallow forms of verification.” This was highlighted in one of the key Monthly Monitoring Returns (MMR), generally referred to as the ‘fasttrack’. It gave a measure of the total number of inpatients, long waiters, outpatients, and CHD patients. It also gave an overview of the referral method of these patients, for example GP referral. The ‘fasttrack’ acted as a summary of more detailed reports which show waiting list activity. The importance of this return was because it showed the number of ‘breaches’ for the PCT’s population in a month. A ‘breach’ was the common term used to describe patients who have gone over the waiting targets.

While board reports are about external accountability, other forms of reporting are about internal accountability. Performance internal to the NHS is about monitoring. One aspect of a performance manager’s role is to liaise with the lead commissioning PCT to provide prospective and retrospective information that allows the PCT to fulfil its obligations and monitor its performance against local and national targets. Where the PCT was the lead commissioner, the performance manager had to act as the Trust’s representative and point of contact for both the local Strategic Health Authority and the Department of Health for all performance management issues and provide information and answer queries as necessary. A performance manager assisted and represented the Trust at monthly performance management meetings with Strategic Health Authority, explaining the Trust’s progress in achieving local and national targets and elucidating plans to improve performance.

During my initial period spent as an institutional ethnographer within the PCT, I observed, that, as the PCT achieved three star status, this happened less frequently than in other Trusts. Performance monitoring by the SHA happened less frequently because the assumption was made that a three star PCT knew how to manage their finances and resources effectively. This relaxation of SHA performance monitoring happened to an even greater extent in Foundation Trusts(FT). FT status only applies to hospitals which must already be three star Trusts, a fact that suggests they should already be high performing, self-monitoring organisations. When the PCT merged in 2006 with its two neighbouring PCTs to become a larger PCT as part of the ‘Patient-Led NHS,’ reconfiguration of financial performance fell dramatically. The SHA, my fieldwork notes

reveal, then increased its monitoring of the PCT, with monthly meetings to review performance. This was part of a process involving the decision that there should be “clear sanctions when performance and efficiency are not up to standard.”³⁶⁷ Where this was the case, Health Authorities were “able to withdraw freedoms.”³⁶⁸

When New Labour came in to office they were able to introduce performance tables and Star Ratings fairly rapidly because there had been a number of high profile clinical failures. The manifest and stated function of this was to improve, standardise and formalise the quality of care patients received. Blair was successful in rapidly changing decades of clinical working by establishing regulation of the medical profession in the form of compulsory clinical audit and assessment. That it was such a lengthy period, following the initial suggestion in the 1983 Griffiths report, to establish this level of scrutiny highlights the nature of the medical profession’s autonomy and its political clout.³⁶⁹ By effectively challenging the medical profession’s belief that it was the sole authority on patient safety, it was relatively easy to establish performance assessments and Star Ratings in PCTs.

From the beginning, there were conflicts in the role that performance management would play; performance monitoring by an external organisation was used as a threat. Strategic Health Authorities had taken on a Big Brother role, the implication being they imposed a level of scrutiny and surveillance that PCTs should fear. As discussed in Chapter Three, Weber and Foucault saw surveillance and self-surveillance as increasing the effectiveness of organisations. Within the SHA’s Big Brother role, surveillance acted to suppress internal criticism. It was failing Trusts, the most vulnerable organisations within the NHS, that were monitored to such an extent that the right to reply, to defend their actions, was lost.

In the past, there was a local structure, in the form of PCT, which had to abide by national targets. This meant that most work concerned meeting national targets, and this created frustration. From 2006 there was a chance for greater freedom. PCTs at a minimum must meet national targets; however they were now in a position to set the local agenda. Chris Ham spoke of the NHS moving towards high street retailer John Lewis in terms of its

³⁶⁷ Department of Health (1997) section 3.13

³⁶⁸ Department of Health (1997) section 3.13

³⁶⁹ Ham, C., (2004) p184

structure³⁷⁰; John Lewis is an employee partnership and staff have a stake in the business and share its profits. Moreover, this setup has enabled its staff to participate fully and engage in setting the direction of the company, ensuring its success. However this metaphor of John Lewis and the NHS has been applied to a wider context including discussions over issues of quality. The public do not want huge disparities between services which can lead to health inequalities, articulated in the media as the ‘Postcode lottery’³⁷¹; rather they wish to see pervasive reliability in the NHS as you see in John Lewis. They want to experience a level of quality which can be relied upon to deliver effective care.

5.7 Fundamental flaws: when disaster strikes it is neither new nor unexpected

There were fundamental flaws in the NHS in both processing and communicating information which a robust performance framework was introduced to eliminate. However, as seen when discussing the application of NHS planning, targets, a central part of the performance work, aggravated and enhanced risk-taking behaviour. During my time as Head of Performance and Information, one of the local hospitals, from which the PCT commissioned services, was investigated by the HealthCare Commission; this was Stoke Mandeville Hospital, part of Bucks Hospitals Trust. Thirty three patients were known to have died of *Clostridium Difficile* (C Diff.) though the figure might have been double that between 2003 and 2005. This was nearly triple the expected number of cases. The HCC carried out an inquiry to assess what had taken place, including the events leading up to the deaths as well as subsequently. The report in 2006 was damning; performance culture had come to be a threat, it was no longer securing the interests of patients; patient safety had become a secondary issue in the race to meet performance targets.³⁷² The HCC noted that trust management failed to learn from the first outbreak of C Diff and implement their own identified changes to prevent further outbreaks. Various staff at different levels in the organisation recognised the continued failings in the system and repeatedly reported this to senior management, who unfortunately ignored the warnings as their focus was on “having to make changes to services, provide new buildings, resolve serious financial pressures, achieve the Government’s targets”³⁷³ and C.Diff was the last priority on their list.

³⁷⁰ How would you save the NHS? Chris Ham, BMJ, 27 January 2007

³⁷¹ <http://www.telegraph.co.uk/health/2700686/Healthcare-postcode-lottery-means-patients-losing-out-on-cancer-treatments.html> (seen September 2008)

³⁷² Commission for Healthcare Audit and Inspection “Investigation into outbreaks of *Clostridium Difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospital Trusts” (2006)

³⁷³ Commission for Healthcare Audit and Inspection “Investigation into outbreaks of *Clostridium Difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospital Trusts” (2006) p84

Being based within the PCT, I noted that there was a feeling that the findings said nothing new, and only served to echo the observations made by staff on numerous occasions. Yet to assign blame to senior management fails to recognise a more fundamental flaw in the system. The Government was not clear in discussions with Chief Executives that patient welfare supersedes all other priorities. This seems obvious to clinical staff and to outsiders but senior management were under constant pressure to achieve other targets, for example the 4 hour maximum wait in Accident and Emergency; consequently the principle of patient safety seemingly obvious, appeared to become less so. When more recent crises have hit the NHS it has been noted that “when managers do fall below expected standards they often do so in the context of a politicised environment in which honesty and transparency are sometimes actively discouraged.”³⁷⁴ It is also worth taking into consideration that NHS management until recently did not have a Hippocratic Oath or its modern day equivalent ‘duties of a doctor,’ whose first three points are “make the care of your patient your first concern, protect and promote the health of patients and the public and provide a good standard of practice and care.”³⁷⁵ It is only from 2002 that Code of Conduct for NHS managers³⁷⁶ was established. This has sought to rebalance the public’s perception and reassure patients, as seen by the first principle: “to make the care and safety of patients my first concern and to act to protect them from risk.”³⁷⁷ However, my experience of working in the NHS has shown this is not yet the norm. There is still a sense amongst managers that this has only been taken on superficially and has not become embedded in working practices and culture. The reporting of the outbreaks of *Clostridium Difficile* at Stoke Mandeville was regrettably not the first time that the target culture had come under fire³⁷⁸ as a threat to improving the quality of care in the NHS.

The aim of target setting was to focus attention and create competition between hospital providers by driving up overall quality. The important word here is overall: what this meant in practice was that while some Trusts excelled, others fell below standard, as was the case at Stoke Mandeville Hospital. This example illustrates the detrimental effects of fierce competition which were first voiced in relation to internal markets in the NHS - the fear that there would be stratification in quality of patient service, and that the equality of

³⁷⁴ McLellan, A., Regulating manager will not resolve the issues they face, 3 March 2011, <http://www.hsj.co.uk/comment/leader/regulating-managers-will-not-resolve-the-issues-they-face/5026570.article>

³⁷⁵ *Good Medical Practice* (2006), The duties of a doctor registered with the General Medical Council. http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

³⁷⁶ Department of Health, October 2002

³⁷⁷ Department of Health, October 2002, p3

³⁷⁸ Leatherman, S., Sutherland, K, (2003)

care so valued in the NHS would be threatened. By 2006 the Star Ratings system had become redundant; policy seemed to have gone a full circle. However assessments, the results of which were made public knowledge, had not been fully abandoned. Instead they covered a wider remit and took the form of an assurance framework.

The case of Mid-Staffordshire is one example where this new method of assurance has not prevented poor levels of care. An initial independent inquiry published its findings in February 2010. It reported there were 400 unnecessary patient deaths between 2005 and 2008 “due to the hospital being concerned primarily with targets and cost cutting.”³⁷⁹ Andy Burnham, then Secretary of State for Health, stated: “this was ultimately a local failure.”³⁸⁰ However, the suspicion that this behaviour was widespread did not diminish and continued public outrage led the new Secretary of State for Health, Andrew Lansley MP, to announce a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust.³⁸¹

5.8 Seeking assurance or requiring reassurance

As a performance manager I had to ensure that appropriate quality standards were achieved by the PCT and that all work I directed had the desired results within a defined budget. With the Head of Risk and Head of Quality, I had to ensure a quality assurance system was in place for the development and delivery of services and maintain clinical governance frameworks to support the continued delivery of high quality services. Two documents, the PCT Assurance Framework and PCT Declaration on quality standards, submitted to the Healthcare Commission, the then regulator, represented a contract between the public and the state. Here the HCC judged compliance that systems were in place to ensure and provide evidence that the PCT could meet the core standards. The PCT alongside its local partners had to provide a Declaration of how far they had complied with the standards.

This was a more collaborative approach in comparison to the previous Star Rating process. The HCC then corroborated, by cross-checking, the declaration with the results the trust had recently achieved. Inspections were undertaken where the HCC had concerns about compliance. Random spot checks of PCTs also occurred to assess whether standards

³⁷⁹ <http://www.midstaffspublicinquiry.com/previous-independent-inquiry>.

³⁸⁰ In response to the findings Andy Burnham addresses parliament. 24th February 2010

³⁸¹ On 9th June 2010 a public inquiry into the bodies responsible for monitoring Mid-Staffordshire NHS Foundation Trust was set up. Chaired by Robert Francis QC who conducted the initial inquiry, its findings are due to be published January 2013.

had been breached. The role of the HCC from its original inception had changed with reference to performance assessments: by 2006 there was far greater cooperation between Trusts and the regulator. While it remained the arbiter of ranking within the NHS, the HCC was more concerned about overall improvement than merely achievement against targets. The performance manager's role in this process was largely about ensuring the HCC received the declaration in line with its timetable as the PCT under the scoring system could be penalised for a late submission. The declaration was 'signed off' by the PCT Board with the performance manager providing adequate data, information and evidence to support its submission. I also acted as the PCT co-ordinator for Audit Commission on behalf of the Director of Finance. As performance manager I was required to supply evidence on PCT performance in any given area. My role in this context was not dissimilar to the role I played in bringing together the PCT's HCC declaration.

5.9 Collaborative working: covering all bases

Blair's government talked a great deal about joint working across different areas of government, "to get the NHS to work in partnership. By breaking down organisation barriers and forging stronger links with Local Authorities."³⁸² The intention behind collaborative working is to close gaps between organisations and increase knowledge in areas where this was previously lacking. In addition, this multidisciplinary approach would provide a deeper understanding of true risks faced by organisations. However, the rhetoric and the practice were very different. One of the central aspects of the performance manager's role was to ensure the completion of DH or Healthcare Commission reviews. In the late spring of 2006, the PCT was asked to undertake a Childhood Obesity Review. This was the first obesity review and was requested by the DH; it acted as a baseline assessment of childhood obesity. This arose from the Public Service Agreement (PSA) target on obesity and was the government's first, high level response to the major health problem posed by the continuing rise in obesity. The target of "halting the year on year rise of obesity among children aged under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole," was challenging. The target was jointly owned by the DH, the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport (DCMS) in acknowledgement that its delivery would depend upon a concerted, joined-up effort across government and at a local level. Local data on childhood obesity was needed for the

³⁸² Department of Health (1997) section 2.4

following purposes: to inform local planning and targeting of local resources and interventions and to enable tracking of local progress against the PSA target on obesity and local performance management. ‘Measuring Childhood Obesity: Guidance to Primary Care Trusts’ was issued by the DH on 11 January 2006 and further ‘Guidance to Primary Care Trusts’ on data handling from DH on 3 May 2006. The review was to consist of PCTs measuring all primary school children in Reception Year (aged 4-5years) and all primary school children in year 6 (ages 10-11 years).

Fieldwork notes taken during the meeting of the Information Monitoring and Definitions Group (IM&D group) at SHA highlights the issues surrounding measuring obesity and the sharp differences between the rhetoric of partnership working and the reality. The hoarding of power within the Department of Health made a mockery of this ideal. Moreover, these internal conflicts between state departments were replayed at a local level. The Minister had said that all children up to the age of 10 should have their Body Mass Index (BMI), a score for assessing if an individual is a healthy weight, recorded. How to achieve this was problematic; there were significant time constraints. Anger was felt that PCTs had received complete guidance only at the beginning of May when pupils would break up for summer holidays from early July onwards. Most child health requirements were done within the school system, i.e. through the Local Authority, thus PCTs could not understand why the same approach was not being taken for the childhood obesity review. However, it was noted that GPs under the Quality and Outcomes Framework (QOF) were recording the BMI of all patients between 15 and 75. Questions raised by individuals around the table included: “What happens to the recordings between the ages of 10-15? Is this when you are allowed to be hugely obese? Why is there no screening programme for obesity the same way there is for cervical cancer?” I later posed this same question to a public health specialist within the PCT. The response was that screening programmes, like those around cervical cancer, can take place only when there is a clear evidenced-based treatment path. In the case of obesity such a path did not exist. There were conflicting theories about what was the best practice for treating childhood obesity; hence the purpose of DH’s obesity review was to inform local planning and target local resources rather than to identify and treat individual obese children. This made me realise that public health input was vital and that lack of this wider knowledge hinders information gathering at all levels. It was apparent that the recording of BMI was significant as it clearly underscored failings in the system. Obesity was high on the health agenda; however there was no systematic process of collecting data. Data collection

should already have been occurring but had not. Moreover conflicting messages were voiced by various parties involved in child health.

Much work was carried out between myself and the Public Health Obesity Specialist on behalf of the three PCTs. In 2007 the work was being led by the Provider arm with little direct input from the public health directorate. On completion of the 2006 review, and once the DH published their initial findings, a 'suggested protocol for measuring childhood obesity' was created. In 2007 'Childhood Obesity: data quality' was part of Healthcare Commission's New National Targets. Therefore the work done in 2006 as part of the DH review, including measuring all children aged 5 (reception) was undertaken again in 2007, but this time did not affect the PCT's overall yearly performance nor its national standing.

A considerable amount of a performance manager's time was spent on bringing together information for HCC's in-depth reviews. This was an assessment by the independent regulator. The focus was on: 1) an aspect of the patient pathway such as a service or across organisation; a population group, e.g. children or a condition, e.g. diabetes; 2) a domain of the developmental standards; 3) leadership and organisational capacity. One such review was the HCC improvement review in 2006 of Tobacco Control. A member of the public health team was the lead co-ordinator, with advice required for the performance element of the review. Once again the work was carried out across the local health economy which comprised three PCTs, though each PCT was assessed independently. The results of the improvement review for Tobacco Control were expected a few months after its completion. The hope was that the PCT would achieve a 3. There were 4 levels, from 1- 4, with 4 being the highest. The PCT's Public Health Specialist had spoken to the Thames Valley SHA representative who had told her that the majority of PCTs would fall into a level 2, that no-one in that year would achieve a level 4, and only exceptional PCTs would receive a level 3. It was disheartening to hear this news as we believed that the PCT provided a better than average service. Besides, it was a huge piece of ongoing work, for which effort to receive only a score of 2 seemed inadequate.

5.10 Lack of feedback & follow up invalidates conducting lengthier reviews

In the end, the PCT where I was conducting my empirical research and the neighbouring PCT scored a level 3, while another adjacent PCT achieved the highest score, a level 4. This illustrates the expectation that we would score lower than we actually achieved. This was a great affirmation of all the work which had been done by both the Public Health

Directorate and the Smoking Cessation Service. There was however an expectation that the three PCTs would receive feedback/actions on the completion of the review on which they would then be assessed at a later date. Though the HCC referred to this process as review, like all its reviews it had the hallmarks of a large scale national audit which is why there was a presumption there would be specific feedback. To an organization such as a PCT, there is little value in an audit without such a response. The Healthcare Commission did not produce any such local action plan, which was disappointing for those who worked on this improvement review. Good feedback, staff felt, would have provided clear direction on which areas need attention. Instead, the Healthcare Commission produced the national document, “*No Ifs, No Buts*,”³⁸³ which PCTs were expected to work towards. This was a more generic response to all PCTs rather than the more specific actions hoped for. Staff were more than aware of the gaps in the Smoking Cessation Service; had these been identified in a Healthcare Commission Review this would act as tangible evidence, to a wider audience, of where resources would need to be located. For staff who were involved in the review, its remit was not only to assess the current standard of performance and to highlight the risks, but, more importantly, to provide actions and solutions in difficult areas. All this was missing. By calling it an improvement review rather than an audit, the HCC had managed to cut corners in terms of what was expected from them as a regulatory body. As previously discussed in Chapter Three, the principles behind undertaking audits are the highlight and lessening of risk, providing clear lines of accountability to a public audience. While Power argues they are not always successful, what is clear here is that even these shallow processes of risk reduction are not used effectively. Moreover, this diminishes New Labour’s earlier claim, as set out in Chapter Two, that performance management’s purpose was to mitigate risk through increased accountability and effective regulation.

5.11 Achievement of targets are dependent on organisational ownership

New Labour prioritized action on tobacco control soon after coming into office³⁸⁴. Shortly after, a key target for PCT concerned smoking cessation; in Bucks PCT over 2000 people had to stop smoking each year. For the last three years, with tremendous effort, the PCT has exceeded this target. 2004 saw the government first propose a smoking ban in public places.³⁸⁵ The acting Public Health director and the Public Health director who was appointed in Jan 2005 lobbied for a smoking ban in the belief that it would encourage

³⁸³ Healthcare Commission, *No ifs, no buts: Improving services for tobacco control* (January 2007)

³⁸⁴ Department of Health, *Smoking Kills A White Paper On Tobacco* (December 1998)

³⁸⁵ Department of Health *Choosing health - Making health choices easier* 2004

people to give up smoking. During this time I noted “Today Public Health team has been listening for news on the Smoking Ban as the vote is later tonight. The MP for X appears to have changed his opinion and it seems he will be voting for a smoking ban. Both Directors of Public Health (DPHs) are on annual leave (it is half term), so the rest of the public health team are unsure whether to send more information to the MP or whether this would be too much pressure, and hinder rather than help the case. ...All of Public Health team were happy today, they won a smoking ban!” Nevertheless, national debates take longer to permeate public NHS culture. At a local level, during this same period the Public Health director was still fending off questions at Board meetings as to whether there was any value in Quit Smoking targets. Quitting smoking has an immediate impact on the life chances of individuals. Almost 1 in 4 deaths in people aged 35-64 in the South East are due to smoking. This represents a burden to the NHS as 44,000 people in the South East were admitted to hospital with smoking-related illness in 2003/4, accounting for estimated costs to the NHS of £238 million.³⁸⁶ That there were questions around the value of the smoking target being asked raises the issue of how much understanding management had of NHS priorities. There appeared to be no recognition of the financial risk and consequences faced by the NHS resulting from continued tobacco use.

However, by late 2006, achieving the yearly, Quit Smoking target for 2006-2007 appeared a near impossibility for the PCT. This was because of low prevalence rate and patient reports to their GPs of their intention to give up when the smoking ban came into place which was not until 1st July 2007, namely the end of the financial year. Compounding this problem, the scale of deficit needed to be overcome had been misjudged. The forecast was based on upward trends in quarterly figures that failed to materialise. I arranged a meeting with the Smoking Cessation Service relating to the performance monitoring of this target. The central concern under discussion was that the delivery of the target required more than just the smoking cessation service.³⁸⁷ In contrast to the prevalent idea that the smoking cessation service alone could deliver this target, I understood that lasting success required the involvement of a wider number of people, including those from other directorates. As performance manager, I experienced an acute sense of failure. However, there was also a recognition this transient dip in morale could lead to a more widespread and damaging sense of underachievement amongst the team. The greatest failure would not be missing the target; the real failure would be abandoning smokers merely because an

³⁸⁶ SEPHO Choosing Health in the South East: smoking report

³⁸⁷ NHS smoking cessation services and smoking prevalence: observational study Eugene Milne, BMJ 2005;330:760 (2 April)

arbitrary quota now appeared beyond the PCT's grasp. A performance manager has to put aside feelings and focus all energy on rallying the team to forge ahead on a recovery strategy. Some individuals around the table were resistant to this notion that the smoking target had anything to do with them; they required significant persuading. The separation of the service level agreement (SLA) performance monitoring from the actual operational delivery of service to meet the target was introduced, as well as the interim measure of having an operational group to promote work already occurring and encourage the additional work that needed to be undertaken. The smoking target crystallized my view that the delivery of a key target is dependent on more than just one group. However specific targets are often seen as belonging to a particular directorate, who are responsible and accountable for its achievement. In the case of the smoking target, this responsibility lay with public health. Hence other directorates were not keen to get involved, particularly as their involvement was only sought when the target appears to be failing; staff had neither the desire nor wish to be associated with a failing target.

One significant issue in increasing the number of quits was making sure referrals got into the service. Success in an initiative such a smoking cessation requires constant dialogue with the public to bring to the fore their concerns and expectations. Feedback from consultation with the public told me that they would value a more immediately accessible smoking cessation advisor. To this end, a couple of smoking cessation advisors were permanently based in the PCT's largest practices. I encouraged the rest of the service to continue with this dialogic approach given the collaborative nature of this endeavour. Similarly, I recognised internal PCT communication was important, in orchestrating a drive to monopolise on the peak Quit Smoking periods of New Year and No Smoking Day. Hence the PCT sought to establish a smoking service team, including a representative from communications, commissioning, primary care, public health and senior management support from the provider arm. This type of open discussion forum and close monitoring aided not only the achievement of the immediate target and the strengthening of the service but also fortified the battle against tobacco domination. As performance manager, my principal aim was to reduce the absolute number of smokers within the PCT population. The intersection of this objective with the meeting of the target would be ideal, though a secondary outcome. However in this role there was an awareness that this approach was contrary to the purpose of my employment. Focus should be on achieving targets, and if I failed to do this I was seen as having failed - a very short-term approach to healthcare. As discussed in Chapter Two, New Labour introduced performance management in order to increase accountability thereby reducing the risk of

future crises within the NHS. Yet what this example illustrates is that clear organisational ownership of targets is missing and because of this the associated risks remain in spite of New Labour's emphasis on performance culture.

Attendance at the monthly Adult Mental Health Performance meetings with the Mental Health Trust (BMHT) was useful as several of the PCT performance targets were discussed. Information from this meeting was fed back into the board report; this included explanations for over-and under-performance, management action to address over-and under-performance, and ensuring information for statutory returns were as accurate as possible. The PCT targets covered were: Commissioning of comprehensive child and adolescent mental health services; Commissioning of crisis resolution/home treatment services; Commissioning of early intervention in psychosis services, CPA 7-day follow-up; assessment of older people's mental health needs and services. However "waiting times are not measured for mental health services and, unlike elective care, targets for reducing them are not in place.....overall the mental health system remains poorly focused and poorly coordinated."³⁸⁸ Waiting times for mental health services were some of the longest; the lack of performance targets in this area reflects understanding that the achievement of any adequate performance would require sustained amounts of money and resources, which were not available. Mental health was one area where the public, including lay groups, had a strong voice. The expertise of the medical profession was not taken to be infallible and as a result there was a greater debate over what value targets have.³⁸⁹ In addition, the government appeared to have thought it better to have no targets in this area rather than to be seen as constantly failing against a specific target. This served to prevent Mental Health Trusts being labelled a failing service and politicians having to deal with all the entailing baggage. Psychiatry and other mental health services were often referred to as the 'poor relations' of the NHS; they did not share the prestige or the budgets of services such as oncology or cardiology. Funding was always under constant threat. This was also an area which the NHS commissions the service but does not solely provide it; it relied on both social services and the local councils. This could be problematic as targets set in the NHS for PCTs were sometimes not targets for Local Authorities or Social Services. What this meant in practice was that a target may not have been a high priority for other organisations and their staff, so the level of commitment a performance manager received varied.

³⁸⁸ The NHS and the NHS Plan: is the extra money working? A review of the evidence in 2006 James Gubb: Institute for the Study of Civil Society, p28 <http://www.civitas.org.uk/pdf/NHSBriefAug06.pdf>

³⁸⁹ Ham, C., (2004) p185

5.12 Ineffective measuring creates a false sense of security

Using two examples from my time spent as an institutional ethnographer within a PCT, I illustrated in the previous section how New Labour's introduction of performance management to increase accountability as an approach to reducing risk had proved ineffective. This section demonstrates how measuring, another key aspect of performance management, was applied by New Labour as a means of mitigating risk. I argue that this too was ineffective; measures were not a clear and appropriate reflection of health policy and data used was neither accurate nor robust. This created a false sense of security as those not directly involved in the process were unaware of the limits of the information. The following is an example gained while located within the PCT as Head of Information and Performance.

There were two measures around the target of infant health: breastfeeding initiation rates and smoking during pregnancy. This target was about reducing health inequalities and about providing the best start for newborns. The information was provided to Share Services by individual Trusts; the PCT would then get this information from the two main hospitals in the area. A huge amount of work was undertaken by a public health specialist over a period of two years on improving the data quality on the smoking target. The measure for breastfeeding initiation rates moved from initially being a public health issue to a data quality target. The indirect outcome of the introduction of the measure was not to improve the breastfeeding initiation rates, (the original aim) rather the target's focus became the measuring of data quality in this area. The aim was to increase the number of women breastfeeding. In contrast, the target's construction led to a focus on 'data completeness' as the numerator measured the number of women breastfeeding at birth plus the number of women not breastfeeding at birth over a denominator of total number of pregnancies. Therefore the aim was to have a figure of one, and deviation from this value was unacceptable to the SHA on the basis that it was illogical. Women must either be breastfeeding or not and this figure cannot be higher the total number of births. However, systems did not cover all the data requirements hence the denominator was taken from Hospital Episode Statistics (HES), while the value that makes up the numerator is taken directly from midwives. While the numerator and the denominator gave real and accurate values independently, the different data sources led to discrepancies in the end value. Each quarter, after the submission of the LDPr on which this data was collected, this discrepancy between the numerator and denominator would be queried by the SHA on behalf of the DH. Each quarter the performance manager was in the position

to alter this figure, so that the end value was the expected 'one'. As Porter states: "The Latin root of validity means 'power'. Power must be exercised in a variety of ways to make measurements and tallies valid."³⁹⁰ Here is a clear example of such power, where a performance manager's role is to ensure such validity.

This example highlights an unwritten ethos of 'don't ask, don't tell,' a combined process of concealment and unquestioned acceptance of how the figures were achieved and created. Accomplishing the impossible had become the standard, the norm. The normative aspect of performance management includes the aspiration of sharing good practice and ideals around benchmarking. Yet the descriptive process of day to day work involves fudging and distorting figures. A performance manager's likelihood of partaking in dysfunctional behaviour increases when they sense that a control mechanism, in this case the adherence to a flawed measure, has been imposed against their will.³⁹¹ There was a lack of true autonomy, of acting rather than being acted upon. Instead a sense of heteronomy pervades where individuals feel subject to factors beyond their control. This was initially discussed in Chapter Three by Bauman in relation to bureaucracy and moral detachment. Here is clear example of displacement of responsibility; for how can an individual be responsible for something over which they hold no control?³⁹² While an outsider might see behaviour as risky, the effect of repeating the action and therefore the risk means that it ceases to be considered so by those working in performance management.³⁹³ Contrary to New Labour's desire for performance management to decrease risk, it in fact had the opposite effect. Performance management was a kind of accounting of which there are two forms: firstly, accounting for an action, that is to provide accountability to a wider audience; secondly, providing an account, in this case a false one, in order to accomplish meeting a target, preventing SHA monitoring, and the sustaining of a good reputation. The introduction of performance management aimed at lessening risk but because of false accounting this was not the case. There was a process of normalising this deviance, a culture of turning a blind eye to the obvious, an unspoken understanding between those shaping the figures.³⁹⁴ This balanced scorecard target/indicator crystallised my view that one cannot turn a poor measure into a good one and this was acknowledged and understood from the beginning of New Labour's time in office. "Experience shows that the way in which performance is measured directly affects

³⁹⁰ Porter, T. M., (1996) p28

³⁹¹ Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995) p197

³⁹² Berlin, I., (2003) p61-62

³⁹³ Vaughan, D., (1996)

³⁹⁴ Leeson, N. & Whitley, E., (1996)

how the NHS acts; the wrong measures produce the wrong results.”³⁹⁵ Ten years on, poor measures are still affecting the actions of staff. The targets around infant health illustrate that it is possible to have a good policy, a stretching target, but also a poor measure, ill-conceived and unconstructive. The distinction between policy, targets and measures needs to be more clearly understood by those creating policy. There is no point having idealistic policies in place if the measures do not accurately reflect what it is you seek to measure.

5.13 The role of IT in reducing risk

I have illustrated New Labour’s emphasis on measuring; this in turn led to information technology (IT), a means of enabling measuring to be done, enhancing its status within the NHS. Moreover, as previously mentioned in Chapter Two, New Labour were keen to be considered modern and IT was one way of reflecting this progressive outlook. Information Management took on a significant role after 1997 as the NHS moved to implement the internal market. This was contrary to early claims made by New Labour that their strategy was to move away from information technology in the NHS which focused on supporting the transaction processes of the internal market³⁹⁶. Moreover, market reform policies to increase “plurality and diversity”³⁹⁷ in healthcare provision meant private and voluntary providers had the opportunity to compete for NHS business. By 2008, this was up to as much as 15% of all NHS operations;³⁹⁸ it was considered essential by both Prime Ministers Blair and Brown in expanding overall capacity within the NHS, while enabling waiting times to be reduced for surgery, as well as providing an impetus for improved efficiency in NHS hospital trusts. In addition, under schemes such as Practice-based Commissioning, the requirement for detailed information had become a necessity. PCTs needed to be in a position where they could confidently state: ‘cost savings have been made.’ Without an accurate baseline no effective comparison could be made, and no confident statements asserted. As Head of Information it was necessary to support the growth of an information culture within the Trust by assisting staff to understand and use the available information and evidence provided by the department to inform decision-making and the planning of current and future provision of care throughout the Trust - “Information is at the heart of everything we do in the NHS.”³⁹⁹ There had been a slow recognition that within the NHS there is much data, but little information. There may be several local data sources, in some cases over 40 different

³⁹⁵ Department of Health (1997) section 3.14

³⁹⁶ Department of Health (1997) section 3.15

³⁹⁷ Department of Health (2002) p25

³⁹⁸ Baggott, R., (2007) p169

³⁹⁹ Kennedy Report (2002)

ones,⁴⁰⁰ but there was no common glossary of terms, consistency or integrated approach. Moreover, the antiquated manual processes did not give visibility to all interested parties. There were often questions about the timeliness of data as well as issues of quality. This lack of alignment between the data and strategy was raised in the Audit Commission Report “Aiming to improve: the principles of performance measurement.”⁴⁰¹ New Labour, like Harold Wilson’s Labour, was once again quick to realise that though there had been rapid growth in information needs there had not however been a corresponding growth in the necessary IT infrastructure.⁴⁰² People within the NHS developed ad hoc solutions to get the information they needed. Prior to my undertaking this empirical research, there was a move to combine the roles of Head of Performance and Head of Information based on the belief that, without a good understanding of what and where the information came from, it was impossible to score well in performance frameworks.

Local and national requirements drove the need for an effective performance monitoring system. A flexible reporting capability was needed to bring together clinical, financial and resource information to provide good quality management information to the PCT managers and to produce regular reports for those who required them, including statutory returns. Tools were required to enable the PCT to respond to performance data, changes in ways of working (e.g. for the provision of new service models) and to facilitate planning. Locally, a tool was needed to enable anybody who had a need to access and manage data, including main Board executives, managers and clinicians, to make informed decisions and implement improvements or corrective action. Timely, accurate and relevant information was required to enable staff to take appropriate action. Nationally there was a requirement to report performance and clinical governance details outside the local area, e.g. the DH. A key imperative was the ability to justify the PCT’s performance for national ratings with sound data. The NHS worked to replicate information management systems similar to those in the United States which were seen by the Department of Health as robust and effective. However, this is because US medical care was funded by private healthcare insurance. The competition between health providers means that they must have the most detailed information on costs. This motivation did not exist in the NHS, nor had there until recently been multiple providers. Instead, what was seen in the NHS are characteristics of a prisoner’s dilemma in relation

⁴⁰⁰ NHS performance Indicators- A consultation, (May 2001)

⁴⁰¹ Audit Commission, (June 2000) “Aiming to improve: the principles of performance measurement”

⁴⁰² Driver, S. & Martell, L., (1999) p37

to the scrutiny of data: the costs of scrutinizing data far exceed any benefit to an individual, although such scrutiny may benefit the wider community.⁴⁰³

Within information management, the principal data sets used concerned elective access that is, planned appointments. Examples of the most frequently used include waiting times and activity (both Inpatient and Outpatient), diagnostics, and 18week referral to treatment. On the Public Health agenda, the key data sets were smoking cessation, coronary heart disease (CHD), obesity and genitourinary medicine (GUM) while, on the Patient Safety agenda, key data sets were around Healthcare associated infections (HCAIs) including Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium Difficile* (C Diff.). Finally, on commissioning, the key data set was around the LDP. Data sets around 'access' (to primary and secondary care) changed in the way items were measured; this led to different values but the motivation and meaning behind requiring this measurement remained the same. Data sets within public health move up and down the national priorities. For example, during the 1980s AIDS moved up the political agenda but slipped back during the 1990s. Now in the new millennium it is back on the agenda through the GUM because of the increase in Sexually Transmitted Diseases, STDs. In addition, some data sets such as those around MRSA have become more robust as people's interest in HCAIs had risen, highlighting the risks society perceived it faced. Movement and change seen in the data sets used reflect public opinion; this is one of the few observable impacts of indirect democracy. Individuals and groups have "stressed the importance of addressing the 'democratic deficit' by making NHS bodies in some way accountable to their local public. The NHS has not been directly linked with local democracy since local councillors were removed from Health Authorities in the 1970s."⁴⁰⁴

There were several key tools used within Information Management. The private company Dr Foster was a 'real time' monitoring and performance investigator. Dr Foster was the most popular performance information provider in the public sphere. Previously Dr Foster was an independent company, and many of its findings were published in the national press, e.g. The Times. However, there had been more collaborative work between the DH, the NHS and Dr Foster. Data from different sources often gave conflicting answers. By working with the most publicly recognised health information provider, the DH hoped this would provide some consistency within the public consciousness. There had been

⁴⁰³ Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995) p196

⁴⁰⁴ Health Select Committee "Patient and Public Involvement in the NHS", 20 April 2007. section 2.27 <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/27805.htm#a4>

much work undertaken by private companies external to the NHS. The use of consultancies had been one of the biggest outsourcing projects of the NHS though probably the least publicised. 2.9 million was spent on external consultants by the local SHA in 2006/7. New Labour had encouraged the partnerships with private firms under the banner of modernisation; unfortunately these same firms had exploited both NHS managers' and civil servants' inexperience and incompetence to make excessive financial returns.⁴⁰⁵ While "experienced buyers create and benefit from competition, innovation and lower prices; inexperienced buyers reduce competition by handing the keys to the castle over to a few big operators. Reduced competition means less innovation and higher prices."⁴⁰⁶ This had been seen in the NHS, from when New Labour came into office in 1997, when the big four consultancy companies, McKinsey, PWC, KPMG and Andersen Consulting had free rein over NHS contracts, though this was scaled back slightly under Gordon Brown's premiership.⁴⁰⁷ This will be discussed further in sections on organisational change, an area where these companies had huge impact.

Other information tools include Secondary Uses Services (SUS), previously the Nationwide Clearing Service (NWCS). This held data sets on Practice based Referral (PbR), Practice based Commissioning (PbC) and the eighteen week patient pathway (18 weeks). Hospital Episode Statistics (HES) captured all patient-admitted data and Map Info showed the geographical map against an indicator/target. The most compelling and frequently used indicator is Life Expectancy. Within the PCT there was a difference of ten years between the most affluent and deprived areas. In addition, the performance manager had responsibility for the introduction and application of the recently acquired performance management tool, Pbviews, into the PCT. Pbviews was a performance monitoring tool, being fed by data on pre-agreed performance measures used by all organisations, to create a 'common view' and approach across the SHA. Its presentational style utilises a dashboard effect, based on the traffic light red, amber, green, on measures such as finance, manpower and activity. It took a complex area and reduced it to terms of risk. However, my time spent as institutional ethnographer within the PCT allowed me to observe how the complexities within the Balanced Scorecard were lost until it became just a method of presenting data; just a piece of paper with traffic lights, just a compilation of national targets and summary of PCT performance. All perspectives were lost when objectives, measures and targets become traffic lights. This dashboard effect was

⁴⁰⁵ Craig, D, Brooks, R., (2006) p196

⁴⁰⁶ Craig, D, Brooks, R., (2006) p233

⁴⁰⁷ Craig, D, Brooks, R., (2006) p27-30

supposed to bring clarity, but this form of systemisation - over-simplifies situations and problems. PbViews was hosted by a Shared IT Service. However, I had to oversee the management of the information and knowledge bases held by the Trust (database maintenance), support Information Analysts both in the PCT and Shared Service around data quality-improvement programmes, as well as negotiate with software suppliers in association with the Head of IM&T, to ensure upgrades and revisions were consistent with the PCT's needs. The Strategic Health Authority procured licences to implement a version of PbViews (from Performancesoft) performance monitoring software at each NHS organisation across the patch. There was an expectation that each PCT would have done this by 31st December 2005.

Both performance monitoring software and the Management Information Systems (MISs) they support act as a form of surveillance which, as first discussed in Chapter Three, is central to providing a sense of security, through possible risk reduction, and forming administrative structures and procedures. The history of surveillance, however, can also be viewed as a history of information management, of bureaucracy.⁴⁰⁸ As information management has evolved and developed, so too have the tools at its disposal, now including MISs. The PCT, where this empirical research was undertaken, had been working on the procurement of a full Management Information System (MIS) and had reached the final interview stage of the tendering process by the summer of 2005. The possible introduction of a management information system was not without controversy; in the PCT it was seen as a highly politically-motivated decision. This was because MISs often change the configuration of how information flows; the very nature of MISs alter the distribution of how, when and which staff receive data and in so doing the structure of power inevitably would be changed. Within the PCT where I was located, and nationally within other NHSs organisations, MISs were recognised as having three principal functions, including bolstering the information processing facilities of an organisation, a surveillance mechanism for management to exert control, and a decision support system.⁴⁰⁹ All these functions to varying degrees were considered valuable to the PCT as an organisation; the utilization of MIS was seen as promoting greater efficiency and effectiveness. However, with the publication of "*Commissioning a Patient-Led NHS*" in August, the decision was made to suspend procurement. This was because no future new organisation would have wished to be tied to a significant financial commitment. The performance manager spent much time with the PbViews training and meetings. PbViews

⁴⁰⁸ Giddens, A., (1985) pp41-49

⁴⁰⁹ Holloway, J.A., Lewis, J.M., Mallory, G.R., eds. (1995) p32

was a piece of performance software which was introduced in my PCT. The idea behind it was that people within the organization could have access as to how the PCT was doing on any given target at any time. Unfortunately, it was not the all-encompassing system the PCT originally intended to buy. However, the SHA, without proper consultation, bought licenses for all the PCTs in its area. The change in circumstances meant it would have been pointless to buy the MIS as the organization originally intended. A lot of time had been wasted putting together business cases. This example illustrates clearly how a lack of appropriate staff consultation on significant projects within the NHS causes much resentment and frustration. As one interviewee comments:

PCT Governance Manager: “Nobody is ever held to account; within the IT there’s been so many examples of projects not being properly performance managed and huge losses and what happens? Nothing really happens; I don’t know that they really learn a huge amount from it. I guess, things have improved, I’m not being completely negative, but, we don’t run a very tight ship as an organisation really. Also, it’s just the culture, most people on the shop floor who actually influence how resource is spent, don’t even know anything about performance management.”⁴¹⁰

Politicians of all political persuasions have recognized that public consultations are often fruitless exercises where policy has already been formed and politicians and public organisations are simply going through the motions of local engagement. The Health Select Committee, which consists of cross-party politicians, reported that, “Public trust has to be earned and is easily broken. In some places, consultations have been a sham, elsewhere NHS bodies have sought to evade their duty to consult entirely. The Department needs to take a lead and make it clear that such behaviour will not be condoned.”⁴¹¹ More importantly, internal decision making, which I was privy to witness in a variety of key meetings, left a lot to be desired and often it was about politics and upholding the conservative social order that exists within the NHS. Yet this has not been recognised nationally. Why should staff recognise the value of public participation when their own participation is not appreciated? It is difficult to implement both policy and change when principal parties have been kept out of key decisions. This then in turn affects their ability to implement improvements, developments and reform within their

⁴¹⁰ Senior Governance Manager, p4

⁴¹¹ Health Select Committee “Patient and Public Involvement in the NHS”, 20 April 2007. Section 6.280 <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/27809.htm>

own organisations as there is a culture of disenfranchisement. Denying senior management the ability to influence key decisions leads to a basic lack of local engagement with key policies. Where there was no sense of management ownership, of buy-in, on specific decisions, a wider lack of direction and a sense of aimlessness was generally felt by all staff.

Blair's rhetoric on technology and modernisation went hand-in-hand.⁴¹² The two themes were supposed to signify to the electorate New Labour's modern approach to the NHS. In a globalised world, the communications and information technology sector provide the bulk of work, overshadowing the traditional industries. New Labour had been keen to devolve the post - industrial economy promoting partnerships with the private sector to innovate technologies.⁴¹³ Nowhere had this been more apparent than in the significant amounts spent on the National Programme for Information Technology (NPfIT), now rebranded Connecting for Health. It was overseen by Richard Granger (previously of the consulting company Deloitte) and should have delivered a range of new systems to the PCT between 2006-2007 e.g. New National Network (N3) connections to all NHS sites including GP Practices and branch surgeries, Care Records Service (CRS) functionality in Community Hospitals, Choose and Book (CAB), Picture Archiving Communication System (PACS), SUS etc. None of these projects have adhered to original timetables. Some of this work was managed and coordinated nationally and the rest more locally; the role of outside consultancies however is a constant.

There were risks associated with any significant implementation of a new system. In general, when trying to quantify levels of risk around NHS IT, 'the more ambitious the solution, the higher the risk' works as an accurate guiding principle. It should be acknowledged that the 'do nothing or little' option often runs the risk of failure to meet other strategic policy imperatives or business objectives.⁴¹⁴ As with all big IT projects within the public sector, when there were delays in implementation, costs escalated; in this case the financial burden was felt by the NHS.⁴¹⁵ In late January (26/01/06) Heads of Information were informed of the delay in the launch of Secondary Uses Service (SUS) by the SHA. Concerning SUS there were data quality problems and the roll out was once again delayed. People were unsurprised to hear that the launch was to be postponed from

⁴¹² Department of Health (2002a) Delivering 21st century IT support for the NHS: national strategic programme

⁴¹³ Driver, S. & Martell, L., (1999) p42-44

⁴¹⁴ Department of Health (2002b) Securing our future health: taking a long-term view - the Wanless Report

⁴¹⁵ Craig, D, Brooks, R., (2006) p183-197

1st April 2006, with no new date being issued. As earlier mentioned, the NHS looks with envy to American Management Information Systems. The reason private insurance is so keen to have credible information is because it makes a more accurate assessment of risk possible. In a society such as United States, where the threat of litigation is higher, compensation claims financially more lucrative, viable private health insurance companies want to feel that they have covered all eventualities, thereby minimizing the risk they take on. Nevertheless, during the 1980s the US public sector was exploited in a similar fashion to that which was currently seen in Britain; what prevented this continuing was the move from voluntary self-regulation to the introduction of 1996 Information Technology Reform Act. However the Labour government shied away from introducing comparable legislation for fear of being seen as anti-business and therefore Old rather than New Labour.

5.14 Conclusion

Performance management was introduced to eliminate risk by increasing patient safety, preventing scandals the size of Alder Hey, Bristol Infirmary and Shipman but also the incidents that never made it to the mainstream press. Performance within the NHS, according to New Labour rhetoric, was implemented to address issues of risk management. However, as seen, the manner in which it was introduced left much to be desired; there have been many inconsistencies within its application and processes were rarely evaluated. During the start of New Labour's term in office, performance managers were appointed in Trusts throughout the NHS, their presence to draw attention to underperforming areas, their role to act as risk minimisers. At their disposal were tools such as the Balanced Scorecard, a high level strategic document which enabled the Board to identify areas of action. Star Ratings were supposed to make organizations more publicly accountable; however as financial independence and rewards came with being a high rating Trust, playing the system and gaming increased to an extent where it became the norm.

Annual planning cycles were designed to prevent problems from arising, yet the same problems occurred time and time again and the crises that happened were invariably expected. Performance managers did not significantly increase accountability; it was not assurance against standards that was being sought by the Department of Health and the health regulator but reassurance; their role was thus to reassure the organisation that everything was satisfactory. The value of collaborative working was often lost; engaging

with other departments and organisations was often mainly concerned with dividing responsibility and protecting oneself in areas that were already considered to be high risk and with a high likelihood of failing. Conducts of audits and lengthier reviews were invalidated by a lack of genuine feedback and advice; a simple score was not conducive to sustainable improvement. The setting of targets and creations of numerous standards were only attained if specific senior individuals were tasked with their responsibility. To say it was the entire organisation's responsibility was inadequate. What I evidenced in this chapter was this: where there is no ownership of a target, it merely becomes what Arendt terms a "floating responsibility." Moreover, achieving targets, being labelled a successful organisation could be deceiving, as all assessments were based on historic data. Furthermore assessments undertaken presented only an overview of an organisation, often missing pockets of poor and even substandard practice.

During this period the NHS did not have sufficiently robust information systems and hence measuring became a shallow form of verification, losing the trust of its staff. Their accounts informed wider debates, creating an atmosphere of public disbelief about the information produced. Other types of organisational intelligence should have been used; moreover a review should have been undertaken into how effective the new performance system was in achieving its goal of reducing risk, thereby providing real scrutiny in the NHS. Ineffective measuring creates a false sense of security, but to focus all attention on implementing, upgrading and purchasing the latest IT systems as a means of reducing risk was to invest too much expectation in technology's ability to solve deep seated problems. Newer technologies are only as good as the systems, staff and data they support. Nevertheless, to disinvest in IT was a false economy. A satisfactory compromise was required, one where staff's accounts of areas in which they are experts are accepted and given credence and if necessary supported by quantitative information. This chapter has illustrated that was the opposite of what actually occurred. Inaccurate numbers were given primacy, thereby increasing risk and decreasing the quality of care patients received.

Risk reduction was the normative account the state used to introduce performance management; detailing the work of the performance manager, we see this role in fact was minor in relation to the goal of performance. However, this narrative of risk successfully acted as the catalyst to bringing about a more compliant, less challenging, workforce and enabling the state to introduce performance management with minimal disruption and interference from public and staffing bodies. Early government rhetoric about the proliferation of performance was centred on reducing risk; the evidence suggests that the

tools employed have not delivered the desired results. The NHS flounders from one crisis to the next. Thus if performance's sole purpose was to reduce risk, it should be considered a failure. However, in the next chapter, I propose that performance has had another function, that of rationalisation, and here it has been most effective.

This chapter has relied heavily on data gathered through my observations as an institutional ethnographer. This provided a rich, complete and detailed account of work done within performance. It did not give or lend support to personal narratives around risk. Rather, the sole quotation used was from the in-depth interview with the governance manager who provided a narrative which made clear the link between performance and rationalisation, the with notion of risk left unspoken. Being based within the PCT enabled me to see that individuals did not make sense of their world or their work through an understanding of risk. Risk was the voice of the state, but not the rhetoric used by individuals or organisations to make sense of their work. Its absence was telling. What this chapter has illustrated is that risk was the elephant in the room. All the apparatus at a performance manager's disposal arose from a risk culture. Risk management has a clear process: identify risk, put mitigating actions in place, understand what factors are outside an organisation's control, and put contingency plans in place, reassess and review the risk, take action and plan as appropriate. To understand risk it is necessary to look at the risk faced in its totality. Those working in performance went through all these steps on the Trust's behalf and yet it was not the choice of rationale for individuals in aiding them to describe, understand or explain their work. Rationalisation as set out in the next chapter was what gave meaning to the performance agenda.

Chapter 6

Rationalisation: Statecraft Work

6.1 Organisational Rationalisation

The move from Labour to New Labour was considered by some political commentators to be a marketing ploy and by others as providing a visible shift in the direction of the party from left to centre-right politics. However, ‘Labour’ as a party name originally referred to work, as it has its roots in the trade union movement. New Labour redefined how it saw work, shown clearly in the dropping of Clause Four⁴¹⁶ prior to the 1997 election. Within the NHS the effects of New Labour were seen in the new labour of performance management as described in detail in the previous chapter. This distinction is important because as Marcuse stated: “Social change is a qualitative change if it establishes essentially different forms of human existence, with a new social division of labour, new modes of control over the productive process, a new morality, etc.”⁴¹⁷ Thus, New Labour oversaw the shift from performance as an operator, a mechanism, to performance management which was not merely a transformative form of work in the NHS but also a process of organisational and hence social change.

I will argue in this chapter that rationalisation in its many forms, as will be illustrated, permeated the NHS through performance management. Performance management was the vehicle for statecraft, previously described in Chapter Three, and performance managers the tools of the state. Performance managers, through their work and the process of

⁴¹⁶ Moran, M., (2011) p291 The wording of Clause Four of the Labour Party’s constitution changed in 1995. The original Clause Four read: “To secure for the workers by hand or by brain the full fruits of their industry and the most equitable distribution thereof that may be possible upon the basis of the common ownership of the means of production, distribution and exchange, and the best obtainable system of popular administration and control of each industry or service.”

⁴¹⁷ Kellner, D., ed. (2001) p37

rationalization, enabled the state to see into areas over which they had had little or no control hitherto. The evidence presented here shows that, in the rush to meet targets, critical thinking regarding what Trusts were seeking to achieve was abandoned. Tabularisation allowed immediacy in judgements to be made, on a basis solely of weak quantified information, while evaluative decision-making processes were bypassed. Patient care slid down the list of Board priorities as the focus was on financial management. Organisational rationalisation brought with it structural reorganisation during which those staff, with sufficient seniority and authority to raise pertinent questions about the policies being followed, were made redundant or relocated.

The idea of rationalisation can be applied to organisations, in the changing shape of the workforce as well as wider structure of the NHS. Before taking office, Tony Blair spoke of “An NHS for the future: the NHS requires continuity as well as change, or the system cannot cope. There must be pilots to ensure that change works. And there must be flexibility, not rigid prescription, if innovation is to flourish.Our fundamental purpose is simple but hugely important: to restore the NHS as a public service working co-operatively for patients, not a commercial business driven by competition.”⁴¹⁸ And once Labour was in government he went on to say the following: “The government certainly does not want to see reorganisation for the sake of it...mergers arising from local decisions will be considered on their merits, on the basis of demonstrable benefits in health and healthcare, and saving in administration.”⁴¹⁹ Yet the experiences of performance staff, as I will detail, indicate that this normative ideal has been very different in reality.

Long serving staff, those who had been in the NHS for more than a couple of decades, described in both in the recorded interviews and informal conversations the cultural changes they have experienced in NHS. As an organisation, the NHS has seen massive centralisation and a concentration of services in which the personalised approach has gradually been phased out as organisations favour greater efficiency. All these are features of rationalisation and modernity as previously described by Weber. A PCT governance manager sums up the situations as follows:

GM: The changes I have seen are from a very focused local service and, almost, not a personalised service, but a personal service, to a very large, and

⁴¹⁸ Labour (1997) manifesto

⁴¹⁹ Department of Health (1997) section 6.26

what is fast becoming an impersonal service. And that's how certainly the members of the public that I know in my community, that's how they see it. They now see the PCT as just a large, impersonal organisation, which is moving from its local roots.⁴²⁰

Far from there being a steady state or a slowly evolving organization, change has been rapid, continuity has in many cases disappeared and any sense of stability within an organization is no more than a dream for those working in performance management. In the words of one PCT commissioning manager:

CM: Depends, depends at which point in time. Now, we're probably going to the right level across a region. Where we had three PCTs, we're now going to one PCT across a county. That's probably the right level to do it at. Sooner or later somebody'll have a great idea and put it back up to a health authority level, and we might not have PCTs; or somebody might have a bright idea and split us all up again into smaller PCTs because we're not being responsive to our local needs.

IV: Okay, so are you...?

CM: We change too often. We change too frequently; we don't allow change to embed. It takes five years for organisational change to embed, and for cultures to embed within that. What we end up doing is we do this in a cycle of two to three years, we rip everything apart. All the systems that we've had in place, where they were just about to start having some benefit to the corporation, we then put everything in disarray. We lose very good members of staff to the private sector or out of the NHS full stop, because they no longer want to work in healthcare. We do it too quickly, too frequently.⁴²¹

The interviewee states that the effectiveness of rationalising a workforce is dependent on when it happens. Three PCTs are merging to become one and he is part of this process of rationalisation. He suggests that organisational change can always be justified, whether it is to create a smaller organisation or a larger organisation, and that there is a sense that change is cyclical. However he goes on to say that change in the NHS happens too frequently, so that any positive impact felt by the implementation of that change is negated. The process of change is not experienced in any organised fashion and the

⁴²⁰ Interview with a PCT Governance Manager p3

⁴²¹ Interview with a PCT Commissioning Manager p5

disorder created leads to people leaving. For example this same theme was taken up by the PCT governance manager.

GM: Most people work here because they fundamentally believe that it's a good organisation to work within. I think it's just the number of changes that have been forced upon it. Even though some of them are justified and things do need to change, there's not enough time for systems to actually settle down and be implemented before they're thrown up in the air again and there's more change. People get more sceptical, everyone knows there's going to be change again within the next year; there's no way the proposed structure will stay, it's too unstable.⁴²²

Here the interviewee talks about organisational change being forced onto the PCT, a sense of things happening which are beyond its control, a sense of powerlessness against an outside force in a position to instigate this change. As the changes become more frequent, staff become more cynical, as illustrated by a PCT risk manager.

RM : It's probably the most stressful environment I've ever worked in and I worked in the city, in finance, in a very wide term, in merchant banks, in insurance, in international finance. And that's public sector, international finance, and the NHS is very stressful in that things are constantly changing. And I wouldn't say they're evolving. They are changing. And I've forgotten the name of the woman now, she did a very good article, I think it was in Health Service Journal (HSJ), about investment threshold, in that healthcare organisations are never given sufficient opportunity to demonstrate that their improvement measures are effective because they're never given enough time. I think it's a four year parliamentary... the word escapes me, in that government is in power for a period of four years, but they never seem to give NHS organisations that period to implement measures which have been legislated upon or advised by government. Because an election is approaching, the government will introduce certain measures and it doesn't matter whether those measures contradict, ones that were introduced two or three years ago. We will just turn the whole apple cart upside-down and see

⁴²² Interview with a PCT Governance Manager p5

what comes out. And it doesn't matter how many apples are bruised in the process.⁴²³

Here the interviewee talks about the stress caused by the constant change in the NHS, the negative emotional impact rationalisation generates; this aspect of rationalisation was first introduced in Chapter Three. He notes that this is far worse than any previous environment he has worked in. He comments that the change is driven by the timetabling of elections, rather than any internal reason for change. He also feels the need to corroborate his opinion, by mentioning an article published by the HSJ which presents a similar idea. He uses the metaphor of the apple cart being tipped over, to describe a sense of chaos, of staff hurt and of no clear outcome.

Continuous flux within the system and formations of new organizations mean that there is little trust between organisations existing within the system. Reorganisations and constant movement of people has led to a lost history. Individuals described the loss of organisational memory.

PM: I'm getting on a bit now. I've seen things go around and come around many times. I see initiatives with new names that in substance have been around a few times, and because I'm getting old and grumpy, I find the jargon irritating. We don't call things what they really are, we just create new descriptions for old things. And there's very little memory in the NHS, there's very little organisational memory of, well, hang on, we did that ten years ago – it didn't work then; but we're going to call it something else and do it again. What are we doing here folks?⁴²⁴

The interviewee, someone with a long career in the NHS, states that much of the recent change he has seen before in previous incarnations; to him it is simply a case of rebranding old initiatives. For him much of this constant change is due to the lack of what he refers to as organisational memory: the NHS repeats its mistakes, not learning from past failures.

As all these quotations demonstrate, perpetual change is experienced, but this is not regarded as an evolving NHS nor is it necessarily regarded as progress by staff. However,

⁴²³ Interview with a PCT Risk Manager, p4

⁴²⁴ Interview with a SHA Performance Manager, p8

the more things change, the more they stay the same. There is a perception of running fast but standing still.

PM: well, since 1987, I've probably forgotten how many restructurings of the NHS I've seen. Regardless of the number of restructurings, probably what makes it effective is that generally speaking, there is a common aim behind the treatment of patients. And I genuinely think that that is kept largely at the forefront of people's minds. We all know that sometimes various targets that aren't necessarily patient related can go up the rank of importance. But, because people generally work around the way the NHS is structured, it does ensure that certain outcomes, at least, come out of it. People tend to keep the outcomes in mind, even if sometimes it could be better. Obviously, having a change vote on average every three years means that by the time you've bedded in the last change, potentially there's another one coming around which obviously, isn't always particularly beneficial.⁴²⁵

The interviewee experienced restructuring on several occasions; his belief is that the patient is at the heart of these reorganisations. However, he goes on to say that there are times where reorganisations are not patient-orientated, that they do not work in the best interest of patients, and in these circumstances staff work around this difficulty. The interviewee discusses how reorganisations can coincide with political upheaval therefore any perceived potential benefit is lost. The interviewee is articulating his belief that politicians come from a consequentialist position. Reorganisations in themselves may be damaging but they are a means to an end, the end being a better NHS.

In these interviews, the lexicon of everyday work experience includes feelings of nostalgia. Nostalgia is a yearning, a longing, for the past, and yet there is hopefulness for the future. People see the positive in previous times. There is nostalgia for a world which was perceived as not changing, a world which was stable, and a world where individuals knew their roles. When others (politicians, new PCT staff) imply what has gone before is worthless, their response as illustrated by the above quotes is to essentially say, 'no, what we did had value, it still has value'. They are reasserting their contribution to work as worthwhile. While individuals were nostalgic for the past there were often contradictions in staff opinions. As discussed in Chapter Two, the founding principle of the NHS was

⁴²⁵ Interview with a SHA Performance Manager, p1

that care would be provided on the basis of individual's need for treatment and not on the individual's ability to pay; some staff believed this ideal was being eroded. Interviewees reminisced over a lost golden age of the NHS, but nostalgia for these values did not prevent them discussing rights and rationing in the same breath.

PM: I've noticed that the politicians have stopped saying NHS and the National Health Service; they just talk about the health service now. They don't talk about brand NHS, there is erosion around independent, private and NHS, it's just the health service... Everybody should be responsible for their own healthcare needs, and if that means a dual service between NHS and an insurance scheme, then that's the way we should go. Germany's got one of the best healthcare systems in the world; one of the most efficient healthcare systems in the world. But I believe it's fully insurance-based, whereas France has got a dual-part, of some of it's state and some of it's insurance-based.

IV: Okay. So, if Germany is one of the best in the world, and it's fully insurance-provided, and that's the most effective, or not, why not go straight down the insurance route?

PM: Because I don't think the public will allow you to. The NHS has too many values to it. It's coming up for our 60th anniversary, so we're not going to, all of a sudden, give up the core-values of the NHS, of being free at the point of entry.⁴²⁶

The performance manager has an open admiration for healthcare systems where individuals have to take out private health insurance and states that a fully insurance-based system is desirable. However he reminisces about the loss of NHS values. In his eyes, the variation within the NHS throughout the country means it is no longer truly a national service. That private providers are at the core of NHS business means that neither is it any longer a public healthcare system.

This inconsistency in thought is not unusual amongst NHS management. Performance managers are no different. While based as an institutional ethnographer in the PCT and SHA, I was often privy to discussions on the NHS rationing of services. Examples include treating only specific illnesses; state funding for secondary care but not primary, which would be funded privately; A&E being the only service that was free at the point of

⁴²⁶ Interview with a SHA Performance Manager, p9

treatment, all other services being paid for by health insurance. This dichotomy, a belief in the founding principles of the NHS and rationing of services, is not new. When performance managers discuss this they refer to it as rationing, as this language is used by the media, and yet it is also the most obvious form of rationalisation.

6.2 Measuring, quantifying & evidence

As previously discussed in Chapter Three, modernity values both the rational and the scientific as well as placing a strong emphasis on the idea of progress. Quantification is attractive when making claims about progress; they become more difficult to refute. Discussions about progress necessitate thinking about future states, what is achievable and what has been achieved. In defining progress it becomes appropriate to have goals and aims. Under New Labour, those working within public services have seen these goals and aims translated into targets. Measuring is an intrinsic part of performance management. It focuses not on the norm but on deviations; what is different, what is distinct, and captures the interest and attention of those doing the counting and later those making policy. Counting creates subdivision, which in turn generates further divisions.⁴²⁷ When applied to individuals, this becomes a process of categorisation. However, categories are neither fixed nor static; new ones come into being and a history lies behind each category⁴²⁸. The process of counting and classifying leads to an exponential increase in that which is measured. NHS policy focuses on measuring through the work of performance managers. This has led to new realities, new ways of seeing and, more importantly, new ways of referring to patients⁴²⁹. This is articulated clearly by a performance manager working in the SHA.

PM: To me performance management is about... it's a technical exercise, it's looking at trends, it's looking at performance against trajectories and it's about, if you like, flagging this up to the organisation, or in a critical way. Performance improvement is something, is more about site postings, about showing best practice, it's supporting organisations and individuals who are perhaps most challenged and actually helping them. It's a lot more of a supportive role and that's where with my improvement tools and techniques, I

⁴²⁷ Hacking, I., "Making Up People" in Biagioli, M. ed. (1999) p161

⁴²⁸ Hacking, I., "Making Up People" in Biagioli, M. ed. (1999) p168

⁴²⁹ Hacking, I., "Making Up People" in Biagioli, M. ed. (1999) p163

can offer something that traditional performance managers would not be able to do.⁴³⁰

The interviewee makes the distinction between performance management and performance improvement; clearly in his mind there is a difference between the two. According to him performance management is about ensuring organisations are in line with plans and following forecasted trajectories and projected plans. Performance improvement by contrast for the interviewee is encouraging excellence and aiding Trusts to improve their services. There is a dual function, a clear division of roles in how he sees his work. In contrast to the traditional role where the majority of time is spent holding organisations to account for their performance, the latter aspect that of performance improvement is more supportive and the focus of his discussion. My work as an institutional ethnographer within the SHA shows that this is not an accurate reflection of the actual work. The description gives an account of 40% of time being spent on traditional performance management and 60% of time on performance improvement. However, having observed performance managers, I know this not to be the case; the inverse is actually true. This is significant because the majority of time spent by performance managers is on measuring and quantifying, key aspects of rationalisation, rather than risk mitigation. It would appear the interviewee has internalised New Labour's rhetoric on risk and is keen to present this normative ideal.

In the previous chapter, I discussed how there was a fetishism of planning in an attempt to control risk factors. I stated how the Local Delivery Plan (LDP), a framework which details what services NHS Trusts will be providing for the financial year, was ineffective in both understanding variables and risk reduction. The following is an extract taken from an interview with a PCT Primary Care Manager. Every NHS organisation forecasted data at the beginning of the year and populated the LDP with actual information on a quarterly basis throughout the year. He discusses the nature of his work in terms of measuring and monitoring, features of rationalisation, in relation to the LDP.

PC: The thing that I would say about the whole LDP and other initiatives like that, is that it seems to me that the organisation never talks to each other in any great way. One group say, want smoking statistics and obesity statistics, with their certain parameters. Then it's done again, inside the QOF [Quality and

⁴³⁰ Interview with a SHA Performance Manager, p2

Outcomes Framework], but to a different set of time periods and different parameters, it's still a statistic, but nobody seems to want to mould together, to make the one target, that everyone can use. We keep reinventing the wheel, that's what I'm saying.

IV: Is it a case of different people requesting information in different ways?

PC: Yeah, different departments. Just ask for it in different ways, yeah. But it is being done in so many different ways. There is similarity, but differences, so you can't use it.⁴³¹

The interviewee discusses how the information required varies each quarter and that those monitoring the information use slightly different measures, thereby preventing information from being replicated. This is important as nationally the normative account of measuring is to compare like with like, in a systematic approach, letting the data speak for itself. Yet the interviewee's description of the process calls this version of events into account. The situation he describes is an environment which appears to hinder this type of comparative assessment.

Within Chapter Three, I gave an account of Ritzer's theory of McDonaldization, the rise of uniformity and standardisation within the workplace. The following is a quotation from a PCT Risk Manager who appropriates this idea, by stating the need for greater integration in reporting.

RM: I don't find my job difficult; it would be easier if there was some uniformity of reporting. Every body and I mean that in terms of every body, rather than people, requesting information, seems to request it in a different format. If there was some uniformity of format in this reporting process, that would make life a lot easier for everybody concerned.⁴³²

Here the interview notes how different organisations within the NHS all require the same information in a different format. There is no set way of reporting this information. He believes a greater degree of homogenisation would result in simpler working practices. This then is an example of the ideology of rationalisation, rather than the New Labour's rhetoric of risk, giving meaning to work.

⁴³¹ Interview with a PCT Primary Care Manager, p4

⁴³² interview with a PCT Risk Manager, p8

New Labour were keen to modernise the NHS; one such technique was to make its work evidence-based, so that approach and decision-making were more scientific and rigorous. Below a PCT Public Health manager discusses how successful this has been, what problems he has incurred in trying to search for basic information. Emphasis has been marked by italics to the citation. To stress his frustration he repeats his words to reiterate his point, ensuring that I, the interviewer, understand the difficulty of the situation.

PH: Increasingly, particularly over the last five, maybe four or five years, there's been a much stronger push around ensuring that the work we do is evidence based, and sometimes that presents challenges because sometimes the evidence isn't there, it's not always click up, to be honest. One of the most frustrating things is that, and I only said this to X actually the other week, is that public health analysts are poor; we need, we're really lacking in the PCT compared to other areas, and it's been a constant battle for as long as I've worked out here really. There's sometimes information that we need at our fingertips, and I find myself *scrabbling around for information*. Like for example, with the smoking recently, like we have now over the last years, we've established a lot of data through the QMAS (Quality Management and Analysis System) system, so we've got a lot of information on our patients regarding smoking status and people with long term conditions who are still smoking, but it's like *you have to scrabble your way to find the information, and nothing seems coordinated*, and if ever I need public health analyst support for information, which has to be at my fingertips with the sort of work I do, it's a bit of a battle. We're really lacking in the PCT in that side of things.⁴³³

The interviewee states how scientific and rigorous decision making promoted by New Labour was deficient by having limited access to appropriate data and information. There are not enough analysts employed to support this evidence based way of working. The interviewee notes how rather than the analysts it is he who has to pull together the necessary information. Where the technical systems and the corresponding analysts are not in place, the others step in to create and piece together information. Extracting the appropriate data is a skill, and where an individual does not have this skill things are very challenging.

⁴³³ Interview with a PCT Public Health Manager, p6

One interviewee, a PCT Public Health Manager, used the example of breastfeeding to question the value of measuring.

PH: For Performance Management *per se*, I sometimes worry that we are all running around counting things and, yes, that is a good measure of how well we are performing, but, sometimes, it is not a good measure, because, for example, with the breastfeeding one, lots of women initiate breastfeeding, and the definition of initiation is so brief in terms of the baby is put to the breast, and that is it, and from a Public Health perspective, it would be much more relevant to measure how long someone manages to breastfeed. That has health impacts on the mother and the baby. It also tells us a little bit more about the service we are providing, because if someone has been able to breastfeed in hospital, and has managed to establish it at home, and keep going for even two weeks, that tells you much more about the service they have had than someone who has just had the baby put to their breast in terms of ticking the box to show that is done.⁴³⁴

While initially stating that measuring had some value in assessing the performance of a service he notes that some measures do not accurately reflect what the State is trying to measure. Measuring is supposed to give an outsider a clear picture of progress; in this case it is clearly failing. There is a sense for those working in performance that the NHS is measuring for the sake of measuring, that they are going through the motions to imitate a scientific process, when all the while the measure is ineffective. This is but one example out of many, accumulated in my fieldwork, where an individual feels that what is being measured does not relate to good public health. Therefore progress in this measure does not correspond to progress in healthcare. There is no long term value to the work being done; it merely fulfils statutory information requirements.

PH: There has probably sometimes not been enough input, because quite often these things feel like they come down from above. You do not feel like you have much input into how they were created. For example, on the obesity one, it probably is a good idea to know what level of obesity we have in our locality, but it is very unlikely to be that different from the national average. It might be a bit lower. And with that information, what can we do, because it is

⁴³⁴ Interview with a PCT Public Health Manager, p3

quite a universal issue? It is not like we can target a particular area, because there are a few children in every school who are overweight. It's not like there are all obese children in one school and we could make a big intervention. Even for that one, given the level of work required to collect the data, I am not entirely sure it is useful. It may well be five years down the line when we have got more trend data, I wonder whether they could have done that on a sample size, rather than on a national programme.⁴³⁵

The PCT Public Health manager is questioning the purpose of measuring and monitoring when no clear action can be taken. Collecting information can seem like a pointless exercise if appropriate intervention does not follow shortly afterwards to those working in public health. The interviewee uses the example of obesity where large scale data collection has little value, so no intervention can be taken even when children have been identified as obese. The argument put forward is: if all you want to see are trends then carrying out a study on several small sample populations would be more appropriate. Measuring all the children adds little extra value and thus seems unjustifiable.

In the following excerpt, a PCT Clinical Governance Manager talks of his experience working in another health economy and how this compares to the NHS.

CG: I haven't worked in the States; I don't know whether it's actually more effective, I just think they've always been sort of ahead of the game in defining what data can be collected. One of the weaknesses of the NHS is that we do have a lot of data, but it isn't actually that useful; it is actually quite difficult to get the information so we haven't routinely collected a lot of this data so therefore it's quite hard to manage performance and see how we've sort of improved, I guess.⁴³⁶

The interviewee mentions that there is a huge amount of data and information within the NHS but accessing this is extremely time-consuming, and that information which is available is of limited use. Assessing progress as part of the performance management is therefore difficult and can only produce judgements which are not based on either accurate or complete data. The interviewee believes that the quality of US data and information collection is of a higher standard. While this may be true, the reason for this is primarily

⁴³⁵ Interview with a PCT Public Health Manager, p3

⁴³⁶ Interview with a PCT Clinical Governance Manager, p3

due to the US system being one of multiple private health insurance companies. Consequently, investment in information and technology which supports data gathering has been a priority since its inception.

The effect of change on systems, organisations and individual work will be studied in greater detail in the following chapter, on stigma. However, I will provide a brief quotation from a PCT Public Health Manager to highlight how constant change can affect data capture.

PH: I think it probably becomes less robust, because things change so frequently and because, sometimes, gathering the data is a difficult thing in the first place. When people change, or when systems change, it takes a while to get the quality of the data up again.⁴³⁷

The interviewee comments that information is no longer reliable because what is being collected changes frequently over a relatively short period. Hence it is difficult to make comparisons which in turn means that any fluctuations within similar data sets are missed. Good data quality is reliant on stable collecting systems. It is worth remembering that within bureaucracies features of rationalisation include objectivity, quantification and reliability; under New Labour performance management's role was to provide this to NHS organisations yet continuous change meant this was not always possible.

Another PCT Public Health Manager gives an account of how data is gathered; he speaks of an accumulation of facts and figures which leads to nothing and nowhere. This is contrary to the idea that data is collected in order to alter behaviour, whether this is of doctors or patients.

PH: They used to do a Health Visitor audit which looked at the activity of Health Visitors, which did record duration of women breastfeeding. I pulled out some of that data from a very clunky system and looked at it, but no-one else had. They collected all this data for years and years and no-one had used it. That is where Performance Management gets a bad name, because it's as if they do not want to fill in more forms because I never see the outcome of it. When we presented the Health Visitors with this duration data and said, this

⁴³⁷An interview with a PCT Public Health Manager, p4

many women are breastfeeding for six weeks, three months, or whatever, and these are the areas where they are not, down to specific GP practices, you could then target intervention. This is good use of data collection, but if you are not using it, I worry about why we are collecting it.⁴³⁸

The interviewee recognises that data collection occurs but information analysis often does not. The purpose of data collection is for it to impact treatment and better health outcomes. Where this is not happening, data collection appears a cumbersome and meaningless task, particularly to those in working in public health. There appears to be no justification for this kind of work. However, if we return to the work of Scott, (see Chapter Three) and his notion that the State requires data to provide eyes into previously unseen areas, then this offers an explanation to what is occurring. New Labour wanted to know about all areas of healthcare provision; this is about establishing power while maintaining the appearance of a decentralised government, about retaining control even at a distance. This then is not New Labour but rather the behaviour of Old Labour.

Another PCT Public Health Manager states this:

PH: (There is) far too much information to effectively manipulate the data,⁴³⁹

A very short but pithy observation. The public health manager believes that the volume of the information available makes the issue of understanding the data difficult. It brings to mind the adage “can’t see the wood from the trees.” With reference to bureaucratic regimes and their effects, the intended impact of rationalisation is to streamline processes through accurate information but in an organisation as large as the NHS the sheer volume of information generated means that rationalisation has the opposite effect. Excessive amounts of data were produced, without the necessary resources, manpower, skills and analysis to make sense of it.

According to an SHA Performance Manager, what is lacking from performance culture is what Scott describes as *metis*, described in Chapter Three: knowledge gained through experience, learnt wisdom which is local to its conditions and context.

⁴³⁸ Interview with a PCT Public Health Manager, p5

⁴³⁹ Interview with a PCT Public Health Manager, p4

PM: We don't have detailed knowledge, well; it's more difficult to have it at this level, when you're at a greater distance from the point of delivery. But we measure lots of things, and balancing the books is very important, achieving some of these national targets. Do we really look to see how our family of organisations are relating to their service users and their customers? Is there any kind of measure around that? It isn't high on the agenda, and it's one of those more quality things.⁴⁴⁰

The interviewee states that generally SHA performance managers lack detailed knowledge of clinical practices. There are a large number of targets; however, financial balance is the priority. Though standardisation allows for increased measuring and for a greater number of comparisons to be made, the interviewee believes the most crucial comparison is not considered. This for him is the comparison between organisations as to how they relate to their users, which does not appear high on the agenda. This is an example of the effects of rationalisation. Quantification was driven by the need for greater efficiency and economy but doing so resulted in the customer, that is the patient, being expunged, erased, forgotten. The process that remained was one which was depersonalised and anonymous. This is concerning because it creates a culture of what Hannah Arendt called floating responsibility, (see chapter three) where responsibility is no one's, and risks, like those New Labour were seeking to avoid, increase.

According to the PCT Elderly Care manager, the true purpose of measuring is to demonstrate that any comparisons made are done on an impartial basis. Yet impartiality, independence and objectivity come at a cost, that of ownership. A sense of responsibility for the quality of the work constructed is lost.

EC: It stems from wanting to be able to be fair and be able to demonstrate and to be seen to be fair, and they want to be able to compare things, which is fine. But they just need to understand that if – well, it's the garbage in garbage out, isn't it – you try and collect data for the sake of collecting the data for a target, actually the people putting the data in, aren't going to care and they'll put anything in. They're not meaning to cheat the system or anything like that, it's just that unless you feed back to them what the data is, they don't own the data, they have no interest in it and they'll be careless with it and they won't

⁴⁴⁰ Interview with a SHA Performance Manager, p9

make it accurate. Whereas, if you encourage them to use the data and see what it's used for then they take more care to get it right. It's kind of an understanding that if you are setting targets and you have a performance framework, you've got to set it in a way that people will be interested in their own performance, and see it as a useful measure of their own performance. Because if they don't, then it won't be worth the paper it's written on. And there are some things we're asked to do by the DOH, and we just do it because we're asked to.⁴⁴¹

The interviewee believes that the DH fails to understand that where staff feel no ownership of a target and see data collection merely as an arduous task, the information produced will invariably be of poor quality. Staff do not seek to manipulate the data or deceive, but rather have no interest in the process. Moreover, where data collection does not bring about appropriate change this disincentivises staff still further. Staff need an emotional investment in the data they are collecting in order to guarantee accuracy; it must correspond to their own understanding of their work and inform what they do. If this is not the case, the information collected is not only worthless but demoralises the workforce. This is detrimental as it is an alienating experience of work; staff undertake measurement merely for the sake of compliance. There is a sense of imposition; performance management adds to the burden of work.

Under New Labour measuring became a central part of performance management work. As shown, data collection, counting and categorisation were key activities that made up performance culture; being embedded in NHS organisations enabled me to witness the exponential increase in this form of rationalisation. The following section looks at how targets were formulated, how staff made sense of these new measures, realities and perhaps, most significantly, ways of seeing patients.

6.3 Arbitrary nature of targets & measures

Performance management endows a certain objectivity, rationality and credibility to how issues are seen; this is similar to the process and purpose of audit previously discussed in Chapter Three. Information goes through many versions because there are constantly shifting requirements from outside bodies, e.g. the Department of Health or the Healthcare Commission. Data is malleable at the hands of analysts, figures are added and deducted.

⁴⁴¹ Interview with a PCT Elderly Care Manager, p8

Performance managers confer meaning on data, often blurring boundaries between the known and the implied. They act both as witness to the transformation, having seen the data in its raw state, and also as spokesperson. Performance managers are representative of how the new should be viewed and discussed. They act as reference points for other managerial staff.

However, in the creation of new targets, performance managers themselves appear to be unaware of any rational reason as to why specific policies, targets and measures have been chosen. From my fieldwork I observed that performance managers are often cynical about politicians' motives, believing that their policies are ones that lead to high media visibility. While quantification and measurement frequently lead to a meticulous application of rules, this precision is often thought to be missing in the formation of the original policy. The rational, scientific and objective approach that is sought through measurement is not always apparent to performance managers in a policy's inception and subsequent establishment.

Below is a series of quotations from three SHA Performance Managers as they deliberate about the arbitrary nature of target setting, each speculating as to why this is so.

PM: Politically there is a need to challenge the NHS and to challenge the status quo. Five years ago it was not unusual to have three year waiting lists for hip replacements and that type of thing and anything that challenges and forces the service to improve, has to be good. I mean 18 weeks is fairly arbitrary, I don't think there's any particular top level thinking as to, why 18 as opposed to 16 or 23, but why not have 24?⁴⁴²

The interviewee notes that while targets push organisations to stretch themselves, the end goals of many targets seem arbitrary in nature, as illustrated with the 18 weeks target. As discussed in Chapter Four, there is no rationale as to why the Department of Health chose to focus on 18 weeks. Reducing waiting times was an election issue and weighs heavily in a positive public perception of the NHS. However, as the interviewee points out, the 18 weeks policy could have just as easily been 16 weeks, 23 weeks or even 24 weeks. Policy setting in this respect appears completely arbitrary and irrational to performance managers, as there was no wider recognition of the government's election pledge to

⁴⁴² Interview with a SHA Performance Manager, p6

reduce waiting times from 18 months to 18 weeks, which, at the time, was a challenge to the status quo.

PM: 18 weeks, big political hot potato, to show the government up as looking and focusing on patient satisfaction, to make sure that their pathway through the NHS system, from first point of contact, going to see their doctor, right through to having whatever treatment they needed, and getting home, is as short as possible, and they pin that on 18 weeks. No idea why they pinned it on 18 weeks, as opposed to 15 weeks, or 20 weeks. 18 weeks is quite a catchy little number, isn't it? It is just about that, patient pathways in all specialities, and making sure that it happens as quickly as possible, and that it's the patient who is satisfied at each stage, which is why we have the stages of treatment and the milestones within it. There was some extra emphasis and investment put into it by tagging some areas as further faster, those that might qualify for going even quicker, and that's what they called further faster. I didn't know that for some time. There's all the jargon that's attached to it, RTT, I didn't know that for goodness knows how long, and now I do.⁴⁴³

The interviewee notes that 18 weeks become a priority for government in order to demonstrate that they were addressing a public concern and increasing overall patient satisfaction in the NHS. Once again the performance manager speculates about the arbitrary nature of 18 weeks target.

GM: It's probably political, I guess; waiting time was originally 18 months, it probably seemed a good idea. We'll transform 18 months when we come into power to 18 weeks, as an absolute number. There is genuine commitment within the government to get waiting times down. There is evidence that two to three years ago, it was considered one of the public's particular gripes about the NHS.⁴⁴⁴

Here one of the few performance managers to recognise that 18 weeks was not an arbitrary target but rather was based on a wider political commitment. The above is the sole comment to recognise that the 18 weeks policy was a political pledge whose mandate came directly from the electorate. 18 weeks was a response to public dissatisfaction with

⁴⁴³ Interview with a SHA Performance Manager, p5

⁴⁴⁴ Interview with a SHA Performance Manager, p4

long waiting times and as such was made a priority within the Labour Manifesto. While it is true that the figure of 18 weeks is arbitrary, its implementation as national policy was not. However, 18 weeks, unlike many measures, did not have this element of public accountability. It is unsurprising for performance managers to assume the introduction and setting of 18 weeks was arbitrarily set. As seen in the previous section, this sense of arbitrariness permeates all aspects of the target culture, including individual measures, setting of baselines, and definitions of success and failure.

This section gives credence to Power's comment that "measures of economy, efficiency and effectiveness may be arbitrary"⁴⁴⁵ and illustrates what Foucault referred to as *governmentality*, elucidated in greater detail in Chapter Three; it is the creeping in of the governing modes of thought. There was no clear direction, no grand design, no master plan, and no conscious overarching scheme by the state. Nevertheless, what becomes apparent from this series of quotations is that while New Labour wanted simply to implement its manifesto pledge, reducing the time taken to receive treatment from 18 months to 18 weeks, this implementation had a significant impact on how work was undertaken and how it was viewed. Performance managers gave meaning to data; though not always successfully, they attempted to bring reason and a coherent rationale to political policies. My observations as an institutional ethnographer within the SHA reinforced this position; performance management made a connection between the known and the implied. Performance managers acted as eyewitnesses to the transformation of data into information and spokespersons for the state. Performance managers were ambassadors, who determined how the data was viewed and discussed, and who took arbitrary targets and attempted to articulate a meaningful narrative. In so doing they were endeavouring to provide a common sense of purpose to all staff who did not have everyday exposure to the target.

6.4 Tabularisation; its purpose and proliferation

Tabularisation or the use of tables, charts & dashboards are hugely popular in performance management; application is widespread and not restricted to one specific area of healthcare. As a technology, dashboards make possible assessments at regional and national levels as they rely on rigid units of measurement, rules, and fixed conventions. Dashboards remove local context and customs, histories are lost and traditional practices are stripped away for practical purposes. Human activity is disordered; however through

⁴⁴⁵ Power, M., (1994b) p28

the use of these technologies and a system of codification order is brought and imposed upon the chaos. This process of streamlining, applied social engineering, allows the state to make comparisons that would otherwise be impossible.

Dashboards are used in the delivery of 18 weeks (see pp274-277 Appendix E for examples of 18 weeks dashboards); they allow performance managers to convey over time a situation with minimal input. The dashboards are actants.⁴⁴⁶ Performance managers themselves rarely use the dashboards because of what they omit. However, they are keen for others to engage with the dashboard. The dashboard forces a reality onto that which it counts. Individuals who look at the dashboard are compelled to talk in the terms defined by the dashboard. It is not possible for two individuals to look at the dashboard and discuss what they see and understand without employing the vocabulary and concepts set out in the dashboard. Generalisations are only feasible because of the standardised approach offered by the dashboard phenomena.

The SHA performance manager explains the purpose of dashboards, in the following:

PM: I don't think there is much value in sharing this wider than the SHA, it doesn't show trends particularly, it just shows a snapshot in time. It really is for our internal purposes only, it allows us to quickly identify at an SHA level where the strengths and weaknesses are.⁴⁴⁷

Here the interviewee states that dashboards were primarily for internal purposes, within the SHA, providing an overview highlighting each organisation's achievement. However, it was the weekly routine for these dashboards to be sent to organisations. At first glance it appears that the performance manager is challenging Scott's idea of seeing like a state; but my observations as an institutional ethnographer enabled me to ascertain that SHA performance managers acted as surrogates for the State, their evaluations being equivalent to the government's. So while the interviewee states dashboards were used for internal purposes this in no way negates Scott's claim that rationalising technologies enabled the State to see.

The quotation below shows a performance manager making sense of a dashboard (see Appendices) and wishing to share this understanding with his counterparts in other

⁴⁴⁶ Latour., B., (1987)

⁴⁴⁷ Interview with a SHA Performance Manager, p9

organisations. This is important because it illustrates how the interviewee carries out his role as a performance manager; the knowledge he holds on behalf of the SHA is disseminated through him to Trusts.

PM: we routinely send these (dashboards) out, because I wasn't aware of the executive members, so I had to make leads. They were getting them and they were trying to run their organisations based on what we were sending them. The first thing I had to do is explain that we assumed that they were getting their own intelligence and certainly that it was not the expectation that executive dashboards⁴⁴⁸ would be used as an operational management tool. This is about giving the SHA an overview of performance across the patch; it is not really for individual organisations to start managing their 18 weeks.⁴⁴⁹

What the above illustrates is how performance managers share their way of interpreting the dashboard, thus ensuring that their way of seeing things becomes the standard. As the interviewee goes on to say that, within the organisations he was monitoring, nobody in the early stages knew or understood how to read the 18 weeks dashboards. It is a clear example of a performance manager corroborating Scott's explanation of rationalisation, the idea of state surveillance as described in Chapter Three. The new dashboards aimed to standardise patients, procedures and processes, making them streamlined and highly rigid. Change was imposed by the SHA as New Labour's intermediary in order to rule, regulate and manage from afar. Although external NHS organisations, PCTs and hospitals did not understand what the dashboards were supposed to tell them, they nevertheless endeavoured to use them to help run their Trusts. The interviewee then states that he had to inform staff the dashboards were not to be used in such a manner; the SHA would expect Trusts to be using their own data and information for operational management. Though this example draws on the 18 weeks dashboard; it highlights the general confusion about the purpose of dashboards and who they were designed for. My observations as a performance manager confirmed this; trusts often came to their own incorrect conclusions as to what they should be doing with the dashboard. 18 weeks dashboards were primarily a monitoring tool for internal purposes, but as they were used to measure the performance of organisations then organisations felt it was necessary to know what they were being measured by. As such the dashboards were often distributed more widely than originally

⁴⁴⁸ (see pages 274-277 Appendix E for examples of 18 weeks dashboards)

⁴⁴⁹ Interview with a SHA Performance Manager, p10

anticipated by the SHA. When Trusts received tabularised information, they had a sense they must do something with it.

The following excerpt is from an interview with a SHA performance manager who states dashboards are unhelpful as information shown is not current, providing only a picture of the past. To question an organisation about past performance is ineffective; one of their first comments will be “that was then, we are no longer in that position”.

PM: The reason I don't pay particular emphasis to them (dashboards),⁴⁵⁰ I used to, is, firstly, because (Row) A it is monthly, and it's November, and we've moved on. (Row) C is monthly as well, and they talk to me about their data completeness, and where they're at more recently, on the phone, so I don't say to them, well, your thing is saying this, because they'll say to me, well, that's back in November.⁴⁵¹

The interviewee highlights the inadequacies of tabularised information because it is a snapshot in time. As the performance manager points out, data will be out of date in comparison to what is actually happening in the hospital. However this was an effective device as it necessitated the performance manager based in the PCT (primary care trust) to explain how they had moved on from the dashboard while still using the vocabulary employed by the dashboard.

The following SHA manager provides a conflicting perspective to the above performance manager's use of the dashboards.

PM: I to use them to see movements in performance over a period of time, I look more importantly at the graphs on the back, to see which way the trend is moving over a period of time.⁴⁵²

Unlike the previous interviewees he used the dashboards to identify trends. However, this was because he ignored the front sheet page completely, focusing instead on the back which provides graphs. What became clear through the interviews is that each performance manager had his/her own way of reading a dashboard. This was unexpected

⁴⁵⁰ (see pages 274-277 Appendix E for examples of 18 weeks dashboards)

⁴⁵¹ Interview with a SHA Performance Manager, p7

⁴⁵² Interview with a SHA Performance Manager, p5

as one of the original aims of a dashboard was to limit the number of ways a particular set of circumstances is seen. It appears that performance managers were, in certain aspects and behaviours of their work, finding the means to break away from this imposed conformity. Dashboards were supposed to have a rationalising effect, their purpose being to provide a single perspective, to prevent multiple ways of seeing events. The dashboard was intended to take what would otherwise appear as chaotic data and produce a comprehensive picture to any viewer where facts could speak for themselves. What this example illustrates is the way in which performance managers inverted this ideal by taking a more personalised approach, an individual narrative, while still utilising the dashboard. This then was not about streamlining and simplification but rather about attempting to retain the complexity of patients' lives alongside the standardised information reports produced.

Once again an SHA performance manager states how little the dashboards help inform organisations of their performance or their progress.

PM: I think, someone that didn't have an understanding or background knowledge of 18 weeks, it would be very difficult to explain these four particular pieces of paper to; like my husband, who has no knowledge of 18 weeks. But I believe it helps inform me of what position my organisations are in the delivery of the programme. I tend to relate more to the organisations, themselves, and what they tell me, as opposed to what, statistically, these charts tell me.

IV: Why is that?

PM: Because I need to understand what's happening on the ground, operationally, with the organisations in the delivery of the programme. Statistics don't, necessarily, reflect what's happening on the ground.

IV: Do your conversations with your PCT give you a more operational view of what's going on?

PM: Give me a rounded view to be able to assess what the statistics are telling me and why and what lay behind what they're telling me.⁴⁵³

The dashboards did not reflect what was actually occurring; the interviewee was reasserting her belief that to gain a real understanding, it was necessary to talk to individuals working within the Trusts.

⁴⁵³ Interview with a SHA Performance Manager, p4

If these dashboards were routinely sent to organisations, but were of little or no use, then what was their purpose? It would appear that performance managers were not using this tool for its intended purpose. Rather this technology allowed performance managers to weave an official narrative, an authorised account around how policy, in this case 18 weeks, was being implemented and delivered. Dashboards provide standardisation, a one-size-fits-all approach to highly complex patient pathways. Tabularisation was meant to be reductive by nature. However, quantification does not mean that it is a more accurate reflection of a particular situation or set of circumstances. Measuring does not automatically confer a greater knowledge about the phenomena under examination.

Tabularisation was but one tool at a performance manager's disposal. Another was the use of the data dictionary as means of aiding measurement; like tabularisation, it too was supposed to be reductive. The NHS Data Dictionary "provides a reference point for assured information standards to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS."⁴⁵⁴ It is an information tool: the nature of language is precise and meanings fixed. For example, search for 'Accident and Emergency Time Seen For Treatment', and the following is found : "Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a health professional to diagnose the problem and arrange or start tests and start treatment as necessary."⁴⁵⁵ A list of where this information was used is also given. Initially created to provide NHS staff with a wider understanding of all aspects of a target, it was used predominantly to programme IT systems. This is because the language is rigid and inflexible. My time spent as an institutional ethnographer allowed me to observe that while a requirement to efficient tabularisation, it was ineffective in describing the realities which staff experience. The data dictionary was but one example of staff working and operating in two minds. The process of measuring has created an environment which does not correspond to what they know. As it was impossible to avoid the impact of targets, standards and measures, staff alternated between vocabularies, seeing the world either in one way or in the other. Performance managers however negotiated both worlds, not only sustaining but developing and promoting the language of tabularisation.

⁴⁵⁴ <http://www.datadictionary.nhs.uk/>

⁴⁵⁵ http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/accident_and_emergency_time_seen_for_treatment_de.asp?shownav=1

These examples demonstrate that performance management's focus on measuring particular aspects of healthcare presented a distinct view of the NHS. Performance management, through the technologies it employs, attempted to provide an authorised account that was consistent with New Labour ideology. Tabularisation as a technology sought to make possible comparisons at regional and national levels; therefore it became necessary to apply rigid rules to ease the process of measuring. However, dashboards removed local context and provincial organisational practices were stripped away for practical purposes. While human activity is chaotic with patient histories reflecting this, these tools enabled a system of codification to be imposed, allowing the State to make assessments that would otherwise have been impossible. These examples also show how in some instances SHA performance managers tried to reintroduce the complexity they saw in the NHS Trusts they were monitoring; they were opposing the rationalisation they helped both create and embed.

The use of charts such as dashboards was to enable the SHA to assert control over the way in which a problem should be viewed. Moreover through this regimented process, it allowed quantification and thus comparisons to be made which would otherwise have been impossible. How relevant these comparisons were is questionable. Trusts vary considerably in terms of population, economic deprivation and allocation of resources. All these factors and many more were excluded from the charts. The 18 week dashboards simulated a false sense of uniformity; organisations became homogeneous as dashboards imposed a set of rules on behalf of performance managers and the State.

6.5 The rationalisation paradox

The use of charts and dashboards was common practice within performance management. As stated in Chapter Two, their application had become more widespread as the risk culture had become more prevalent in the NHS. Charts allowed organisations to attempt to quantify all aspects of a pathway; this simplification was an administrative convenience, drawing attention to the risk areas. While this was not always successful, the unintended consequence was to engender a workforce which was in some cases more risk averse but in others complacent about risk. Either way, this was not the culture that New Labour had intended to propagate when embedding performance management into the NHS.

In the following excerpt, a PCT Clinical Governance Manager comments that charts should not be relied upon to highlight risk.

CG: There needs to be the balance, you need to be able to demonstrate they're performing well. If that's then stable you can then allow people to take risks and be innovative, but they need to have that understanding that it's okay; because they might try something and might fail and we can't afford to try something and it fails, the system won't allow for it, and unless you can show an incredible business case, for instance, no one's interested.⁴⁵⁶

The reason the interviewee was wary and cautious in the use of charts, dashboards and the like was because it could focus on the minutia and as such compound and magnify risk thereby preventing real innovation; innovation requires an element of risk which this process of rationalisation, tabularisation, discouraged. Small negative movements shown on a dashboard without more detailed context were viewed as a threat to the overall delivery of the target and so were discouraged. The interviewee stated that the system prevented failure; while not literally true, he corroborated the rhetoric New Labour promulgated, that of a risk-averse health service. While this may on the surface appear to be an advantage, in the long term it proved detrimental. As pointed out, any business case presented needs not to be credible, but incredible.

A Public Health manager articulates his view that part of strong and effective leadership is being able to take risks, to represent the needs of your population.

PH: Leadership is things like being able to take tough decisions, not always towing the line, risk taking, radical, inspirational, taking staff with you, being able to tackle the giants of the NHS – not being afraid to speak up for what locally is the issue, against the sort of bureaucratic giants like the Strategic Health Authority or the Department of Health, being able to put their head above the parapet, really, and a motivator.⁴⁵⁷

The interviewee believed that Trusts see organisations such as the DH and the SHA as bureaucratic machines. Good leadership, thus, is about being able to voice the local health priorities and organisational concerns to these bodies, irrespective of the political climate.

⁴⁵⁶ Interview with a PCT Clinical Governance Manager, p8

⁴⁵⁷ Interview with a PCT Public Health Manager, p9

He also made the claim that leadership is about making risky decisions, thereby speaking clearly against the risk aversion element of New Labour's vision for implementing a performance culture within the NHS. Rationalisation encourages standardisation not only in protocols, processes and procedures but also in people and their behaviours as expounded in the McDonaldization thesis, explained in Chapter Three. However, this interviewee states the opposite; in order for a Trust to be successful it must have a leader whose actions are distinctive to the organisation he manages.

In recent years many patient pathways had been redesigned by Trust staff, placing the patient at the heart of the process. Moreover, when engineering these pathways, attention was given to ensuring they were neither financially burdensome nor resource intensive. Long term sustainability was taken into account by hospital and PCT senior management teams before a new pathway was considered viable. However, a change in the definition of a measure led to a corresponding change in monitoring and on occasion there was a decrease in attainment against the target. Pathways were then altered in order to achieve the target, but in so doing sustainability was jeopardised. The clearest example of this was the Accident and Emergency target: 98% of people should be seen in four hours. This target was assessed by the health regulator on an annual basis, and, in the months towards the end of the financial year, the clinical pathway would be re-evaluated with both money and staff being allocated heavily in this area to ensure the target was met. However, as the next fiscal year began, this additional investment which had enabled the target to be met invariably was removed, being too costly to sustain.

Rationalisation as seen by the use of charts can lead to greater risk. From observations as an institutional ethnographer I witnessed how staff become so familiar with seeing a negative position that it was no longer considered a concern, or a borderline position would be over-analysed. The paradox is that rationalisation seeks to minimise risk by quantifying all known factors. It goes one step further in attempting to also quantify the unknowns. What this leads to is a false sense of security because the unknowns, no matter what value is given to them, still remain indecipherable; furthermore there remains that risk that was so obscure it was never considered. However, it is all too easy for organisations to comply. Even the most difficult organisation will eventually step into line as their colleagues adapt to the new ways of measuring. This illustrates Power's concern, as detailed in Chapter Three, that with greater rationalisation comes the introduction of auditing tools including both measuring and monitoring which do not however necessarily lead to a lessening of risk. Rather the shallow forms of verification, offered by these

technologies, make organisational accountability more difficult. In addition, risky behaviour is more likely and examples of this will now be elucidated in the following section.

6.6 Transparency and Gaming

As set out in Chapter Three, one aspect of rationalisation is about providing transparency to processes, about ensuring all aspects are accounted for. This is the idea of revealing that which had previously been hidden, allowing full knowledge about previously concealed ways of working, making public supposedly private matters. In so doing, the performance management culture had become a dominant force within the NHS. One specific aspect of this culture, that of targets, has flourished more than others. However, with new targets have come other behaviours that were not expected though were extremely predictable. With the introduction of new targets and ways of measuring came a corresponding set of new actions. Rationalisation was in part about simplifying complex processes; it was no surprise then that for a short period of time there were grey areas, which did not fit easily into narrow parameters, where suitable boxes had yet to be formed. In these grey areas where boundaries are blurred or non-existent, organisations found the greatest scope to game.

The subsequent account, by the PCT Clinical Governance Manager, sets out his belief that the issue is not the existence of targets but rather the targets' focus.

CG: I don't know that it's [targets are] not effective, I don't think we necessarily always monitor the right things. The problem is that people game to provide the data that they need to provide, so a lot of it is about organisations and executive directors providing the information that they think the Strategic Health Authority or the Department of Health wants them to provide and altering the way they run their organisation to provide that information. It isn't an organic thing, it's an imposed thing rather than an organic thing; to a certain extent, not all of it, but there's a danger that it actually skews performance, not necessarily always in a helpful way. I guess, some things will be really positive like, hopefully, reacting to infection rates for example if you've actually got proper data.⁴⁵⁸

⁴⁵⁸ Interview with a PCT Clinical Governance Manager, p3

The interviewee explains how Trusts try to pre-empt what the SHA and the DH will request, providing these bodies with information that does not necessarily reflect what is happening in the organisation. My observations as an institutional ethnographer within the PCT verified this: PCTs gave information that led to minimal intervention by the SHA and DH. Sometimes, it is a case of “giving them what they want to hear, to get them off our backs.” This idea of gaming, of playing the system in order to produce the best results for a Trust, certainly does not improve the service.

In the following, a PCT Public Health Manager offers an explanation as to the difference between the reality experienced by staff and what is reported.

PH: What is reported and what is reality are sometimes different across the board. It is not always people trying to be creative, it is just that the systems do not count right, for example, on the breastfeeding one, they have changed the form that it is recorded on, and now it is on page twenty, not page one. Is our data suddenly going to dive because people don't get to page twenty of the patient record? When it was on page one it was easy to tick and they remembered to tick it because it was there in black and white. Will our breastfeeding rate suddenly dive because of the practical issue of where it is on the form? It probably happens with quite a few things, unfortunately.⁴⁵⁹

The interviewee notices that reporting does not reflect the world that staff encounter. This is not always due to manipulative practices but rather inadequacies or changes in data collection. The example of breastfeeding was used to show how a small change in the form could lead to completion rates falling, resulting in an apparent dramatic drop in the actual number of mothers breastfeeding, though in reality, there was no change. This is not gaming as no deliberate manipulation occurs; neither is it an example of falling performance. It is an illustration of the ineffective results of monitoring incomplete data, which leaves the State with inaccurate information thus no closer to understanding this area of healthcare.

An SHA Performance Manager describes, in the following, what being an effective manager entails. It is an account that contradicts New Labour's rhetoric that a performance

⁴⁵⁹ Interview with a PCT Public Health Manager, p4,

culture would increase transparency and accountability thereby decreasing risk and the likelihood of further scandals.

PM: Until you've been there and done the operational role, so you understand the pressures that are on you and the ways to bypass some of those, some of the games and tricks you can do to hit targets, make it... I'm not sure how you can be an effective performance manager unless you have a background of delivery.⁴⁶⁰

To be an effective manager you need to have worked in a hospital to understand the pressures faced by the staff and especially the operational staff. That way you learn how individuals will play/work the system in their favour. Being a good performance manager is often about thinking ahead, keeping one step ahead, knowing what short cuts, tricks, games Trusts are likely to carry out. As the previous example shows, this is not always about outright deception. Organisations are merely trying to place their Trusts in the best possible light as achieving targets can result in financial rewards, greater autonomy and independence, or simply a higher status amongst peers.

With the introduction of a new policy and its corresponding target there is a higher chance of gaming, as seen with inpatient and outpatient waiting times. The following is a description from a SHA Performance Manager as to how and why this occurs.

PM: Originally there was a lot of gaming, there was a lot of loopholes in the way that you could classify patients. Was it an endoscopy? Was it an outpatient procedure? Was it a day case? You know, if you want to increase your day case percentage, you call it a day case. You know... and all providers talk to one another... and we soon found out the ways to kind of get through. Almost the course of least resistance. What could we do that would keep the government off our backs, but would deliver the health care, so the targets didn't get in the way of what we were doing? If you talked to a nurse and say, how has 18 weeks affected you, she wouldn't know what 18 weeks was. She might have noticed that there's a lot more managers around with stopwatches, but fundamentally it hasn't changed the way that she practises her profession. In the past it was not heard of for patients to be asked to come

⁴⁶⁰ Interview with a SHA Performance Manager, p2,

in on their birthdays for operations and normally they would turn that down, or at Christmas, that enabled us to suspend them or re-start their clock and that was quite a normal practice⁴⁶¹.

The interviewee notes certain procedures such as endoscopies may be moved from being an outpatient procedure or a day case procedure dependent on which percentage hospital management were most concerned about. It is entirely rational for hospitals to choose the route which will provide them with the greatest gain with the least effort. The interviewee continues by noting how often front line staff, such as nurses, do not know what the key policy initiatives are as their work is unaffected, though they do notice an increased managerial presence for a limited time. As part of the gaming culture, patients have been called to arrange an appointment on a birthday or at Christmas, as staff know that the majority of people will turn this date down. This means that the organisation has offered an appointment and it was the patient's choice to reject it. The clock is then re-set to zero, and the patient's waiting period begins again. Their period of waiting prior to the offering of an appointment is not held against the hospital. This is a clear example of gaming: managers are working within the rules but are not adhering to the spirit of the policy. Moreover, as previously detailed in Chapter Three, this gives credibility to Porter's claim that measuring for public purposes is far from straightforward; for it to be effective, people as well as instruments and processes must be disciplined, controlled.

6.7 Rationalisation and increased bureaucracy

Rationalisation has led to a centralised administration, within organisations and within the structure of how healthcare is delivered. Performance managers apparently provide the State with bird's eye views of all organisations. However though their function leads to increased rationalisation, performance managers themselves have become more prominent, leading to the charge that the NHS has become more bureaucratic.

A Primary Care Manager who had previously worked in the Royal Air Force and who was therefore used to large scale organisations, comments that the NHS' size puts it at a disadvantage, preventing it from being competitive in comparison to smaller health providers and failing to optimise its productivity.

⁴⁶¹ Interview with a SHA Performance Manager, p12

PC: Well, having been in the Royal Air Force, which is a large organisation, any military service or large organisation, you understand the size of the whole thing. It [the NHS] is a really huge organisation and sometimes it loses contact with each other because of its size. Efficiency wise, it's probably very difficult to be as efficient as it can be, because it's just such a huge dinosaur sometimes. Lumbering along, lots of smaller services can actually run circles around, but the wheels keep turning, but they're getting older all the time and slower.⁴⁶²

The size of the NHS precludes its knowing what is happening in all areas. Despite economies of scale, he doubts how efficient such a huge organisation can be. He likens the NHS to a dinosaur, because of its size and fast approaching extinction. He talks of smaller services, meaning GPs, holding both the purse strings and the power to the wider NHS; yet, even these seem outdated and unable to serve patients' needs.

A PCT Clinical Governance Manager describes the improvement he has seen under New Labour in how key performance indicators (KPIs) are set. This then is recognition that the initial measures were often inappropriate.

CG: The most evident thing in organisations is that we've been better at defining sort of key performance indicators and things that we want to achieve. They're very tightly defined, not compared to somewhere like the US where they're very clear, you've got the Balance Scorecards and things like that, which are only snapshots, but at least they give people an overview of how an organisation's performing. We've got the annual health check which is performance management, but it's fairly unwieldy.⁴⁶³

This means that performance management has improved at defining targets, though this is less effectively done than is achieved by indicators used to measure performance in the States. However the use of Balanced Scorecard and the introduction of the Annual Health Check, initially discussed in Chapter Five in relation to risk, though cumbersome, were a more appropriate and effective technology for performance management.

⁴⁶² Interview with a PCT Primary Care Manager, p6

⁴⁶³ Interview with a PCT Clinical Governance Manager, p3

In the following, a PCT Risk Manager describes the bureaucratic burden: rationalising processes, introducing monitoring systems and increased measuring, which oblige staff to spend an increasing amount of time providing information for reporting structures.

RM: Everybody wants to believe that they're performing well and somehow good performance is being translated into monthly reports and quarterly reports. But a lot of PCT staff see the constant performance reporting as burdensome in that there are performance reports to internal management, there are performance reports to the regional health authority, to the Strategic Health Authority, there are returns to the Department of Health. We could look at our working timetable and it would be a series of reports to one body or another, which is a good thing but we need to ensure that in completing these performance reports, in a standard format, we can translate that format through board meetings to the public and general information leaflets to the public. Some organisations have hammered that happy balance between reporting statistics and reporting reality to the public.⁴⁶⁴

The interviewee lists four different bodies requiring reports on performance: internal management, regional health authority, SHA and DH, thus validating the NHS Confederation's summary: "Strategic health authorities (SHAs) and the DH were responsible for more than 60 per cent of the data requests placed on NHS organisations, the reporting was on average required monthly, and the data returns took medium to high effort to collate. In addition, a large proportion (58 per cent) of the data collated could not be used for any internal purpose, nor was it seen as useful."⁴⁶⁵ While it may be necessary to provide accounts, to these bodies, it matters more to relay performance to the wider public. For the interviewee, it is about striving to achieve that balance between narrow statistics and conveying a meaningful reality to the public. The Risk Manager has recognised the contradictory effect of rationalisation. It aims to streamline and standardize; yet Trusts, being accountable to various organisations, must report to a variety of different bodies each with varying requirements and statuses in the regulatory hierarchy. This feeling of being overwhelmed by reporting was reiterated to me frequently while I was embedded as an institutional ethnographer in the PCT and SHA. Staff often communicated their frustration concerning a lack of coordination between bodies and the replication of information which did not directly benefit the individual NHS Trusts

⁴⁶⁴ Interview with a PCT Risk Manager, p2

⁴⁶⁵ NHS Confederation (2007) p5 The bureaucratic burden in the NHS

collecting the data. The predominant impression presented by performance culture on staff was that it merely added to the bureaucratic burden rather than increasing accountability.

6.8 Economy, Efficiency and Effectiveness

The three Es, Economy, Efficiency and Effectiveness first put forward by Thatcher, and previously discussed in Chapter Two, sums up the rationalisation ideal. During the 1980s, performance culture was focused on these areas to deliver a more cost effective healthcare service. Conversely, for New Labour performance management emerged from risk avoidance culture, but I argue that the values of economic rationalisation as illustrated were still dominant during Blair's and Brown's terms in office.

In the extract below the Primary Care manager doubts that the public understand the costs of running the NHS.

PM: The public don't appreciate the cost of healthcare. All they see in terms of the NHS is either the headlines in the papers, saying we are so many million overspent, and the majority of the public would wonder how we got to be so many million overspent. Or they look at their payslip, where they're then being deducted a couple of hundred pounds a month. What they then don't realise is that a hip operation can cost between £5 000 and £10 000, depending on how severe it is and what else is needed for it. And all the other parts of a hospital around that, the MRI scanner and everything else, costs millions. They don't have a full understanding of how much healthcare actually costs. But that one episode of care, outpatients, in-patients and then follow-up...⁴⁶⁶

The interviewee knows the cost of healthcare is huge but believes the public does not realise the true cost. Newspaper headlines recount millions of pounds of debt, while individuals, seeing how much money is deducted from their payslip, don't understand how this can be the case. He uses the example of a hip operation. It is not just the operation which costs; so do the appointments that follow it, the cost of the equipment and hospital running costs. The Primary Care manager is aware of units of cost which the process of rationalisation makes manifest, but the public do not consider the price of all parts of the treatment process. This contrasts with Nigel Crisp, who before becoming Head of the

⁴⁶⁶ Interview with a PCT Commissioning Manager p3

NHS, as stated in Chapter Two, noted that staff had no access to the financial value of activity. This then is a dramatic change: staff in NHS organisations under New Labour now know the financial costs and expect the public to value the NHS in these terms. The ideology of economic rationalisation has been absorbed by the NHS. New Labour, while not making this their primary motivating ideology for proliferating a performance culture, did, nevertheless, instil these values, values that were formerly considered conservative dogma.

Next, a SHA Performance Manager discusses the introduction of the national GP contract and its negative impact on both performance and raising standards in the NHS. The contract was supposed to deliver higher productivity, but by explicitly stating what was expected of GPs for their salary, it had the opposite effect. Anything that had not been taken into account at the time of writing the contract had to be negotiated on an ad hoc basis at additional financial cost to the government. The uniformity of the contract for all GPs failed to take into account the difference in roles; consequently, the expected saving never materialised.

GM: GPs generally do a pretty good job. The GP contract, though, was one of the worst negotiated things I've seen in the NHS in the last ten years. It was appallingly negotiated. To some extent, it doesn't achieve its aim: that they get paid for their improvement in performance. The quality targets that GPs have to achieve, for their pay, are so low as to be almost meaningless. Despite the fact they probably had the biggest pay rise in any area of public sector, they're arguing about doing two to three hours extra out of hours work. That's very frustrating; all they're doing is coming across as a sort of money-seeking group of individuals. Oh, it's frustrating at times. But, that's ignoring all the good things that happen, but it's the sort of thing you tend to blow your top about, with fellows who're working in the NHS. But you don't sort of nag on about it to people outside of the NHS, where you end up finding yourself defending it.⁴⁶⁷

When the GP contract was rationalised, it was supposed to be about greater economy and efficiency, getting more value for money for the public, and rewarding clinical effectiveness. GPs were being performance-managed to deliver in the three areas on

⁴⁶⁷ Interview with a SHA Performance Manager, p7

which Thatcher had focused: economy, efficiency and effectiveness. However the standards were set extremely low, the targets were easily achievable and yet they were financially rewarded. Accordingly, GPs were required to work extra hours outside their contract, but saw no reason why they should. It appears that GPs are financially driven while the NHS is inadequate, despite the contract having been created by the DH, the State, not the NHS. The interviewee comments on how this frustrates him and other colleagues, yet beyond the confines of the NHS he finds himself defending this poor contract. He seeks to defend the NHS, seeing it as under attack from outsiders, but in so doing must defend the actions of the State, that is the New Labour government.⁴⁶⁸ My fieldwork notes as an institutional ethnographer corroborate this position; performance managers frequently defend New Labour's actions to those external to the NHS because they feel it is necessary to defend the NHS and its values. Financial rationalisation, the push for greater efficiency and economy mean performance management staff feel established values, such as free care at the point of delivery, are exposed and vulnerable to reform.

A PCT Clinical Governance Manager gives an example of economic rationalisation; patients were seen in primary care settings (GP surgeries) rather than secondary care (hospitals) as an efficiency saving.

CM: It was originally set up in a hurry and the idea was to try and save money by pulling patients out of the acute trust; and by being clear what the threshold for referral for GPs should be. Performance management was set up around that process at the time, but given the current deficit in the PCT a turn around team is being put in place and so they have set up a number of cost improvement programmes/performance management initiatives and that sort of thing, so I am being performance-managed now more than before.⁴⁶⁹

This case of rationalisation was not directly connected to performance management, but was part of a bigger national policy, as being seen in a GP practice or a community setting costs less than being treated in hospital. However as the PCT was in financial difficulty

⁴⁶⁸ Patricia Hewitt, Secretary of State for Health, stated, "The NHS is under attack. It is under attack from those who've never believed in a comprehensive NHS, free at the point of use, and those who don't believe that the NHS is sustainable." This quotation was from the start of her speech - 'The NHS: the next 10 years' at the London School of Economics, 14 June 2007. It highlights how NHS staff reflect political thinking and language.

⁴⁶⁹ Interview with a PCT Clinical Governance Manager, p1

there were many more performance management initiatives instigated to cut the deficit. Performance management here is very much about financial rationalisation.

In the extract below, a SHA Performance Manager questions the notion that NHS Trusts should make a financial saving or a profit. His concern is that, unlike in other industries, in healthcare money not spent is not a valuable saving but is detrimental to the treatment of patients.

PM: Two years ago, in terms of financial performance, there was about £500 million deficit, which sounds a big sum of money but is less than half a percent of total NHS funding. There was an awful lot of pressure put on the NHS to reduce those deficits, which was largely done last year. Now, all of a sudden, we are struggling to keep surpluses down. Because of political changes and that's an example in terms of finance, but various things, in performance terms, go up and down the ladder.⁴⁷⁰

The NHS was in £500 million in deficit, a sum which deceptively sounds like a large amount, though it is actually less than 0.5% of the total NHS budget. Yet when the figure hit the media politicians came under huge pressure to improve performance in this area. Now the NHS is in surplus you could say performance has improved, but, while there is unspent money, people still wait for treatment. The interviewee indirectly refers to performance culture's renewed focus on economic rationalisation, with Thatcher's three Es taking prominence. New Labour had reacted to the press coverage by bearing down heavily on the leadership in NHS Trusts, ensuring it focused on organisations' financial positions. Performance management was initially about the State retaining control from the centre through tools such as measures, indicators and targets, but towards the end of New Labour's time in office this changed. Through working in NHS for over a decade I was able to see the shift in approach. The government no longer worried about being thought of as Old Labour with regard to the State preserving power; its fear was that the image of Old Labour, unable to control finances, would return to haunt them. The Department of Health was clear that being in the black mattered; organisations could not be in deficit and should at the very least strive to break even.

⁴⁷⁰ Interview with a SHA Performance Manager, p1

6.9 State surveillance

Performance managers are tools in the state's surveillance system, as discussed in Chapter Three. Foucault would consider performance management a panoptic exercise of power. It attempts to make visible all that is done within the NHS, to transform the way people act, and more importantly the way they think. Conformity becomes obligatory and monitoring produces a sense of false compliance. The monitoring reports are explicit technologies, an exercise in State power. However, performance managers themselves can be regarded as a similar technology. Performance managers show that action is being taken in the here and now; the past in this respect is of no consequence. Upon the introduction of a new policy, there will often be a corresponding target. This is because it is difficult to propose intervention or suggest causal improvement without supporting evidence. Monitoring offers reassurance to the government that it does control the situation and knows what its citizens are doing.

As illustrated in the chapter on risk, monitoring is a continuous process. That which has been identified to be measured will be observed at regular intervals. Subsequently a system of recoding will be put in place allowing for the counting and verification. All stages will be repeated and replicated in part to bestow a scientific authenticity on the process and to ensure that staff remain vigilant. Monitoring at first creates a hypersensitive environment, but over a long period apathy takes root. Small changes in monitoring, the addition of new targets and measures, ensure that staff cannot become complacent and in this way the state reasserts both its authority and control.

In the following extract, a PCT Clinical Governance manager sets out his belief that the culture of quality improvement is not ingrained in working practices within the NHS.

CG: If there was a proper culture of quality improvement people would be empowered to change things at whatever level they worked at. They would be interested and have that mindset to look at things and change them or suggest things that could be changed on a daily basis. Balanced with performance management it might work better because people are more creative rather than feeling like they're being monitored all the time. They kind of close down and perhaps aren't as innovative as they could be.⁴⁷¹

⁴⁷¹ Interview with a PCT Clinical Governance Manager, p8

This interviewee feels that staff are not thinking on a daily basis how their service could be improved; this aspect of performance management is ignored. Instead, performance management imposes conformity, as staff feel their actions are being monitored and this stifles creativity and innovation. Individuals, and organisations, are inhibited from considering new ways of working. Staff feel restricted in their behaviour and fear failing publicly. The sense of being watched curbs both thought and action.

Next, a short passage from a SHA Performance Manager's perspective on the effects of managing an organisation that has been labelled as failing. It corroborates Onora O'Neill's comments to hospital staff that they labour under 'Herculean micro-management' which she believes is a symptom of the State's failure to trust.⁴⁷²

PM: The flipside is being micro-managed.... I've learnt to give everything time, and to expect things to be very cumbersome, very bureaucratic, very long-winded, and have lots of people involved.⁴⁷³

Where an organisation is failing, not only is the organisation performance managed, but also the performance manager comes under inspection. This reassertion from the centre of discipline, as set out in Chapter Three, is a type of power. Hyper-rationalisation comes into play, when a greater degree of scrutiny, monitoring and measuring occurs. Management control increases exponentially. At this stage trust has broken down; all actions, meetings and conversations require evidence, all of which must be recorded.

A SHA manager elucidates the role he plays. According to him one of the central roles of a performance manager is about monitoring targets, having explanations for both good and bad performance.

PM: It's about key targets, knowing what your key targets are and monitoring them, looking for areas of low activity, or low performance, and getting action plans and assurances that they're going to be improved. If they're not, what it needs to make that improvement, does it need more money, does it need more staffing, and you can do that.⁴⁷⁴

⁴⁷² O'Neill, O (2002) 'Called to Account' Reith Lecture no.3
<http://www.bbc.co.uk/print/radio4/reith2002/lecture3.shtml?print>

⁴⁷³ Interview with a SHA Performance Manager, p3

⁴⁷⁴ Interview with a SHA Performance Manager, p9

Organisations, the interviewee states, are expected to provide details of where they are against trajectories, and their relationship to plans. Where they are off course, the cause is sought and remedial action taken. They must then provide an account of what is being done to rectify the situation. Each step is monitored; an organisation is under the watchful supervision of a performance manager.

In the following, the SHA performance manager reflects on whether his role adds value. The account he provides refers to conversations he has had with senior management.

PM: What I do in performance, does it make a difference to organisations performing to what they should be, and I tested this. I said to a Chief Exec, because they are having trouble with their providers, and getting them to deliver on their targets. I said, what makes you deliver when it comes to getting the numbers ready, and having your data ready to tell me. He said it's your phone calls, it's the fact that you phone every week, it makes us look at things we're supposed to have done, and that our performance is achieved, and that we've improved. He said, it's not the only thing that makes us, but it keeps us on our toes.⁴⁷⁵

The interviewee notes the Chief Executive of the organisation he performance managed, felt the constant monitoring and scrutiny kept the organisation ever vigilant, as they required changing and having appropriate answers to the questions they faced each week. Trusts could not be seen to falter in the responses given; this puts an element of doubt into a performance manager's mind. He speculates if there is a real grip on the issue or whether organisations have just got better at providing suitable answers to stop the questioning. His unease reflects the fact that performance management under New Labour was supposed to be about risk mitigation but if organisations have merely become rather become more economic with the truth, altering their words, but not necessarily their behaviour, the risks remain or indeed accumulate. The State, for all its surveillance, still fails see what occurs in NHS organisations.

A SHA Performance Manager states next that where organisations have deviated from their plan, performance managers expect an e-mail or telephone call explaining what has happened and what measures are being taken to revert to the original plan. Successful

⁴⁷⁵ Interview with a SHA Performance Manager, p10

organisations do not wait for the performance manager's call, but will e-mail or call, in order to reassure the SHA performance manager. This also enables Trusts to set the agenda and avert any further escalation, such as formal reporting or the involvement of an outside organisation.

PM: I don't expect to form an action plan, what I expect is an e-mail back, telling me what the assurances are to get it back on track, and they might have already done that, which often happens, because we're a little bit late with our info, just a bit, on the monthly stuff. I get a mental health report every month and I also get an assurance report from the overall Trust, but timing is an issue in terms of how timely things are, but that's always been an issue with reporting, since the year dot.⁴⁷⁶

The interviewee is articulating his belief that good management is seen to be dealing with issue internally. Poorly performing organisations however are less reactive, providing a response only when asked a question about unsatisfactory delivery. The difference between successful organisations and mediocre ones is the provision of answers before the questions have been asked. Successful organisations are aware of being monitored, of being observed; they can pre-empt and predict the minds of performance managers.

Below, a SHA Performance Manager describes his role. What he expresses illustrates Foucault's description of self-surveillance. Performance management is the eye of the state entering local NHS organisations without direct intervention. It is also an example of what Foucault referred to as the clinical gaze, (see Chapter Three), shifting from doctors to performance managers.

PM: I know from working in Trusts myself, the general thought is the SHA is overseeing us, it's looking to see what mistakes we're making, always on our backs sort of thing. But you hope that isn't how we're seen; hopefully that isn't how we act. We still have a role in overseeing targets and know how the government decisions are taken, it's increasingly important, particularly with our relationship with the commissioners that we act in a way of enabling them

⁴⁷⁶ Interview with a SHA Performance Manager, p13

to do their work better. You need to work with them rather than just tell them what they should be doing.⁴⁷⁷

The SHA performance manager notes how Trusts assume that the SHA is waiting for the organisations it monitors to make errors, to fail. While he recognises that there is an overseeing role for the SHA, he hopes that this is no longer the case. He sees his role within the SHA as being an enabler, providing support, using and sharing best practice. The role is not about dictating what should be done but working with organisations to improve the delivery of care. The performance manager's clinical gaze is one that leads to a prescription, a course of treatment, a list of remedial actions for organisations. He describes how he encourages the Trusts he manages to monitor their own behaviour. Like the responsible citizen who recognises the need to care for one's health, this is replicated within organisations; self-surveillance is internalised so that Trusts become their own overseer.

The SHA Performance Manager provides an outline of his role, which he sees as aiding organisations to achieve the goals set out in the Annual Plan as well as keeping them on the "straight and narrow:", he must rein in behaviour which would endanger their success, such as focusing solely on one service area and ensuring the achievement of national targets.

PM: The SHA is there to support the PCTs, to help them achieve, to provide the services that their population needs, to provide possible additional finance that they may need. To try and keep them on the straight and narrow, but at the same time to try and teach them how to manage their own performance. Possibly there could come a time where they are self-sufficient in understanding where the directives are coming from, and to know what actions they need to take accordingly, without being accountable to the SHA.

IV: You said, to keep them on the straight and narrow. What do you mean by that?

PM: Not focusing on one target; they take the whole lot and get a balanced approach to them all. It's easy to stick to an area that they know, and they're confident in delivering. Whereas another target may possibly be set too high, and they're thinking, oh no, we can't achieve this, let's not worry about it. It's

⁴⁷⁷ Interview with a SHA Performance Manager, p2

trying to get them to take a broad approach rather than fail miserably over the whole areas, or to do really well in one area and not so well in lots of others.⁴⁷⁸

The interviewee sees his role primarily as creating an environment where Trusts have a self-sufficient and sustainable performance management function, in order to diminish the SHA's interventionist role. Once again organisations are being encouraged to take on self-monitoring behaviours, which fits Foucault's wider description of self-surveillance. Trusts should be in a position to understand the directives coming from external bodies such as the DH and Healthcare Commission and take appropriate action. Consequently, the State no longer needs to exert its power directly; self-surveillance automatically leads organisations to seek to comply.

The following is a short description provided by an SHA Performance Manager; he discusses compliance and recognises it is often unnecessary to punish; the threat of increased external surveillance is regarded as punishment itself.

PM: Performance means a mixture of behaviour, a mixture of actions and delivery on certain things and that's good, as well as not so good. It's about understanding what behaviours mean and what out-turn, what's delivered by their behaviours.⁴⁷⁹

Performance management entails a mixture of behaviours, but primarily it is about knowing and understanding what are the consequences of certain actions and moreover what the wider impact will be if these actions go unchecked. This illustrates how rationalisation subtly affects performance managers' behaviours. Their internalisation of government expectations corresponds with Foucault's concept of governmentality, which is the process of entrenching governing modes of thought. Performance managers' role in this respect is dual aspect: to provide surveillance, being the eyes of the state, in addition to acting as the conduit for state control at a distance.

6.10 Conclusion

Rationalisation in the NHS takes many forms, whether through organisational change, streamlining of work practices or the homogenisation of human activity. Organisational rationalisation occurred with greater frequency under New Labour than under previous

⁴⁷⁸ Interview with a SHA Performance Manager, p5

⁴⁷⁹ Interview with a SHA Performance Manager, p5

governments. This rapidly altered the work and the workforce of the NHS; as has demonstrated it became more bureaucratic. Through the expansion in use and application of tables, charts and dashboards, health has become objectified and there is now a sense of shallow uniformity. The use of key performance indicators (KPIs) to measure, quantify and evidence performance, across different organisations with local variation taken out of the equation, enabled the state to make like-for-like comparisons. The state now believes itself to be in a position to evaluate improvements, consider progress and judge failure.

The introduction and proliferation of quantification as seen in the target culture has permeated all levels of the NHS. On a superficial level the purpose of performance measurement was to push forward improvements in future performance. However this chapter has evidenced how performance management was the vehicle for statecraft and performance managers the tools of the state. It gave the state information about the work being undertaken by the NHS. Modernity has a love affair with all things scientific. It is no surprise that performance management values objectivity, detachment, quantification and replicability. Nevertheless, risk is associated with uncertainty and it is virtually impossible to perfectly quantify risks. The purpose of putting performance measurement systems in place was not only a way of tracking progress against targets but also a way of monitoring patients through the system.

Rationalisation has been delivered through the use of performance management. There was an on-going process of classification, regimentation and standardisation. Unfortunately, what rationalisation discourages is open scepticism and the notion of considering what is reasonable or plausible. I think it is important to distinguish this from cynicism which is based around a lack of trust. Moreover, it must be remembered that rationalisation, with its focus on risk, suppresses innovation and increases the incidence of gaming. This weakens the NHS; sustainability is threatened, leading in the long term to less economy, efficiency and effectiveness. This chapter has illustrated why I have deep reservations about the arbitrary nature of targets, particularly quantitative targets and the efforts organisations go to achieve them. Trusts' preoccupation with targets has led to a neglect of broader concerns and this had resulted in a deterioration in the quality of care patients receive; and at the extreme patient harm ensued.

Performance against key targets was assessed in terms of whether the target had been achieved, to assess whether there was some degree or a significant amount of underachievement of the target. The key targets which formed the basis of Star Rating

system had a definite reward and penalty schedule. Hospital Trusts obtaining three stars for a consecutive number of years could apply for Foundation Status. FT conferred significant financial and managerial autonomy, an independence from regional and central government. Therefore, the incentives to ensure the best possible outcome were very strong. Distortions arose as Trusts sought to maximise their results through a broad interpretation of the target. A fudging of figures might occur which showed them in a better position than in reality; this did not tally with either actual activity or patient experience. Consequently, while national comparisons were now possible, the issue of public transparency became more opaque and the public became more disenchanted with performance management.

Performance management, contrary to New Labour rhetoric which focused on risk, had retained its original Conservative premise; it was a means of driving through the Thatcher principles of Economy, Efficiency and Effectiveness, yet now the State had a far greater degree of control but from a distance. The impression given was of greater freedom for organisations but performance management introduced self-surveillance; self-monitoring became the norm within PCTs and SHAs. While rationalisation increased state surveillance, it is mistaken to think that collecting more information, increasing the number of processes, protocols and procedures, and greater bureaucracy led to a corresponding decrease in risk. Rationalisation as delivered by performance management under New Labour, made the NHS increasingly vulnerable to the unexpected.

Chapter 7

Stigma: Stigmatised Staff, Stigmatising State

The previous chapter looked at performance management as the vehicle by which the state implemented rationalisation, where performance managers were the tool by which rationalisation was driven through the NHS organisations. This chapter looks at the effects of rationalisation on individuals and organisations within the NHS. Constant reorganisations brought unnecessary disruption to staff's day to day work. A sense of displacement and dislocation added to the sense of stigma felt by those working within performance management. The continuous change created a sense of turmoil, isolation and anxiety. Staff described a sense of disenfranchisement and disillusionment brought about by New Labour's consultative approach, that continuously asked for feedback yet never seemed to take on board staff opinion. Moreover, the lack of professional autonomy and the political sensitivities around the role forged a culture and language specific to performance both as a defence mechanism and coping strategy for staff. The language allowed a reappropriation of power, letting performance managers endow meaning that would otherwise have been missing to aspects of their work. This had been stripped away through performance tools and technologies, discussed in the Chapters Five and Six, which saw significance and meaning temporarily shelved as staff engaged with the products, e.g. charts, tables, dashboards and graphs. The language was a subculture where performance managers could talk freely and openly about their concerns about measures and targets which they did not want others party to because of the political ramifications for their organisations.

7.1 Defining stigma

Throughout my ethnographic work, I sensed a stigma around the work of performance management, making individuals need to justify their work, a feeling intensified when individuals looked back to what they perceived as better times in the NHS. As mentioned in Chapter Three, when using the word stigma I do so in the same sense as Erving Goffman, “an attribute that is deeply discrediting,”⁴⁸⁰ with particular focus on tribal stigma which as already stated is the “stigma that can be transmitted through lineages and equally contaminate all members of the family.”⁴⁸¹ Goffman details the role of being ‘wise’; this is the idea of being in the loop, of knowing what is going on and within an organisation this comes through attendance at meetings, committees etc. The ‘wise’ can also suffer stigma as “the individual who is related through the social structure to a stigmatised individual, a relationship that leads the wider society to treat both individuals in some respects as one....all are obligated to share the some of the discredit of the stigmatised person to whom they are all related.....the problems faced by the stigmatised persons spread out in waves, but of diminishing intensity....In general the tendency for a stigma to spread from the stigmatised individual to his close connexions provides a reason why such relations tend either to be avoided or be terminated, where existing.”⁴⁸² However, as stated in Chapter Three, the reason why, Goffman’s idea of stigma has been applied to discourse in the NHS on organisational change and policy implementation is because it would be totally unnecessary to create a new concept when one already exists which is both relevant and appropriate.

The link between stigma and sickness is strong; as first discussed in Chapter Three, the NHS not only treats the symptoms of sickness in individuals but can also be seen as sick institution itself. Targets were a means by which to assess the status, the health, of an organisation and whether it was failing; thus in a system said to be improving the proliferation of targets appears a contradiction. Freidson⁴⁸³ originally suggested doctors in creating new illness inevitably created a demand for their expertise. The same can be said of the HCC; its work has led to a proliferation of targets, as it attempts to assess the status of NHS organisations. Moreover, the HCC previously labelled more organisations failing (now poor) than it offered corrective action.

⁴⁸⁰ Goffman (1976) p13

⁴⁸¹ Goffman (1976) p14

⁴⁸² Goffman (1976) P43

⁴⁸³ Freidson (1970)

Individuals in a Trust deemed failing saw themselves as failures as the work acted as a reflection on their life. When talking about illness certain labels have an associated stigma which can create problems in itself: the person becomes defined primarily by their complaint, separate from the other 'normal' individuals. An organisation said to be failing is associated with a similar stigma. I will argue that PCT mergers within the NHS had a similar effect; this is because a Trust not able to carry on as a single entity must in some way be failing.

The PCT I studied went from being a three star Trust to having to merge with two neighbouring larger PCTs, one of which had in 2005 received only one star. The merger had a huge effect on PCT staff; as an organisation their morale and identity went into crisis. The master status of the organisation was no longer a highflying '3 star Trust' rather it was 'failing PCT'. Staff could not reconcile how quickly the change in status had happened; there was a feeling of incredulity. My ethnographic work both in the PCT and Strategic Health Authority has led me to: 1) recognise that performance management is stigmatised and stigmatising and 2) understand to a greater degree the discourse of stigma in relation first to organisational change and secondly to policy implementation.

7.2 The discourse of Stigma and Organisational Change

The Foreword to *'The NHS Improvement Plan: putting people at the heart of public services'*⁴⁸⁴ was set out as 9 numbered points; there was no longer the standard use of paragraphs. In Point 3 Blair stated the following: "a series of authoritative reports has found the NHS is firmly on the road to a full recovery."⁴⁸⁵ Here the metaphor of illness is used in polemic fashion. As mentioned in Chapter Three, Susan Sontag states disease metaphors "are used to propose new critical standards of individual health, and to express a sense of dissatisfaction with society.....to judge society not as out of balance but as repressive."⁴⁸⁶ Blair compares the NHS organisation to a body which is prone to illness. I will illustrate how NHS staff use this metaphor in a similar fashion. Sontag herself states "there is a tendency to call any situation which one disapproves of a disease. Disease, which could be considered as much a part of nature as health, became the synonym of whatever was 'unnatural.'"⁴⁸⁷ She refers to the nineteenth century, but this could equally

⁴⁸⁴ Department of Health (2005)

⁴⁸⁵ Department of Health (2005) p3

⁴⁸⁶ Sontag (1990) p72-73

⁴⁸⁷ Sontag (1990) p74

be applied to today⁴⁸⁸. I restate that it is not I who chooses this metaphor, but staff and politicians. Illness is used as a metaphor for change, but more importantly this change is seen in a negative light by staff in the NHS who feel stigmatised by that experience. However, “illness comes from imbalance. Treatment is aimed at restoring the right balance – in political terms, the right hierarchy. The prognosis is always, in principle, optimistic. Society by definition never catches a fatal disease.”⁴⁸⁹

7.3 Four aspects of stigma: time, conflict, communication & tribe/community

I contend that there are four aspects of stigma experienced by individuals during organisational change expressed by interviewees and corroborated by my ethnographic observations: time, conflict, communication and tribe/community.

1. Time

As raised in Chapter Two, modernisation and progress have been major themes running through New Labour policies, as exemplified by ongoing changes driven through the NHS. Other parts of the public sector, including education, have also had to show a commitment to the notion of progress. The Nuffield Review focusing on the National Curriculum states: “‘Progression’ is used as though it is self-evidently clear, and yet whether a particular change counts as progress depends on the value attached to what is being progressed to.”⁴⁹⁰ However, NHS modernisation has no end goal; it is regarded by politicians as an evolving process. Moreover, in a quest for ever-improving services, there is widespread organisational turbulence. Blair wrote of the changes under way in the NHS that it was “a good start ... (but) not the time to falter.”⁴⁹¹ This statement was reiterated on different occasions to both staff and the wider public. It recognises the pressure and the anxiety felt by individuals and organisations while also sitting in a timescape. This is important as it corroborates Foucault’s idea, discussed in Chapter Three, that organisations exert power by controlling time and space. Within the PCT the change in locations, in geography, corresponded with an internal sense of shifting power structures.

The following is an extract from an interview with a PCT Risk Manager describing how the organisation he was working for was spread over three sites, each of which should have had, but did not, a senior executive. He discussed the impact on staff morale.

⁴⁸⁸ The press refer to any number of groups as a blight on society, e.g. ‘hoodies’, long term unemployed or Islamic extremists.

⁴⁸⁹ Sontag (1990) p76

⁴⁹⁰ Nuffield Review (2005) Curriculum Summary, p28

⁴⁹¹ Department of Health (2005) Foreword

RM: They've almost become like an invisible body. The idea was to have at least one executive director in each of the three major locations. We have one executive director based here in X and he's here two days a week at most and I wouldn't say that it's a visible presence. I heard a complaint, just last week, that our chief executive has become invisible.⁴⁹²

The interviewee talks about the lack of physical visibility of senior management and how this is a source of grievance to the workforce. My ethnographic observations also highlighted the fact that the lack of 'seeing' senior management made staff feel as if the organisation had ended prior to its official end date. There was a sense that the senior executives believed the organisation had passed its sell-by date, moving from a stale stagnant organisation to one in decline and decaying. Executives were invisible as they did not want to be seen hovering around a corpse.

A PCT Public Health Manager explains how thinking and communication happen separately in each of the different buildings spread across different locations.

PH: It is a function of Chinese whispers, in some respects, in that there are still three separate buildings. Once we are all in one building, it will help, because at least the rumours are circulating in one building, not having to leap across the ether.⁴⁹³

The interviewee illustrates the lack of a coherent voice speaking for one organisation. Rather competing voices vie for attention in the power vacuum that has been created by a loss of leadership.

A SHA Performance Manager described how the building in which he worked was separated into three sections. Even when an organisation was in one building there were separate sections or 'wings'. These wings created mental barriers, which were greater than the physical distance and space they occupied.

PM: To a certain extent, but as you know, we're divided into three wings. You can go day-to-day, unless you make the effort, either not meeting up with anybody in different wings, or seeing anybody from the different portfolios.

⁴⁹² Interview with a PCT Risk Manager, p5

⁴⁹³ Interview with a PCT Public Health Manager, p7

It's very easy to drop them an email to ask the question, rather than get off your bottom and go and actually speak to people. Unless you're really clear who that person is that you need to speak to, it's a bit of a deterrent to you getting out of your chair to go and speak to people because you don't want to look foolish, and go and ask the wrong person that question. We're not very good at going to speak to people that we don't know. People aren't often in the office, so you drop them an email; you get a reply back. You might get your question answered but you still don't know whom you've been working with, because you wouldn't know that person face to face. There are a lot of people here who actually don't work in the office very often because they're based more out in the patches rather than the office. Perhaps an example of that is networks. We're less likely to contact them, because we don't know them, we're not familiar with them. It goes back to my first point on communication. You always go to the person that you're happy to talk to, and ask the silly questions, rather than go and ask that question to somebody you don't know quite as well.⁴⁹⁴

The interviewee articulates the anxiety felt by staff about the possibility of looking 'foolish', of not knowing something, and the fear of this ignorance being viewed in foreign territory acts as a disincentive to move away from one's own turf. This was made more acute by the fact that many jobs are not based in one building. This affects staff in e.g. the Cancer Network, the Cardiac Network and others, who visit different NHS organisations ensuring that people are aware of good practice. Therefore, the rapport that usually comes from day to day interaction between staff was missing. The interviewee noted that these fragmented relationships lead to a reliance on e-mail and a move away from personal interaction. During organisational change there was also a breakup of the informal networks that previously existed.

Below, a PCT Governance Manager talks about how relationships during organisational change became reliant on formal structures, and while this provides 'clear lines of accountability', it created a structure that was more rigid were relationships are dependent on fixed roles. During this time, less official interactions were undermined and devalued, while prominence was given to the relationships illustrated in the organisation chart.

⁴⁹⁴ Interview with SHA Performance Manager, p1

GM: You have to have clear line management, clear accountability and you need to be able to be empowered to do whatever it is you need to do your job, and not be told: no, you can't talk to that person or you can't go to that meeting or whatever; it feels very hierarchical at the moment which I'm not used to. You feel a bit as though you're kind of being squashed down to just do your job at that level, and actually if you're going to achieve change, which is what I'm supposed to be doing, you need to be able to influence people at all sorts of different levels. You can't necessarily do that as easily via other people when you don't know what's being said in exchanges that you're not party to.⁴⁹⁵

The Governance Manager expresses his frustration at how informal channels of communication are undervalued, how this was detrimental to carrying out his job as it did not allow for the need to be able to network to effect change in the NHS, that is, to both negotiate and influence parties that you are not responsible for or managed by. Due recognition is not given to latent, underlying, less-prescribed working relationships which makes the organisation feel very hierarchal. The interviewee speaks of not being party to conversations, leading to a knowledge gap and making future conversations with others more difficult. Drawing on Goffman's concept of stigma, individuals are then deemed deficient when compared to the previous norm.

The change in locations entrenched a formal sense of "them and us." Individuals use the concept of time in 'talk' conversation paradoxically, seeing their input in a temporary light, but the uncertainty of their future as ongoing. For them there is no conflict in this relationship. There was heavy use of the following phrases by the workforce: "We are stuck in limbo", "Everyone has gone, there is no one left, there is only us", "Time will tell", "It is just a matter of time", "There is no direction". It was apparent that staff felt trapped in an indeterminate state, experiencing a strong sense of isolation, not knowing what the future held and lacking any purpose.

Staff experience what Durkheim⁴⁹⁶ calls a state of anomie. It is time of organisational change where the rules are breaking down and structures are more rigid, leaving individuals with a sense of normlessness. The following excerpt illustrates the impact that the breakdown of formal structures had on individuals. Here, a PCT Public Health

⁴⁹⁵ From interview with a PCT Governance Manager, p7

⁴⁹⁶ Durkheim, E. (1997)

Manager explains how organizational and personal work histories are lost; staff find themselves having to, as Beck puts it, ‘produce, stage, cobble together their own biographies.’⁴⁹⁷

“To stop being used as a political football, to let things bed down, to let organisations settle down and have a period of real rest from the constant change. Not to be used as a political football, and from the financial and business point of view, there are lessons we need to learn from the private sector. I’m not saying I want the NHS to become a private sector led type of organisation, but in my experience, the way that the finances have been managed within the NHS is very, very poor. As somebody who’s grown up with relatives who’ve all owned their own businesses and I’ve come from that sort of background, it horrifies me, the way that the finances are managed. You would never do that if you were running your own business. It’s almost like a misuse of public sector monies, the way that things are not tightly reined in and not kept on top of, and if anything, from the finance and business point of view, we need to learn some lessons from the private sector in order to take the NHS forward into the future.”⁴⁹⁸

This illustrates how the interviewee gives substance to Marx’s concept of alienation, a workers’ separation from their labour; this is clear to see when individuals speak of ‘things’ happening to the organisation over which they have no control. There was a disassociation from the decision making process and no sense of when this would return. “It seems possible for an individual to fail to live up to what we effectively demand of him and yet be relatively untouched by this failure; insulated by alienation.”⁴⁹⁹ Interviewees were in a state of flux, time constraints no longer bound their work and there was an indifference to deadlines.

Staff were affected by lack of control, uncertainty and vulnerability. Desiring security, individuals often vocalise their stress. In the shift from a Conservative government to New Labour, health highlighted the differences between parties, with New Labour seen by the electorate as compassionate, in its belief in ideas of society and wider community. However, the day to day work experiences of staff show a NHS community breaking

⁴⁹⁷ Beck, Giddens & Lash, (1994) p13.

⁴⁹⁸ Interview with a PCT Public Health Manager, p.10

⁴⁹⁹ Goffman, E., (1976) p17

down. This substantiates Power's comment that "in pursuit of performance measurement, anxieties have been fuelled that threaten to destroy the commitment of individuals to their organisations to such an extent that this may undermine performance."⁵⁰⁰ Staff feel powerless and think that nobody listens to them; this affects not just their work but their lives. Work becomes a job, a new attitude in the NHS, for previously individuals spoke of working for a common good, a common purpose, with patients as the primary priority. Sheila Slaughter and Larry Leslie⁵⁰¹ made a similar comparison with academia. The changing nature of universities, the introduction of both internal and global markets, has seen these institutions no longer orientated along the lines of the greater good. The principles previously guiding academics were those of service and altruism towards society but this is no longer the case; rather, profit has become one of the key motivators. Furthermore, this change in attitudes of NHS staff links with the work carried out by Marmot on the health outcome of civil servants and loss of identity of former employees of the Longbridge Rover car plant.⁵⁰² However, Marmot concluded that instability and insecurity by its nature can only be experienced briefly. Experienced over a long time, these factors become the norm, a part of everyday culture, and in this sense the feelings associated with stigma can become institutionalized.

2. Conflict

As already explained, one of the four aspects of stigma as defined by Goffman is conflict. The language used by NHS staff during organisational change is that of a person who has a severe illness, or a person engaged in battle. As explained in Chapter Three, Sontag first detailed the relationship between illness and warfare, how doctors and the wider public employ this metaphor⁵⁰³. There was a move from early Christian ideas of a specific illness being an appropriate punishment for certain behaviours and sins to illness being symptomatic of a failure of will.⁵⁰⁴ This way of thinking leads to cancer patients being victims, deserving of their illness and in part to blame for the illness. Sontag notes how the vocabulary of cancer uses military terminology such as the invasiveness of cancer cells which colonise the body, breaching the bodies' defences; treatment includes tumours being bombarded, cells being killed.⁵⁰⁵ The disease-warfare metaphor establishes ideas of enemy through the imagery of foreign bodies and alien invasions creating a distinct sense of the other. A person with an illness such as cancer is defined by this false rhetoric.

⁵⁰⁰ Power, M. (1994b) p33

⁵⁰¹ Slaughter, S & Leslie, L., (1997)

⁵⁰² Marmot, M., (2004)

⁵⁰³ Sontag, S., (1990)

⁵⁰⁴ Sontag, S., (1990) p43

⁵⁰⁵ Sontag, S., (1990) 64-65

I contend that the language and discourse of organisational change draws on these metaphors by speaking of overcoming difficulties, of having to face adversity head on and voicing feelings of betrayal and abandonment. There is also a sense of open isolation: organisational isolation is experienced on an individual level.

Sentiments such as these were voiced frequently during the restructuring. Walking through the building at any one time, one heard discussions using the following language. “We don’t stand a chance”, “Everything is against us”, “When is it going to end?”, “We have been abandoned”, “You have to face it head on”, “It is an uphill struggle”, “We have come this far...”, “I have been through this before, I can do it again”, “I have been through this before but I don’t know that I will come through this”, “You think it can’t get worse but then it does”, “We have to hope for the best”, “Oh well it is going to happen, you just have to be prepared”, “They will catch you unawares”, “You have to make yourself known, it is about reputation”, “We can’t fall at the last hurdle”, “It is crumbling all around us”, “We are cast adrift”. These brief extracts are a small sample of how staff spoke, providing a clear sense of the separation people felt. The language was a reflection of inner turmoil, mirroring the disorder, confusion and uncertainty facing the organisation. Moreover, this language of conflict and despondency was echoed during the implementation of a national, standardised, pay structure for NHS staff.

Over a period of two years, achieving one HR target had become central to PCT success. Its implementation was to be a source of much conflict and resentment. In October 2004 Agenda for Change (A4C) was introduced into the NHS. A4C is a national framework on which pay is decided, consisting of several bands ranging from 1 to 9. Its purpose was to ensure that all NHS staff were paid equally for the work they did. As discussed in Chapter Three, Scott identified that, where the State has neither the knowledge nor the capacity to understand local conditions, it creates new rationalising systems. A4C, while not only stigmatising certain job roles, was one of the clearest examples of this type of rationalising behaviour. The A4C programme includes: “a job evaluation-based process that harmonizes reward mechanisms and improved structures for learning, knowledge, and skills framework, continuing professional development; a common pay spine, rather than separate pay arrangements for different staff groups, rewards for increased knowledge and skills rather than time served; real incentives for staff and managers to change existing patterns of working and embrace new ones.”⁵⁰⁶ This new pay system excluded directors,

⁵⁰⁶ Department of Health (2004), section 6.18

doctors and dentists; its focus was on non-medical staff. The system was seen by Human Resources departments as effective for clinical staff, but less so for non-clinical jobs. Jobs like those of Head of Performance and Information and similar performance roles went through the A4C process.

The process of introducing Agenda for Change was a perfect demonstration of statecraft as described by Scott, in Chapter Three, the process by which the state sees the workings of an organisation by imposing its own order. The rationalising processes introduced job profiles involving measures comparing and contrasting types of staff, including and excluding specific tasks, as well as differentiating and homogenising all actors and actants. An example of how this affected a performance manager is illustrated below. Like Scott's examples detailed previously, the New Labour government imposed practices and job profiles based on a centralised rigid structure which led to certain functions, skills and qualities being seen in a negative light. Specific staff were suddenly stigmatised through having attributes that were deemed deeply discrediting;⁵⁰⁷ this was a source of anxiety, bitterness and conflict amongst individuals. Practical, site-specific, local knowledge and expertise were replaced or often just cast aside. This process resulted in loss of context, organisational memory, and the abandonment of previously established practices. Hence decision-making during the transitional period at ground level was ineffective, awkward and generally burdensome. Although the introduction of rationalisation processes made claims to greater efficiency, the new system decreased overall efficiency while increasing State intervention, surveillance and, more importantly, control over the type of workforce employed by the NHS.

A performance manager reveals how stressful day to day work became, on a personal level, for staff affected by the introduction and implementation of Agenda for Change, then a new grading and pay system.

“The main reason for not wanting to come back to work today was due to the fact that I had a meeting with the HR director and my manager (the Director of Finance) about A4C. Jobs like mine fare particularly badly under the review as it is a hybrid of several roles. I am going through a process of appeal as I sit on the top of a band, and can't progress any further. I believe that work expected of me is at a higher level than that which I am currently on. I feel

⁵⁰⁷ Goffman, E., (1976) p13

compelled to go through this process because I know the level I am expected to work. Plus, I am aware through discussions with other Heads of Performance and Information in the SHA that they have all been banded one level higher than me. NHS management should not be a snow-capped mountain.⁵⁰⁸ A couple of years ago I read an article that said women don't often discuss pay because it makes them feel uncomfortable and that this is the start of the inequality pay gap between the sexes. Well, it is embarrassing and it does make me feel wretched, frustrated and angry. I am fighting a system where it is assumed I can't win but I don't see why I should be disadvantaged by an arbitrary system.⁵⁰⁹

It was said, of the A4C review, by a variety of local PCT HR directors, that the government were keen to be seen paying nursing staff an adequate salary as they were delivering the frontline services. Those who worked within management and did not have direct contact with patients felt that this was being done at their expense. Within the PCT, staff viewed A4C as trying to cost-cut at all levels as the organisation went into a merger, (as part of the Commissioning a Patient-led NHS). The A4C process excluded the PCT Chief Executive and Directors. For them adherence to the strict financial guidelines was paramount; they had most to lose because their jobs would be the first to be placed at risk. Several staff went through the appeals process but were sceptical about its validity. This was not a process that staff could master easily; those who did well knew the intricacies of the language and how it could be used effectively to gain points. Foucault's idea of governmentality, previously discussed in Chapter Three, is clearly applicable here as what is seen is the subtle entrenching of the governing modes of thought. To an outsider, the process and the decisions that were made appeared completely arbitrary. Moreover, there was little support from the HR directorate who were overwhelmed by the entire process, including the number of appeals. Nonetheless, A4C implementation became a central DH performance measure, and NHS organisations rushed to meet the set timetable as their Chief Execs were aware the assessment led to a poor standing nationally. It also became one of the main points of discontent both within the PCT and nationally throughout the NHS.

⁵⁰⁸ <http://news.bbc.co.uk/1/hi/health/2986155.stm>

Trevor Phillips, the Head of the Commission for Racial Equality, refers to the NHS as being a snow-capped mountain; there are huge numbers of ethnic minority doctors, nurses, managers but none reach the top of their profession. "At the base of these organisations you find large numbers of women and ethnic minority workers, whereas at the summit you find a small amount of white, middle-class men. The snowy peaks won't melt overnight."

⁵⁰⁹ Interview with a PCT Performance Manager, p5

Ethnographic evidence as detailed above illustrates that organisational change, undertaken by New Labour, within the NHS was invariably about rationalisation, whether this was mergers or standardising pay structures. Staff affected used the language of warfare and conflict to both articulate and empower themselves, mitigating against the sense of stigma and rejection felt.

3. Communication

Communication is one of the key pillars of a successful organisation. The way in which messages are received and transmitted between staff and how an organisation communicates its purpose and vision tells an observer a significant amount about the state of the organisation itself. Throughout my ethnographic work and interviews, this was a theme mentioned by staff on numerous occasions in various contexts.

The statement below from a SHA Performance Manager highlights the role communication plays, and underscores the central role it plays in a performance manager's work.

PM: Communication is a key thing to the success. Everybody working together, knowing who to work with, who to contact for anything. Being based on one site, as opposed to being on multiple sites, and being able to speak face-to-face with people rather than telephone calls, emails; because they're all quite impersonal. Perhaps telephone calls not quite as much. Having the ability to ask questions, challenge where it's appropriate, and where you're not quite sure of the detail, to admit you don't know, and have the detail explained to you so you get a better understanding. There are too many people who say yes, yes, yes but don't know what the real issue is. It's easier when there are fewer organisations to try and work between, with the partnerships. To understand the relationship between all the organisations that you have to deal with, like the Councils, and PCTs, the SHAs. So you actually make your own organisation more effective.⁵¹⁰

The interviewee sees open communication lines between all staff as central to a successful organisation. Being based in a single site is seen as more conducive to performance work as the interviewee is able to challenge individuals on what is being said without having to

⁵¹⁰ Interview with SHA Performance Manager, p1

use email and telephone exchanges. Personal exchange not only makes questioning given responses less antagonistic and confrontational, but may also highlight a performance manager's own lack of knowledge and expertise in specialist areas. This becomes more apparent to the interviewee when talking with multiple agencies. When organisation is located across multiple sites, the chief executive is one of the few people who has knowledge of what is happening across all of them.

The loss of the principal figure in an organisation, in this case the Chief Executive of the PCT, had a hugely detrimental impact on the effectiveness of communication. Within the SHA, performance managers are aware of how great the loss of a chief executive can be to an organisation's productivity and effectiveness; I witnessed this first hand when working in the PCT. While communication to all staff was not perfect when this post was filled, the departure of the Chief Executive became apparent almost immediately with previously weekly updates about the organisation via email less timely and relevant, fortnightly briefing bulletins scrapped and meetings, once monthly, reduced in frequency. This brought about a greater sense of uncertainty with staff unsure of how their own organisation was functioning; the left hand did not know what the right hand was doing; people were unaware of what corresponding departments were undertaking and therefore unnecessarily duplicated aspects of work.

A PCT Governance Manager talks of feelings of pain, even though he has experienced reorganisation before, and of not knowing what is going on, of not fully understanding the direction and goal of the process.

GM: The biggest problem is the fact that it's been allowed to drag on and there's not very good communication with people as to what's happening; and deadlines have slipped and haven't been performance managed at all.⁵¹¹

Here the interviewee compares the implementation of organisational change to any other piece of work. In this respect, he notes the lack of communication and the missing of deadlines as a failure in the project and comments on the ineffective performance management.

⁵¹¹ Interview with a PCT Governance Manager, p5

In a similar vein, a PCT Risk Manager speaks of experiencing change in his personal life and being unfazed by it; however this is unlike what he encounters in the NHS.

RM: I don't mind change. I've lived in different countries, I've moved house in different countries, I've worked with different nationalities and so my life has almost been a constant change, but it's the change for the sake of change that is the most stressful of all. One thing that the NHS is very poor at is communicating.⁵¹²

Poor communication is also touched upon by the interviewee, and this coming after his mentioning the stress of NHS changes, leaves me concluding that this led to further anxiety and contributed to the pressure and emotional tension.

For NHS organisations the main role of leadership was to articulate the benefits of proposed government changes. Effective leadership was to recognise that a message, proclaimed once, was not necessarily embedded into the organisation and must be reiterated through different media to different groups of staff to become accepted. However, while embedded in both the PCT and SHA as an institutional ethnographer, I observed that, without a chief executive, communication acted in a void.

A PCT Emergency Care Manager described how amongst the workforce the loss of leadership led to low morale.

EC: Morale has been very low and people don't perform well when their morale is low. There hasn't been clear, decisive, leadership because we were without a leadership for six months; which in itself made it very difficult for new leaders to come in. We have been an organisation without leadership, and then when the new leaders came in it was difficult for them to be effective.⁵¹³

The interviewee noted the loss of leadership which lasted for a substantial period and had a knock-on effect of destabilising the new executive management. This is similar to Goffman's concept of stigma being transmitted through lineages, first described in Chapter Three. It saw a previous, positive, group identity, being a member of senior management, become a significant source of stigma.

⁵¹² Interview with a PCT Risk Manager, p4

⁵¹³ Interview with a PCT Emergency Care Manager, p16

George Bernard Shaw said, “The single biggest problem in communication is the illusion that it has taken place”, a comment relevant to the sudden loss of leadership within the PCT. A leader in the NHS must be able to demonstrate the value added, showing staff what contribution their work makes to both the PCT and wider society. “Added value is the difference between the (comprehensively accounted) value of the firm’s output and the (comprehensively accounted) cost of the firm’s inputs. In this specific sense, added value is both the proper motivation of corporate activity and the measure of its achievement.”⁵¹⁴ Without a leader, the main channel of communication dried up, leaving staff to speculate what was happening to the organisation. The mood was sombre and during this period recourse to black humour was all too evident.

The following remarks are those of a PCT Public Health Manager, speaking about the long-drawn-out restructuring process and the many rumours circulating before any official announcements were made.

PH: It has been a series of rumours. As things begin to heat up and you are thinking, will I have a job or not, it is difficult to focus on your role and on keeping your current role spinning, because if your current role is not going to be there in the new structure, what is it worth now? If it is not valued in the new one, do they value it now? That has been quite hard. There have been a lot of people changing. Everyone is very focused on their own worries. We are quite dysfunctional as an organisation at the moment.⁵¹⁵

Here the interviewee worries not just about whether he will have a job in the future, but also the worth of his existing job. What concerns him is not just job security, but the value of his current work. While the previous interviewee talked about shared feelings of disengagement, here the interviewee notes that worry forces individuals to focus on their own concerns. The behaviour identified by the interviewee substantiates Parson’s description of the sick role, discussed previously in Chapter Three. Staff became exempt 1) from performing their normal social roles and 2) from responsibility for their own state. However, sick people are simultaneously required to make a speedy recovery and this is seen in the PCT allowing individuals to concentrate on their own immediate concerns.

⁵¹⁴ Holloway, JA., Lewis, JM., Mallory, GR. (eds) (1995) p280

⁵¹⁵ Interview with a PCT Public Health Manager, p6

Ulrich Beck puts forward the notion of detraditionalization occurring in society; a breakdown of old, closed, fixed structures and relationships. I would argue, based on the ethnographic evidence provided, that during organisational change the opposite occurred within the PCT. As informal relationships were torn apart, staff found themselves falling back on traditional hierarchies, something they felt uncomfortable with because wider society has experienced detraditionalisation. Hence, the organisation they were working in was not reflecting their wider world. Putnam describes a similar process which he refers to as the loss of social capital,⁵¹⁶ the breakdown of ties and informal trust bonds. Putnam uses the decline of social capital with relation to communities in society. However, what my fieldwork uncovered was that NHS organization, where there are strong values, acted as a microcosm of wider society; hence, as I will illustrate, loss of social capital also occurs within an organisation experiencing a comprehensive restructuring. The breakdown in communication is so apparent because it is one of the main features of conversation. As an institutional ethnographer, I frequently heard comments such as: “It is the unknown,... it is the not knowing”, “Nobody tells us anything, we are being kept in the dark”, “No one tells us anything”, “We don’t know where we stand”, “It would be nice to know where we stood”, “We can’t make any plans”, “We will know soon enough...”, “Communication has broken down”. The usual sources of information dried up and this destabilised staff. Information is power; this is true in big organisations such as the NHS where formal communication is slow, but where informal networks work rapidly. With these channels now closed off and no current information available, people began to feel powerless, as if they had no control over their work or future.

According to Goffman, a sponsored publication by those affected by stigma gives voice to shared feelings,⁵¹⁷ often including inspiring stories, personal experiences and ways of dealing with stigma. The central communication document had been *PCT Briefing*. As well as informing and updating staff on PCT matters, it had an equally important secondary function: it acted as a catalyst for more open discussion within the organisation. *PCT Briefing* gave individual reassurance that it was ‘acceptable’ to talk in public about contentious issues affecting the PCT. However, on news of the merger, *PCT Briefing* became less frequent, changing from a regular monthly to a bi-monthly document and taking on an overly positive outlook. In some respects it became propaganda, adopting a revisionist role, something that had been missing from early editions. Furthermore, as the PCT experienced increasing financial difficulties, the publication was dropped. Of the

⁵¹⁶ Putnam, R. (1995)

⁵¹⁷ Goffman (1976), p37

many complaints I heard during the reorganisation regarding the lack of communication, the most vocal related to the termination of *PCT Briefing*.

In the following extract a PCT Public Health Manager complained of the positive spin that was placed on difficult issues, seeing it as patronising, as it dismissed the genuine concerns of staff.

PH: Communication is going to be difficult in any organisation, but I wonder sometimes whether they underestimate us in that they come across that we are very upbeat, positive, we are doing all right, keep going, I know it's difficult things. It is very difficult to come across very genuinely and sometimes it would be nice to say, this is really awful, we are in a financial mess, it's going to remain awful for a little while, but these are the things we are trying to do. It's a bit more straightforward and people like to be treated as adults. That is my perception.⁵¹⁸

The interviewee criticised an attitude which is patriarchal in nature; staff are deemed unfit, immature or emotionally unstable to deal with the difficult issues facing the organisation. The interviewee however understood the severe issues facing the organisation through informal communication channels and remarked that being kept in ignorance of these problems by the new executive team did not aid staff relationships.

I have demonstrated how the lack of clear and transparent avenues for communication within the NHS during organisational change led to staff being stigmatised. By being kept ignorant of the significant aspects of the organisation for which they worked, they became outsiders; they were, as Goffman describes, outside the loop. This was a factor that was detrimental to social interactions and staff were deemed, by those better informed, deficient when compared to the norm.

4. Tribe/community

My fieldwork revealed that during organisational change, there was a greater sense of community felt by staff with regard to the organisation which would soon no longer exist.

⁵¹⁸ Interview with a PCT Public Health Manager, p7

A PCT Risk Manager spoke of his skills not being fully recognised, of not knowing what was happening. He felt demoralised and disengaged.

RM: It's been disappointing. I wasn't given an opportunity to demonstrate that I could do what I said I could do. I'm now in this kind of limbo. I'm not alone, and although it's reassuring to know that you're not alone, it's still a limbo and it's still demoralising and yes, our chief executive finally recognised that some of us are feeling disengaged.⁵¹⁹

He expressed a further sense of disenfranchisement, a feeling that he was separate to the process of change which he was experiencing. And yet he felt a developing sense of community, an experience shared with other staff of not being alone and he gained reassurance from this newly-formed community. This sense was also expressed in other ways. As an institutional ethnographer, I observed the frequency with which staff used the pronoun 'we' instead of 'I' to describe their situation.

A PCT Governance Manager gives a short summation of the impact of organisational change on his working life.

GM: Well, I've been through a couple of re-organisations, nothing as big as this though, this current one is probably the biggest and most painful.⁵²⁰

As staff experience change, there appears to be an underlying sense of worry. Fear and anxiety levels are high as they face the unknown. These feelings are felt irrespective of the number of reorganisations an individual has experienced in the past. In fact experience of past reorganisations and familiarity of the process amplifies the sense of apprehension towards current structural changes, because there is an understanding of what will be lost in terms of people and practices. Moreover, there is an awareness that good intentions regarding greater efficiency do not necessarily lead to correspondingly good outcomes as greater productivity is not guaranteed.

This insecurity and pending doom was heightened by the professional closeness of the relationship between the ex-Chief Executive and the individual concerned. NHS PCT organisational structures are predominantly pyramid-shaped. I observed as an institutional

⁵¹⁹ Interview with a PCT Risk Manager, p7

⁵²⁰ Interview with a PCT Governance Manager, p5

ethnographer that the person at the top of the organisation is the focus of the stigma, and that stigma then flows through the organisation. The tighter the connection, the higher the level of stigma, the lesser the connection, the lower. As previously, discussed in Chapter Three, this is known as ‘in group alignments’ and refers to “like-situated individuals, and this is only to be expected, since what an individual is or could be derives from the place of his kind in the social structure....the individual’s real group, then, is the aggregate of persons who are likely to have to suffer the same deprivations as he suffers because of having the same stigma; his real ‘group’ in fact, is the category which can serve as his discrediting.”⁵²¹ My fieldwork revealed that in the PCT it was the departing Chief Executive who carried the stigma. This passed to his immediate directors (executive team) so that, even after he left, the stigma remained. Middle managers tried to distance themselves from the stigmatised by the use of the organisational chart. There was a sense of guilt by association; the hierarchical structure of an organisation base remained unaffected because the person at the top makes least impact. Those lower down seem untouched by the stigma, just confused by the reorganisation. Moreover there was a sense that when a Chief Executive leaves, he is jumping ship, leaving those staying behind to face the battle alone.

Even before the organisation was officially reorganised, staff were aware that change was on its way as so many senior executives were leaving. However during this period staff tried to keep up the pretence that nothing was changing, carrying on as normal. Conversely as soon as it became official all pretence was pushed aside and staff became overly pessimistic about their future and the role they played within the PCT. While embedded as an institutional ethnographer, remarks I heard frequently were: “We are on our own”, “Our efforts count for nothing”, “We have no support, the directors have jumped ship”, “Where has everyone gone? They have all deserted us”, “Make yourself seen, make yourself known”, “We are good, nothing has changed”, “We were good, we can be again”, “Where did it go wrong?”, “Where is it all going to end?” Such words not only illustrate the feeling of abandonment but also how staff tried to reassure themselves, restore their confidence and re-establish their sense of purpose and belief that everything was fine.

What staff say illustrates the concept of the organisation as ill, and further illustrates the idea of individuals acting as a group, with a collective conscience and an ailing mindset.

⁵²¹ Goffman, E., (1976) p137

NHS organisations and staff have taken on the sick role,⁵²² as described by Parsons; those identified as sick must be seen to be challenging their situation, actively looking to recover. To have an illness means that sanctions or exclusions can be made against you. This can take the form of excluding people from talking or taking part in conversations and dialogue. In contrast society may also deem that exceptions may be made or there may be exemptions made of particular behaviour due to illness. Just as doctors often believe they know their patient's illness better than the patient, the same happens to staff in merging organisations. Outsiders, including external consultants and advisors, believe they are best placed to diagnose what is wrong with an organisation. Goffman states, "The stigmatised individual thus finds himself in an arena of the detailed argument and discussion concerning what he ought to think of himself, that is, his ego identity. To his other troubles he must add that of being simultaneously pushed in several directions by professionals who tell him what he should do and feel about what he is and isn't, and all purportedly in his own interests."⁵²³ During my fieldwork I observed that, at an organisational level, private consultants and NHS recovery teams were dropped in, on an individual basis. The PCT's Human Resources promoted little else than CV sessions, counselling, and retraining to staff to counteract perceived inertia and stagnation.

7.4 The discourse of Stigma and Policy Implementation

Performance management not only shapes that which it is measuring, as seen in the example of 18 weeks in Chapter Six, but performance managers through their work and use of language have shaped how their actions are viewed. Most importantly, by creating a new vocabulary within performance management, they are finding new ways of defining what they do. "The individual is a typified discursive construction: identities are constructed out of a process of interaction. To shift among interactions is to shift among definitions of self."⁵²⁴ "Individual's self concepts and personal identities are formed and modified in part by how they believe others view the organisation for which they work.... The close link between an individual's character and an organisation's image implies that individuals are personally motivated to preserve a positive organisational image and repair a negative one."⁵²⁵ This idea builds on Cooley's theory of the looking glass self,⁵²⁶

⁵²² This view was also articulated by Patricia Hewitt, Secretary of State for Health when she said "We put the NHS into intensive care" in a speech- The NHS: the next 10 years- at the London School of Economics, 14 June 2007.

⁵²³ Goffman, E., (1976) p150

⁵²⁴ Weick, K.E., (1995) p20

⁵²⁵ Weick, K.E., (1995) p21

⁵²⁶ Cooley, C. H., (1902)

where an individual's identity and sense of self is shaped and formed from interactions with wider society. It is through the perceptions of others that the individual sees himself.

The role of Performance Manager is varied; performance managers like chameleons change their outer personae to suit their circumstances. These shifting forms are as much about survival in an ever-changing organisation as they are about ensuring their continued dominance and success in gathering information. Within management hierarchies, information is not only knowledge but power and this is amplified in the role of performance management. This was exemplified in an interview:

“You go around looking, watching, listening, asking, and I've been all around the houses for some stuff, but I'm quite able to voice my own needs. But the role isn't meant to be where you're a master of everything, because it's not possible. It is much more macro, and we are the front person on performance, on key targets. The skills that we need are those of dealing with the people, of working with them, of giving the SHA frontline face, and all that communicating stuff, influencing, persuading, negotiating, all those things, because we're trying to get stuff out of these people. They don't much like the SHA, keep bothering them, but we know, and they know too, but they forget often, because they're under so much pressure, aren't they, and we do too, that it's the next line up to the government, and the politics are rife, aren't they?”⁵²⁷

The interviewee states that knowledge is gained through observation as well as listening and questioning but getting the right information can be an arduous process. However he sees that a performance manager cannot be an authority on all issues requiring his involvement. Rather, the interviewee sees the performance management role as being the conduit for information as well as the portal through which the DH policy is channelled. As he says this involves “communicating stuff, influencing, persuading, negotiating” and this means that the SHA is not seen in a favourable light. The SHA appears to add to other NHS Trusts' workload and also to be playing politics.

A SHA Performance Manager talks about the operational experience adding to his overall authority. He likens knowing what managers have to do to achieve targets to battle scars.

⁵²⁷ Interview with SHA Performance Manager, p4

PM: I am able to add value, because I've been there, seen it, done it and I have an operational credibility. We sometimes talk about clinical credibility, but there's something about managers having operational credibility and having the scars to prove it. That you know what it's like to have those daily meetings, to know the names of the long waiters and sort of trying to squeeze them in somehow. Not sure that's a uniform across the performance management function at the SHA.⁵²⁸

The interviewee believes that hospital experience means that clinical managers are more receptive and responsive to what he has to say. This experience is something he feels adds to his credibility as a performance manager, yet is not a characteristic of all performance managers. Observations from my fieldwork underscore this sense of stigma attached to working solely in non-clinical environments. Performance managers, while holding a wide level of knowledge on a number of areas, often lack in-depth expertise. This was picked up by clinical managers as a sign of lacking a real understanding of the health systems within which they had to work.

In the following extract, a SHA Performance Manager talked about the perception of performance managers. He spoke at length on this topic, demonstrating both his anxiety and concern that performance management is seen negatively by hospital and PCT staff. Part of a performance manager's role is to question, to interrogate assumptions and to ensure that there is enough detail and evidence for plans and decisions being made. The interviewee states that he feels like a 'professional nag' and is fears that he adding to the burden of work imposed on organisations.

PM: Performance managers are a thorn in the side of trusts and PCTs. We're seen as an irritant, and a nuisance. We're the people who are always going in and doing the chasing on the detail, asking for this, asking for that. PCTs and trusts are extremely busy, under a lot of pressure, and in some respects we often add to that and some days I feel like a professional nag. I'm trying to performance manage when I don't have any authority to do that, which is the difficult area for me, and I'm also trying to do it as a generalist, so even though I've worked in the NHS for well over 30 years, and worked at executive director level in PCTs, there are many areas that I don't have

⁵²⁸ Interview with SHA Performance Manager, p3

specialist knowledge in, and, for me, that's the big area of difficulty in the way we work at the moment. Much of what I do is interpreting data that's already been prepared, and applying a little bit of local knowledge to that, and I think that's probably an area of duplication, and I'll come on to the 18 weeks bit in a minute. Certainly, a lot of the data that comes out of decision support could form part of Board reports and performance reports, as it is – perhaps with a little more local tweaking by decision support. I find that working with my organisations, I'm most effective when it's an area where I do have in-depth knowledge and some expertise, because I feel then that I'm adding value in those particular areas, and I'm helping them to improve. In other areas, I don't feel I'm adding much value, to be honest with you, which takes me on to the whole business of the 18 week issue. To have much impact from a performance manager's point of view, you do have to have considerable specialist knowledge in that area. You have to know how general hospitals work in detail. How patients flow through and are booked and seen by clinicians, and you have to understand something about continuous quality improvement – the lean work that's going on. I think it's quite a specialist area.⁵²⁹

This interviewee conveys his insecurity regarding the value he adds as in many areas he lacks real in-depth knowledge. He wonders if his work is of any value as his contribution to an issue is neither constructive nor informative. This lack of expertise affects how he sees his role. Where he makes a difference is when he speaks from experience or where he has a thorough grasp of the subject. This lack of professionalism undermines his authority where clinicians are involved in discussions as they recognise gaps in his knowledge. In the earlier chapter “Formation of the NHS,” I provided the ideal type contradictions between “managerialism” and “professionalism.” The interviewee articulates the feeling that performance managers strive against, which is that they are simply complying with arbitrary rules set from above. However, the sense that they are acting as the enforcers of the State, in this case the Department of Health, meant their legitimacy was further undermined. Those who work in performance management regard themselves as true professionals even though they still adhere to the ideal type framework of managerialism. Moreover, the expectation from other NHS staff, particularly clinicians, is that they work within a professional framework. This disparity between

⁵²⁹ Interview with SHA Performance Manager, p2

expectations and reality is a source of much inner struggle and contention in the work place. Individuals try to rationalise their behaviour and ensure that their work meets the ideal type of professionalism. Unfortunately, this is beyond their remit and often impossible, given the nature of the performance management work.

Frequently performance managers commented to me on the lack of public awareness about their work, and more importantly its value. They feel their credibility is questioned, and their work not recognised. Yet performance managers are often as sceptical as the public about the worth of their own work:

“Performance means different things to different people and while the higher, if you like, Department of Health, NHS level, they might see performance as meeting various key performance indicators and set targets. My view is that a lot of those targets mean absolutely squat to the general public. The general public looks at targets in terms of their expectations, a clean bed, a clean hospital, people who listen, appropriate treatment at the right time and there is still a void in the middle between these key performance indicators and the wonderful reports that are given out every quarter or every year and the feelings of the general public. Whenever we have complaints, we cannot possibly be performing 100% because in the eyes of our patients, we’re still getting things wrong. Wrong might be a minor point, but we’re still getting it wrong.”⁵³⁰

Performance may be understood internally by the NHS and the DH but, to the public, targets and specifically the achievement of targets mean very little. They hold no value as an achieved target may be at a higher standard than that of the target. One of the ways this discrepancy manifests itself is in complaints. Complaints may rise as expectations rise and fail to be adequately met even though all indicators show otherwise. Levels of success are set by politicians and regulators, not by the public. For these groups, success is defined in a range of what is both possible and achievable for the NHS. However, success for the public is not necessarily moderated by either of these two factors:

“I guess in terms of month on month improvements, the public aren’t informed, and I don’t even know that they would know what I was talking

⁵³⁰ Interview with SHA Performance Manager, p2

about if I talked about an 18 week target. All the people in my family, for example, weren't aware that this was a big target in the NHS, but when you tell them, they do say, oh yes, waiting times are much shorter, aren't they?"⁵³¹

The belief being articulated here is that, though the public may not know specific targets, they understand the direction of travel being taken by the government, in this case that there is a focus on minimising waiting times for consultations and treatment.

“The government can make the population believe that anything they do is what the public wants. Any amount of spin can be put on this. Clean hospitals or lack of cleanliness in hospitals has been an issue for several years now. It never used to be an issue, but it is now. Things like the overuse of antibiotics have now become an issue and that is felt to be part of the problem in infections like MRSA and *c.diff*. But we shouldn't be trying to cure the infection; we should be trying to prevent the infection. My view is still that clean hospitals prevent infection and cleaner people prevent infection. And therefore, the DH as any other government department, is very adept at putting its spin on a change in the NHS and it may well be what a few influential MPs as public representatives, campaigning bodies might like to see, but it may not be what the general public has actually said.”⁵³²

The idea of measuring is that facts speak for themselves. As described in Chapter Three, there is an objectivity that is inherent to reducing a problem to the minimum, hence numbers are prized. Nevertheless, all figures are given to interpretation, all targets are translated and no data is provided without commentary. The introduction of targets whether MRSA or *c.diff* allows a narrative to be told. It is one area of improvement where progress in difficult circumstances is being made. And yet, while this may meet the agendas of politicians and self-interest groups, it may not address the public's original concern:

“I don't honestly think the public will have the first clue about, if you said to them about performance. They would think it sounds just like a theatre show or something on TV – I don't think they'd understand the concept of performance as a word in relation to the NHS. What they probably understand

⁵³¹ Interview with SHA Performance Manager, p6

⁵³² Interview with SHA Performance Manager, p9

is media generated, is the performance or the issues in relation to the acute hospitals. What they understand is if you've got to wait for hours in A&E, or you're waiting months and months for an operation, or you can't get on a waiting list – that's the way they view performance. They wouldn't use that word, but that's the way they view the NHS, some of that is generated politically and through the media. I don't think they'd have any concept about PCT performance. They might think about their own GP practice and about whether they can see a doctor when they want to, and the right doctor.”⁵³³

A PCT Public Health Manager thinks the public have a low regard for performance management. The language used highlights both the triviality - “bean counter” - and the apparent pointlessness - “moving bits of paper around” - to emphasise this point:

“I would imagine they think there are lots of bean counters and the NHS is failing because there are too many managers moving bits of paper around. I imagine the only things that impact on them are if they have waited eight hours in A&E themselves, if they are there themselves with their child, or whatever, they would think about that. I shouldn't think they even imagine the other things we count. Most people do not even know there is a Primary Care Trust, let alone Performance Management.”⁵³⁴

The interviewee, though implying that performance management is not a job the public would consider worthwhile, nevertheless goes on to state that this is because the public lack a clear idea of what the role entails. This view was one that I picked up as an institutional ethnographer in the PCT. Senior management thought public perception of performance management was low because it was based on the absorption of a media narrative, often negative in its portrayal of managers in general.

A SHA performance manager puts forward the view that targets in themselves have no value to the public. Instead, targets are a means to an end, a process by which to ensure NHS services are easily accessible to patients and that those services provided are of a good quality.

⁵³³ Interview with PCT Public Health Manager, p4

⁵³⁴ Interview with PCT Public Health Manager, p4

“They realise there are targets and we have to achieve targets to ensure that the services are working, that there are quality services, that they are easily accessible, that the PCTs are working to the best of their ability and that taxpayers’ money is being used optimally. I don’t think that the public is just concerned with targets. I think they are concerned with quality and access.”⁵³⁵

The interviewee believes that targets are a tool by which the state can effectively ensure certain aspects of care are being delivered in a cost-effective manner. As discussed in Chapters Three and Six, this perception of how the public view performance management is centred on how targets aid a system of rationalisation. What is equally important in this statement and evidenced throughout my fieldwork is what is not said, what in fact is missing. There is no mention of employing performance management to reduce risk thereby driving up the quality of NHS services, nor does the response make reference to increased public accountability through the publication of target information. This is significant as it illustrates how performance managers reconcile the state narrative with their reality. Performance management therefore is not considered beneficial in reducing risk or increasing accountability as suggested in New Labour rhetoric, rather it engenders a principle of achieving more for less, with the promise of providing public value for money. Yet targets in themselves do not necessarily encourage economic prudence or financial restraint; they can merely encourage economy of effort. In some cases the achievement of a target may mean simply spending more money, rather than putting in more time and effort to overhaul a service for its long-term improvement, thereby guaranteeing its continued viability.

A SHA performance manager who has been in the NHS for several decades believes that the changes to NHS organisations over the years have meant they are less penetrable and pertinent to the public.

“MN: The public generally don’t understand the structures of the NHS, they wouldn’t understand how performance management takes place. People understood what district health authorities were 20 years ago. From that point on, they lost the plot, and they don’t understand what a PCT is. They know what a hospital is, and they understand that that’s part of the NHS, but they don’t know what a PCT is or a Strategic Health Authority is.

⁵³⁵ Interview with SHA Performance Manager, p3

IV: Why is it that they don't know?

MN: Because it changes so much and it's not hugely rational, because in many ways the modern PCTs are exactly the same as the old district health authorities. They pretty much cover the same boundaries, they pretty much do the same thing, and people know that we've got a National Health Service; I don't think they generally understand, and especially older people, that this is made up of a family of little different independent organisations – they don't quite understand that. What does Primary Care Trust mean anyway, to the public? It's not a self-explanatory term, is it, but people understand health authorities like they would understand a local authority.”⁵³⁶

The interviewee describes how the language used creates a barrier between the general public and the health service. He states the current organisations, PCTs and SHAs, have many of the same functions as the predecessors with the names that are not easy to understand, and do not, unlike hospitals and GPs, feature in the general vernacular. As an embedded institutional ethnographer I heard many concerns on this issue of perceived lack of public understanding, revealing a deeper sense of insecurity felt by those working in PCTs and SHAs, who believe the lack of immediate recognition is poor reflection on their work. For them it highlights the value and worth given to those others who work in hospitals or GP practices. This anxiety however could simply reflect the public's greater awareness of professions which they contact and experience directly.

A SHA performance manager explained how the central directive to ensure patients were seen and treated within 18 weeks of being referred by a GP was a major policy initiative by New Labour. The performance manager referred to the public understanding of general improvements to waiting times, while there appeared to be no similar recognition of the achievement of the specific target.

“I don't believe the patients do understand 18 weeks. X are putting a lot of energy and effort into launching 18 weeks to their public and their patients, explaining what it's about, what it means for them. They're off on a campaign. They believed it should be a national initiative run by the government in trying to explain to people what that means. But there's very little actually coming out, centrally. So, they're undertaking it locally, to explain. They have a lot of

⁵³⁶ Interview with SHA Performance Manager, p7

patient and public involvement and links with partners, stakeholder bodies, to try and get that message out and, of course, with their own clinicians.”⁵³⁷

The interviewee depicted the lack of clarity about performance messages being compounded by the fact that there was no national momentum in announcing the NHS had been successful in meeting a manifesto pledge. Staff felt dissatisfied that their efforts in communication and marketing were not matched by the Department of Health. It was seen as a huge blow to the government that the achievement of such a central target, one of their core commitments to the NHS, was not publicly acknowledged and therefore did not filter into mainstream consciousness.

It was through the eyes of performance management that other NHS staff and the public viewed what was measured and counted. Under New Labour, performance management was not explicitly defined to the public; rather claims about what it would achieve were made. Policy implementation saw performance managers take on multiple identities; they sought to lessen the ambiguity of their role which at times was stigmatising. My interviews have drawn attention to how performance managers through language endeavoured to shape and establish how their own actions were seen and understood. In creating a new lexicon, performance managers attempted to define and demarcate the work they did.

7.5 The political imperative to policy

A performance manager plays no direct role in policy formation, though performance-generated information often influences policy development. Performance managers are seen as enforcers by the State, the Department of Health, as they are involved in implementing policies irrespective of clinical reluctance or physical obstacles. A performance manager must ensure policy and its corresponding targets are achieved and adhered to; because of this responsibility, performance managers frequently find themselves having to defend the introduction of a policy. A constant refrain heard in the PCT was “Why didn’t they (the government) introduce this change of policy earlier?” A naïve answer would be to suggest that policymakers, decision makers and government had not thought of it earlier. The more apparent answer is these same people did not consider NHS staff ready for the degree of change required. This question arises so frequently

⁵³⁷ Interview with SHA Performance Manager, p3&4

because policy is implemented in parts. The thinking behind such a measure is to see how staff react to the new initiative, but more importantly for it to be embedded in the organisation. However each constituent policy may not lend itself to the next policy, and so there is no linear progression. The introduction of policy during this period was like a jigsaw puzzle. Staff were introduced to policy in pieces, and prevented from knowing what the complete picture would be. Thus, it was necessary that each piece was recognisable individually, and should present a complete and coherent picture on its own right.

When the pieces of policy do not fit together precisely, the interconnections become points of tension, manifesting themselves as policy conflicts. At this point the question: “Why didn’t they (the government) introduce this change of policy earlier?” is voiced repeatedly. I realised, while embedded as an institutional ethnographer, that staff were aware of the dominant trajectory with regards to policy; staff had a sense of what was on the horizon. It was foolish, therefore, to assume they live in a political void, free from media or office speculation.

A SHA Performance manager detailed how the NHS was at the mercy of politicians’ whims and this did not necessarily improve the clinical care given to patients:

“PM: But then the NHS is still within the auspices of the Department of Health, and, therefore, is still a political football. It’s all about winning points off the political opponents, either around what used to be the waiting-list size, then it became waiting times, now we’re getting down to 18 weeks. What’s the next one going to be? So we can do four-hour turn arounds in A and E, which show no clinical benefit at all. Patients are sometimes required to stay longer than four hours in A and E, but actually their care could be compromised by pushing them forward into medical assessment units where they don’t have the appropriate care.”⁵³⁸

The interviewee describes how targets appear arbitrary in terms of sound clinical justification. There is no organisational control because management decision-making is dependent on political manoeuvrings. Observations made during my fieldwork corroborated this view that the lack of autonomy regarding decision-making and lack of

⁵³⁸ Interview with SHA Performance Manager, p6

foresight to future policies was destabilising for those working in performance management. Moreover, as Goffman described, and I discussed in Chapter Three, stigma originates when individuals are deemed deficient compared to the norm, in this case other managers and clinical staff. The waning of control over work created both a dependency culture on the State and a sense of insecurity amongst some performance managers. However, not all interviewees took this line. The contrasting view is given in the following quotation:

“Quite often, your performance role changes quite quickly, because there are political imperatives around which become the most important things. It’s not necessarily a bad thing, given the amount of public funding there is, it’s reasonable for politicians suddenly to become interested in one thing or another. It does mean the direction of travel can suddenly change very quickly, which can be frustrating. It also makes medium-term planning probably more difficult than it needs to be.”⁵³⁹

This extract illustrates the acceptance by the interviewee of the changing nature of the work undertaken, and the fact that, at different times, shifting political imperatives will force change in the areas of focus for performance management. The rationalisation for the altering of priorities is that it reflects the will of the people, specifically taxpayers. This is an example of politicians being accountable to the electorate. Nevertheless, though this SHA Performance manager is more positive than the previous interviewee, there is still recognition of the difficulties this style of priority setting generates. The two examples given draw attention to problems in medium-term planning and a sense of frustration as incomplete pieces of work are dropped in favour of the new.

A SHA Performance manager set out his belief that the 18 weeks target was only an electorate pleaser, as all patients prefer shorter waiting times.

“As a PR issue, I do think the government has implemented 18 weeks to make the Health Service look better. And probably, from a financial point of view, because of the savings. I’m not quite sure where the savings are going to be

⁵³⁹ Interview with SHA Performance Manager, p1

made in a pathway, if I'm being totally honest. The Health Service obviously had to reduce its overspend and perhaps they saw 18 weeks as one of them.”⁵⁴⁰

The interviewee acknowledges that, while publicly the 18 weeks target was about reducing waiting times, the latent agenda was about economy and financial savings. The performance manager is not sure how monetary gains will be achieved, but there is no doubt in his mind that this is real purpose of the target. As an institutional ethnographer I observed how this mismatch between motivations influenced the way performance managers were perceived by other staff. Clinical staff viewed them with an element of suspicion and distrust as they were unclear about the aims of performance managers. Again, this corroborates Goffman's description of stigma as a quality which is profoundly discrediting to an individual or group.

Here, a SHA performance manager recognises the importance to government of 18 weeks as a policy, having been a manifesto pledge. The interviewee justifies the need for an additional layer of bureaucracy to measure the target effectively on grounds that shorter waiting times are better for patients.

“My perspective is 18 weeks referral to treatment is to improve patient expectation outcomes and general view of the system. It has to be better for patients, so I believe it's a good initiative. It was a manifesto pledge to cut waiting time, so people will deliver on that, which has got to be good. But the benefit to the patient has got to outweigh any bureaucratic target-setting. There are, obviously, caveats within the rules to enable people to defer treatment for personal reasons and for clinical reasons. Although people seem to be late off the starting blocks in implementing the 18 week initiative, it is a good initiative and will improve the outcomes for the patients. So, it has to be supported.”⁵⁴¹

The interviewee recognised that organisations, both PCTs and hospital Trusts, started to make real and significant progress towards the target only near the official introduction date. As implementation had been left late in the day, large cash injections rather than service improvements and redesign led to the achievement of the target. This was considered acceptable as the outcome for patients, irrespective of the method by which

⁵⁴⁰ Interview with SHA Performance Manager, p3

⁵⁴¹ Interview with SHA Performance Manager, p3

this was accomplished, was shorter waiting times. Whether this is as easy to defend to taxpayers or the public in general is another matter.

A PCT Elderly Care Manager believes that there is a gulf between policy and implementation. He presents his belief that the State, in this case the Department of Health, does not allow enough flexibility for performance managers to use their own judgement on the most appropriate approach to implementing specific policies.

“EC: There’s too big a gap between the DH and the people on the ground. The DH set targets and are fixed on them, they’re not prepared to listen to what people on the ground are saying about what the consequences are, and adapt and have something sensible. They need to let their senior managers manage, and manage to those targets and to that spirit, without having such targets fixed....If senior managers are responsible for targets, should be saying, no, that’s not what we mean, this is how we should be interpreting the targets. Now maybe they’re allowed to, but senior managers within the NHS are given that flexibility to say, look, this is the spirit, these are what our aims are, we are managing it in an appropriate way.”⁵⁴²

The interviewee speaks of senior managers’ lack of autonomy to interpret targets to reflect the motivation behind the policy. Instead, on an operational basis targets are rigidly adhered to, possibly thereby losing the original purpose. This contrasts with idea of gaming, described in Chapter Five, where managers manipulated the rules of the measures that contributed to the target to ensure the best result. Nevertheless, in both instances the original intention behind the policy was forgotten. This has a stigmatising effect on those working in performance management, and furthermore it fits with Goffman’s description of stigma, previously set out in Chapter Three, as a deeply discrediting attribute. The lack of professional autonomy means that often, as witnessed during my period as an institutional ethnographer, performance managers are seen simply as instruments of the State. They are considered by other NHS staff to be the mouth-piece of the Department of Health, with no ability to tackle policies that seem unreasonable or contradictory.

These examples highlight how changing political imperatives fundamentally impact performance management. Directional changes in policy meant that its implementation had become more dogmatic in order that outcomes were delivered as rapidly as possible,

⁵⁴² Interview with PCT Elderly Care Manager, p7

leading to a lack of real professional autonomy, independence and control for performance managers who need time to deliberate on decision making and judgements. As the following interviewee describes:

“I wasn’t performance-managed by anybody else, I wasn’t told whether I was performing or late or anything like that. In terms of knowing that we were going to hit the deadline we set some key objectives and a proper project plan, so, in a way we performance-managed ourselves to make sure that we were going to hit. There wasn’t a budget or anything attached to it, it was more project management than performance management.”⁵⁴³

The long-term NHS performance manager’s description illustrates how the role had changed over the years. Previously, there had been less interference from the Department of Health, allowing a greater degree of personal autonomy. An increase in regulation around processes has reduced genuine independence in how work is done. Targets invariably alter not just the behaviours of that being monitored, but also the behaviour of those placed to undertake the monitoring. Autonomy is important to managers, and more so to performance managers, as its loss corresponds to a loss of credibility with clinical staff. Decreasing credibility is a characteristic which is stigmatising because clinicians are often judged to be those who have the patients’ best interests at heart; thus the balance in decision making is further skewed if clinicians believe they cannot trust the professional independence of the managers with whom they work.

This section has dealt with the politics of policy creation, the lack of involvement of performance management in this process and the resulting stigmatising impact on them, as seen by a lack of professional autonomy and foresight about their work. The next section will consider what happened when NHS staff, including performance managers, were consulted.

7.6 The disenfranchisement of the consultative approach

Within the NHS under New Labour there has been an increased focus on the consultative approach. Public consultations can occur at the local level, within the primary care community, the strategic level within health authority localities or at its widest remit at the national level as part of exercise undertaken by the Department of Health. The

⁵⁴³ Interview with SHA Performance Manager, p2

government's motivation for using a consultative approach was to promote staff, patients and public participation, therefore engendering a stronger sense of local democracy. Much publicity was given to the increase in consultations, asking staff and patients for their views, as this was promoted to increase accountability, staff, patients and public all being active parts of the decision-making process. The reality as experienced by staff was entirely different. Staff commented frequently, during my fieldwork, about the NHS merely paying lip service to the idea as the organisation merely went through the motions. Goffman, as previously described in Chapter Three, asserts that stigma originates when individuals are deemed deficient when compared to the norm. When staff views were sought only to be ignored, as with each reorganisation came a corresponding consultation, staff questioned their value and stated they were suffering from 'consultation fatigue'.

In the following extract, a PCT Risk Manager discussed what he believed was the purpose of consultations. He argued that the government drives through changes, claiming that this is at public behest, yet those working within performance are well aware that the public have little idea about the things done in their name.

“If it was the government's way of saving money, that's fine, then the government should be very honest. But they shouldn't pull this veil over the whole thing that says this is what the public wants. They probably looked at the public purse and the NHS finances and said, we've got to come up with a very good way of saving money. The result is commissioning a patient-led NHS, which certainly won't save money over the next years.”⁵⁴⁴

The reason given by politicians as to why performance management exists is, according to this interviewee, false. Risk, while not stated by the interviewee, is being implicitly referred to, with the phrase “pull this veil”, and it is taken for granted that I as a fellow performance manager will understand this. However, from my fieldwork I was able to ascertain the actual reason for performance management is for greater economy and efficiency, which as previously discussed are aspects of rationalisation.

A PCT Commissioning Manager talked about his experience of consultations, including both large scale public consultations as well as smaller less significant ones.

⁵⁴⁴ Interview with PCT Risk Manager, p9

“There was two pieces of work done with regard to, your NHS, your say, a huge national exercise to find out what patients wanted and what patients wanted was a choice. Choice of provider, choice of clinician, all these issues around single sex wards, they wanted to be treated with dignity and seen quickly and that really was the NHS plan. In a way, our customers, the patients were given the opportunity to say, to shape the direction and actually having a NHS plan has been bloody good, you know, for the first time we actually have a ten years strategy, and we seem to be doing quite well on that. Obviously, the world’s moved on since then. We don’t know if that is still what patients want, or what patients want is no MRSA or good clinical outcomes, it’s almost... you assume that’s what you’re going to get from the NHS. There’s brand loyalty to the NHS.”⁵⁴⁵

The interviewee picks up on the public consultations which occurred for both the publication of “*The NHS Plan (2000)*” and *Your NHS, Your Say*.⁵⁴⁶ He is of the opinion that public involvement provided greater transparency in these large-scale national initiatives. The public, including charities, patient groups, clinical bodies, the Royal colleges, trade unions and NHS staff were involved in the development of these huge policy drives. By incorporating and integrating these groups, the New Labour government ensured that introduction of their early health directives was implemented with minimum resistance. However, the interviewee notes that patients and the wider public were excluded from minor consultations which happened because of changing circumstances. He believes that the public are unconcerned about their lack of input, possibly because of a deeply ingrained sense of loyalty to the NHS brand which continues irrespective of changes. The value of consultations is in theory to help engage with the public to improve the effectiveness of new health policies and increase the efficiency of existing ones. However, consultations can and do occur within the NHS which comply with a set process: for example, regulations on large scale change mean that there must be a process of consultation with staff. Unfortunately, my time spent as an institutional ethnographer highlighted that, in such cases, consultations can be demoralising and counterproductive as NHS staff are left feeling disenchanting when their views are ignored. Once again, this lends weight to Goffman’s idea of stigma, as what we see is a devaluation and constriction

⁵⁴⁵ Interview with PCT Commissioning Manager, p3

⁵⁴⁶ ‘Your NHS, Your Say’ was the consultation exercise led by the surgeon Ara Darzi, on appointment by Gordon Brown, and resulted in Department of Health (2007) ‘Our NHS, Our Future: NHS Next Stage Review Interim Report’ followed by Department of Health (2008) ‘High quality care for all: NHS Next Stage Review final report.’

of personal identity, as the consultative approach appears as a mere formality to the introduction of a new policy.

7.7 The language of stigma

As discussed in Chapter Three, stigmatised groups use and apply concealing behaviours. This allows them to pass off actions that may otherwise be questioned in wider society, in this case the NHS. Goffman says this can include the development of specific terminology, language and forums in which to communicate freely amongst each other. My time spent as an institutional ethnographer revealed the distinctive language within performance management. The public have become more aware of this through political rhetoric such as performance, operationalize and delivery. Other words have become a part of performance 'work.' They include:

- **Active monitoring** - An organisation, which was previously achieving all targets, starts to underperform in certain areas. While this organisation is not failing in these targets, the appearance of poor performance across a number of areas leads to a more proactive scrutiny by the SHA.
- **Gaming** - Individuals work to position their organisation in the best light. The term signals ways in which staff try to manipulate the system for the best possible result.
- **Horizon scanning** - Performance managers attempt to determine what issues may lie ahead which may cause a problem in hitting the target. They are looking for difficulties and dilemmas that may affect the delivery of the target. It is about eliminating perceived risks, identifying threats, and recognising trends that may be detrimental in the near future.
- **Target setting** - This refers to the way in which local targets are set. The process is opaque; however, what it entails leads to a target, which organisations are more than likely to achieve.
- **KLOE** - Key Lines of Enquiry (Pronounced Chloe) - detailed questions that inform audits. Used by auditors and inspection teams to aid both their assessments and judgements.

- ***Intelligence gathering*** - This refers to information, data, plans and people, all of whom have an impact on the attainment of a target. In reality this often involves
- ***Trajectory*** - This refers to a plan for the coming months' activity usually plotted on a graph. Any deviation from the trajectory is seen as a possible cause for concern.
- ***Control and command*** - It is a top-down approach to management and describes the relationship between the SHA and PCTs; it is personified by SHA performance managers. A performance manager's role in this respect is focused on monitoring, surveillance and scrutiny of the actions of Trust staff.

The above words now frame the way in which NHS policy is discussed. However, this use of performance-related language is not solely directed to the NHS; other public services also use it, for example as seen in the education sector. In 2008, Professor Richard Pring referred to the use of performance language in education as Orwellian.⁵⁴⁷ By this he meant that language shapes how we see the world: in performance rhetoric reminiscent of the language of Big Brother, the voice of the State has a greater capacity to control how we think and act. In the Nuffield review of '14-19 education and training Annual Report 2004-05' "The Review noted the poverty of language...The language of inputs and outputs, of curriculum delivery and targets, or performance indicators and audits, is not the aims and values through which one explores the meaning of personal development and fulfilment."⁵⁴⁸ The Review makes a strong argument against performance management language in education. However, the role performance management language plays in the NHS, while still controversial, is more ambiguous.

Language is a central part of the performance culture yet there is another language, internally focused and employed by NHS performance staff to a far greater degree than the general performance language. This language centres around a new section of policy and in some respects is transitory, lasting only as long it takes the individual policy to become the norm within the healthcare setting. To an outsider the vocabulary can appear ambiguous, but to participants involved in discussion there is a clearer message. My fieldwork revealed that it can hide behaviour such as gaming; moreover IT helped create a

⁵⁴⁷ <http://news.bbc.co.uk/1/hi/education/7247160.stm>

⁵⁴⁸ Nuffield Review (2005) Curriculum Summary, p27

stronger bond between those who are involved in performance work, providing a sense of community.

An example of Goffman's concept of concealment, as described in Chapter Three, is given by a SHA Performance Manager. He explains the cautious way in which he tells other professionals what his job entails. He is aware of the stigma and the negative connotations performance management holds and is therefore careful with the choice of words to explain his work:

PM: I play tennis with GPs and dentists and was a bit nervous about telling them what I did. We were driving to a match and they said what do you do? And I thought about it and the way I described it, I said, I hold the NHS to account in X. My role was to ensure that the targets and directives were met and not just around access, but around clinical safety, around infection and really to be a sort of a sign post. But, it didn't help and they still thought I was a bit of a grey suit and part of the problem. But if I was trying to explain to a member of the public that I am there to make sure that we're getting the best possible service for you the taxpayer or patient, I can sleep at night with that role.⁵⁴⁹

The interviewee negotiates around stereotypes of managers. In the chapter "Formation of the NHS," the ideal type contradictions between managerialism and professionalism were listed. The interviewee is aware that doctors and dentists to whom he is speaking believe a distinction between managerialism and professionalism exists. They view him as somebody who is merely implementing the state's agenda, Department of Health policy, which they see as often conflicting with patients' interests. I would argue, based on my ethnographic observations, that those working in performance employ language as a defence mechanism against the accusation that they as managers do not hold the patient's interest as their primary concern. This is an implicit accusation that all managers face from clinical staff, which was brought more sharply into focus by the target culture prevalent under New Labour. The public perception is that performance managers are complicit in adding to the bureaucracy created by the state. Performance management is regarded as part of the state machinery by which the state comes between clinicians and their patients. As discussed previously, performance management is a type of

⁵⁴⁹ Interview with SHA Performance Manager p5

disembedding mechanism: the state requires the public to place their trust in an abstract system and in so doing the state simultaneously removes trust and status from individual clinicians and practitioners. This is a move from an old form of trust relations to the new, from status to performance. Performance operationalises trust relations in that public confidence must be placed in structures and capacities rather than solely in clinicians' knowledge, skills and expertise. This leads to the tension of which the interviewee is aware and which he is trying to deflect.

A SHA Performance Manager expressed his belief that the public perception of management in general was negative.

PM: I think it's kind of anti, there's a kind of anti-management sort of vibe, isn't there? And this also stems from *Casualty* and *Holby*⁵⁵⁰ and stuff with these negative sort of management types and I think that they (the public) see that anything that's removing money from the front line does not advance. That is the general perception of the management within the National Health Service.⁵⁵¹

The interviewee felt that the perception of management was negative because it was viewed as removing resources and funding from front line care. This perspective he thought was due in part to how management were presented in popular medical dramas. Performance management was viewed as hindering care and management as standing in the way of real progress in the NHS.

The language of performance allows discussion about concealed practices such as gaming and in so doing shows an acceptance of, and a way in which to deal with dubious practices, thus a means by which to adapt and disassociate one's self from the stigma.

7.8 A dictionary of terms

Language is a central part of the performance culture, playing a specific role; it allows those working within to describe hidden working practices in a more explicit fashion and acts as a form of concealment. The work of Sontag illustrates how military language is used to describe the treatment of illness, and earlier I detailed how it could be applied to those experiencing organisational change. Now, I want to take it further and illustrate

⁵⁵⁰ 'Casualty' and 'Holby City' are two long-running fictitious BBC medical dramas.

⁵⁵¹ Interview with SHA Performance Manager p6

how it lies at the heart of policy implementation and is a part of daily dialogue. While working as an institutional ethnographer, I uncovered words and phrases which are part of the 18 weeks vocabulary (see p278 Appendix F: Glossary of 18 weeks terms).

As can be seen, the list is lengthy and comprehensive. It covers all actions and behaviours relating to the 18 weeks policy. As discussed in Chapters Two and Three, the NHS has sought to replicate science in its practices in order to enhance its authority. While other professions within the NHS can call upon science for their credibility, this is not always appropriate in management. Nevertheless, in an effort to gain greater authority and status, aspects of science are imitated. Knorr Cetina argues that this is because there has been a move to a knowledge society; this is different from a capital, risk or information society. In a knowledge society, what holds currency and therefore value are knowledge and expertise; science as a form of knowledge production has a particular cache.⁵⁵² The use of charts is one such tool (discussed in Chapter Five); another is the use of technical language. Thus, terminology confers expertise on performance managers and validates their work. Within performance management there is an internal conflict. Managers are policing a norm, i.e. enforcing, regulating and promoting the best practice versus an enacting of the theatre of the absurd. My fieldwork highlighted the pressure performance management asserts in encouraging others to fudge, massage and game while language acts as a way of normalising this behaviour. More important, however, is its ability to empower performance managers. Within this performance culture there is what Goffman refers to as a “sharing of a single set of normative expectations by all participants, the norms being sustained in part because of being incorporated, ...when a rule is broken restorative measure will occur; the damaging is terminated and the damage repaired, whether by control agencies or by the culprit himself.”⁵⁵³ What I witnessed as an institutional ethnographer was the language providing a safety net, hiding a performance manager’s fear of not knowing the subject in enough detail and thus lessening the likelihood of exposure.

7. 9 Language applied: conversation decoded

The following is an example of conversation within a performance meeting. These meetings happened on a regular basis, the frequency of which was dependent on a Trust’s performance in the previous six weeks. This particular extract took place between the lead

⁵⁵² Knorr Cetina *Interdisciplinary Science Reviews*, 2007, Vol. 32 No.4 p361-375 “Culture in global knowledge societies: knowledge culture and epistemic cultures”

⁵⁵³ Goffman, E.,(1976) p152

performance manager for 18 weeks and the Chief Executive of the hospital Trust. Towards the end of the conversation, the Director of Finance at the SHA joined in. The conversation illustrated the pressure Trusts were under to realize the Further Faster 18 weeks target, the methods they employed to achieve said target and how the Trust would break the news, to the public, that the target had been missed. It is of relevance as it highlights issues of gaming, transparency, governance and public accountability.

SHA PM: Is the Trust gaming to get to 85? There is a concern that the trust looks like it is gaming?

CE: What does that mean?

SHA PM: Well the Trust hits the target short term but then falls back.

CE: Well it [Farther Faster] is not a target

SHA PM: Well there are handling issues. We just need to be clear about the story.

CE: I don't recognise gaming; I see the 85% target.

SHA PM: We are worried about bounce back. Sudden death is better than a slow prolonged death.

CE: Are others going first?

SHA PM: It is better to get the bad news out early. There is a story to understand, we need a credible position.

CE: 'Story' has the implication of spin.

SHA PM: What does your Board understand? Is it open?

CE: They have known from last Tuesday.

SHA PM: We need to agree soundbites.

(chair of the meeting) FD to CE: That is the right reaction. I like what I have heard, openly discussed. Quickly, you (CE) do it, the more credible the story. It needs to pass the Daily Mail test.

SHA PM: We need same words between the Board, SHA, PCT; one story

First, I will deconstruct what was being said and what implied above. The conversation starts with the PCT Chief Executive being asked by the SHA performance manager whether the hospital is manipulating the way in which patients are treated in order to achieve the target. Though all those around the table including the chief executive understand what is being asked, he doesn't like the implication that he would have knowledge of that sort of behaviour. Therefore he asks what this means. Not wanting to antagonise the situation, the SHA performance manager explains using conciliatory

language describing gaming as merely achieving the target but being unable to sustain this position. As the target being referred to is a local SHA initiative to be achieved, rather than the national target, the Chief Executive is less concerned. However, as the SHA have made Further Faster a regional priority, allocating additional resources to achieving the target before its national deadline, there is concern within the SHA. This is shown in the comment “we need to be clear about the story”, which means everyone, the PCT, the hospital Trust and the SHA should provide the same reason as why this local target, Further Faster, was missed. The Chief Executive reiterates that he is unaware of gaming. The SHA performance manager, fearful that the Trust will now achieve the Further Faster target, worries that the hospital success, due to an increase in resources and capacity will be a one-off. However, when this is removed, the number of patients being seen will drop dramatically and the graphical trajectory would show a sudden rise. The SHA would rather see the target missed completely than have weeks of slowing performance, because a steady decline would bring greater scrutiny than if the target was missed outright. The non-achievement of a target means that an organisation is still working towards it. A target once achieved and in decline creates more enquires from the media. The chief executive questions whether other Trusts in the same position, that of missing the local target, will make their position public before his own hospital. The reply is that, the earlier the public can be informed that the local target has been missed, then the more time this gives the Trust and SHA to make a robust case that poor performance will not be long term and things are improving. The chief executive, again worried lest he be seen to be manipulating the system, questions the use of the word ‘story’ to describe his approach. The SHA performance manager ignores the comments, well aware that meaning of what has been said is fully understood, but queries who else knows that failure is likely. The response is the hospital Board are already aware. The conversation closes with an agreement that all parties, including the director of finance who has been listening intently up until this point, will have a set of words that explains the missing of the local target. There will be no gaps in the story, and patients’ care will be paramount and hence pass the ‘Daily Mail’ test.

Shapin,⁵⁵⁴ when describing the production of science compares laboratories to kitchens, and this is similar to Goffman’s ideas of frontstage and backstage, described in Chapter Three. As was illustrated earlier, a performance manager’s perception that he or she lacks expertise on specific topics, leads to acting out a role, putting on a performance, with both

⁵⁵⁴ Shapin, S. and Schaffer, S., (1985)

frontstage and backstage aspects. They take on the qualities they believe a performance manager should have. However, this in itself brings its own pressure; the performance manager has to preserve this role. Scambler, when discussing health-related stigma, asserts: “The maintenance of face requires individuals, like actors on a stage, to present and sustain positive images of the self...In the absence of an audience they can stop performing.”⁵⁵⁵ The above example of a conversation about 18 weeks illustrates how performance managers orientate themselves, both acting a role as well as acting outside the role. As Goffman states: “similarly one finds that those who at the moment are routinely concealing their personal or occupational identity may take pleasure in tempting the devil, in bringing a conversation with unsuspecting normals around where the normals are unknowingly led to make fools of themselves by expressing notions which the presence of the passer quietly discredits.”⁵⁵⁶ To an outsider this may appear simply about performance managers asserting their status, creating a sense of superiority, and while this may play a part in the interaction this is not its primary purpose. As an embedded institutional ethnographer I witnessed how knowing the language conferred both status and prestige; moreover, it was also an outward sign to newer performance managers of the community to which they now belong. The language is a symbol and a conduit; it carries social information as well as having the capacity for knowledge sharing. Furthermore, the dialogue shows that the language reaffirms the identity of what it means to be a performance manager; it shows how performance managers embody rules, articulate their roles, and what happens when there is a breach, a breaking of the role. I would argue that individuals who form part of the same organisation or, more specifically, the same profession act in a similar fashion to a family, in that they will repair a breach. Through my fieldwork I observed on numerous occasions that the process of repairing was done by ignoring, isolating or excluding the individual physically or as in this case their contribution to the conversation.

In creating a performance language there was both a subconscious acknowledgement of the stigma and an acceptance that discussion of certain practices could not be spoken either openly or publicly. Therefore, a process of normification and normalisation⁵⁵⁷ occurred through which the performance managers created a vocabulary which acted as framework to their work. The practical day-to-day implementation of policy was left unsupervised by the Department of Health; this was the work of NHS management, in

⁵⁵⁵ Scambler, G., Health-related stigma, *Sociology of Health and Illness* Vol. 31 No.3 2009 p443

⁵⁵⁶ Goffman, E., (1976) p161

⁵⁵⁷ Goffman, E., (1976) p19

particular performance managers. Politicians for the most part remain untouched by the detail of policy implementation and worked around a “don’t ask, don’t tell” rule. Where civil servants and politicians were in a position to know better, it substantiates Goffman’s statement “a phantom acceptance is thus allowed to provide the base for the phantom normalcy.”⁵⁵⁸ It was possible for a ‘normal,’ in this case someone outside performance management, to become ‘wise’, a courtesy member by their ability to spot ‘clues’, recognising the efforts of concealment made by the stigmatised.⁵⁵⁹ Owing to their close relationship with performance management, these people were primarily finance managers and Chief Executives within NHS Trusts. They had the ability to view their organisation through ever-increasing forms of figures which the target culture had created. Performance management was tasked with accomplishing the impossible. Where politicians could take pride in achieving the impossible, when you know how the impossible had been achieved, all sense of accomplishment was lost. This was the art of performance management; the performance manager’s role was to ascertain what the best result was for an NHS Trust and how an organisation could achieve it. Maximizing on targets may be in the Trust’s best interest, but whether this was in the interest of the patients and the NHS in the long term remains to be seen. It was not personal trust, which was in doubt; rather it is institutional trust which appeared to be undermined by the implementation of policy through a target culture. More current research in this area shows that during the New Labour period there were greater resources and funding available, higher levels of efficiency and more openness in the NHS than anything seen in the last three decades.^{560,561} If staff and the public do not trust reforms when they technically work, the reform will be unsustainable.

7.10 Conclusion

One way of describing stigma is to see it as sign of disgrace which sets a person apart from others and in this respect the performance culture under New Labour was stigmatising. Performance management stigmatised those working within in it; moreover, as the application of performance technologies led to organisational rationalisation this sense of stigma widened to affect greater numbers of NHS staff. In this chapter I have focused on stigma, as both a cause and a symptom of rationalisation. I have examined the

⁵⁵⁸ Goffman, E., (1976) p148

⁵⁵⁹ Goffman, E., (1976) p107

⁵⁶⁰ Goody, P. T., (working paper 2006/2009)

⁵⁶¹ The findings, due to be published in January 2013, from the Public Inquiry into the bodies responsible for monitoring Mid-Staffordshire NHS Foundation Trust, chaired by Robert Francis QC contradict the claim of greater openness. Instead the Francis Report will state that there was a “culture of fear” caused by the pressure to achieve targets.

discourse of stigma in relation to organisational change and policy implementation, looking at the political imperative to policy and the language of stigma. As illustrated throughout this chapter, the language of stigma contrasts sharply with the 'risk' discourse of the State described in detail in earlier chapters; it is one which is highly emotive compared to the dispassionate language of risk.

Quantification, the use of dashboards and the application of tabularised information are the embodiment of rationality but the NHS and the patients it treats are complex. While modelling and generalizing can be helpful as conceptual tools, they cannot accurately portray societal relations. Performance management during the New Labour years made no real headway in understanding local conditions. The opinions of staff who had practical implicit knowledge gained through years and sometimes even decades of experience were disregarded. This knowledge, as described in detail in Chapter Three, Scott refers to as *metis*, is of the moment; it provides context to local issues. It is difficult to write, describe and prove, as its non-explicit nature means it does not fit with the positivistic approach to science. However, this wealth of knowledge is invaluable. The tendency to ignore it led to missed alerts and warnings about impending crises, leaving staff feeling disillusioned and discounted.

What has become evident from both ethnographic work including the interviews, 18 weeks case study and observations, is that stigma arises from the fact that performance managers are continuously mediating between two roles: representing the State to Trust staff and representing the Trust staff to the State. The two roles have different purposes and functions, often mutually exclusive, and yet the State demanded total allegiance to its agenda. There was a sense of cognitive dissonance as performance managers inhabited two worlds, had two masters and maintained two identities. This dual role created an apologetic character, one that was permanently trying to please the Trust for which it worked and also the Department of Health. Furthermore, an uncomfortable tension for performance staff was brought about by their propensity to have conflicting opinions and thoughts about the means and methods undertaken to achieve targets. They were aware of their organisations' expectations but also keenly understood the public perception of misinformation, misrepresentation and gaming. Interviews revealed not so much their inner turmoil but the way in which they rationalised and justified their actions.

The performance manager is constantly managing a conflictual situation which explains the use of military metaphors, which draw on imagery of both battle and resolution. In

this way, performance managers use language to convey not only the difficulty of the situation but also their readiness to overcome obstacles. Furthermore, military metaphors express facets of rationalisation. This was apparent in the mergers and streamlining during organisational change as well as the information gathering and surveillance aspects of the performance manager's role. Performance language is a subculture which allows those working in and around performance management to talk openly without being negatively judged or sanctioned. Like all languages it allows communication to flow between peers and excludes those who are not versed in the vocabulary or the work. However, while this language is known to a few, the practices and practitioners that do the work of performance management will continue to be stigmatised. It is only when the language moves out of the shadows and is understood by the majority of NHS staff that performance and the activities of the NHS will become more transparent, providing genuine accountability to the public.

Chapter 8

Conclusion

This research has focused on presenting a descriptive account of the work of a performance manager in order to dispel the myths around its functions. It is only by understanding what is done, by acknowledging what was previously hidden, that we can evaluate the contribution and value of performance management to the NHS under New Labour. Moreover, it is only with this knowledge that there can be any true discussion about the normative ideals of performance management. I return to the questions stated in the introduction posed by Jeremy Dent and Mahmoud Ezzamel in relation to accounting, of which, as I have already stated, performance management is subset. These included: “1) how does accounting fit in the totality of an organisation’s activities? How do such observed abuses in accounting interact with other organisational mechanism? 2) What forces shape the accounting functions in organisations? Why do accounting practices evolve over time? Such questions should, perhaps, be addressed before deriving normative accounting propositions.”⁵⁶² The account I have given of the role of Head of Performance and Information expands on these questions, providing explanations and possible answers with reference to performance management. The manifest function of performance, according to Blair, was to decrease risk by increasing quality, accountability, and transparency. All of these have been achieved to a degree, though in the main this has been independent of the role performance managers played within organisations. The results of my ethnography have shown that performance management has been largely unsuccessful in lessening the exposure to risk to which Trusts are subjected.

Performance, a term that New Labour was quick to appropriate and which was originally taken up enthusiastically by the NHS, has come to cover a range of actions and behaviour. The reason in part was because the term lacked clarity and the resulting ambiguity allowed it to be applied to numerous activities. The versatile nature of the word has allowed it to

⁵⁶² Dent, J., & Ezzamel, M., (1995) p39

be used in various situations in a variety of circumstances. Britain as a Risk State uses performance monitoring in both the public sector and in private industry. It is a way of strengthening modes of surveillance, reporting and tightening regulation. Across all sections of society, economic rationality is replacing morality; we see a move from ethos to instrumental rationality, where relations are measured by transaction costs. NHS performance management in this regard attempts to operationalise trust relations, which is evident in the establishment of performance indicators as a means of measuring and monitoring progress. However, performance has also been reified; this is a new phenomenon. Performance is no longer solely a process, a means to an end, a way of improving the NHS. For the first time in the NHS Plan, we see 'Performance' as a goal in itself, it appears as a thing in itself. Those who worked within Performance, including myself, were the visible aspect of this type of change within an institution; it was part of creating organisational transparency and reaching a wider audience. Nevertheless, a process does not usually have physical representation so the final part of this research examined how complete that 'representation' was. We cannot go back to a time of secrecy, lack of external monitoring, and unconditional authority, but it was necessary to establish what happened since the introduction of performance and performance management.

8.1 How this research advances our understanding of NHS performance management

The nature of institutional ethnography is that it is specific to a time, a place and a set of actors. Nevertheless, this research demonstrates the impact of experiences and events to be more general in terms of the interplay between the State and staff in the NHS. This research has shown that it is not just labour that is undertaken within NHS organisations, but also ideological work. As evidenced in Chapter Seven, as people worked, they reconciled their ideology with their action; this was not a static position, a one-off occurrence, but rather an ongoing process. Performance managers did not embrace the risk rhetoric employed by politicians; they were gripped by the ideology of rationalisation in providing support, substance and value to their work. The ethnographic work exposed the central latent function of performance management as rationalisation. As I have illustrated, performance managers were the tool by which state surveillance was carried out. New Labour understood risk arose from not knowing what was being done. Hence, New Labour governments, realising that there were whole areas of health care, among them services and procedures of which they had no knowledge, sought to remedy this

through surveillance, gathering information in the hope of minimising potential risks. Performance management was the means by which the government was able to extend and exert power over previously unexamined areas.

I began this thesis with a famous dictum from Aneurin Bevan, the founder of the NHS and Minister of Health, 1945-51. He said: “When a bedpan falls to the floor in Tredegar Hospital, its sound should echo in the Palace of Westminster.” This is pertinent as it both set the scene for my research and sums up how performance management acts as the amplifier to actions made at a distance. The NHS was and remains a significant issue for governments; decisions made in this area can sway election outcomes. In 1997, after eighteen years out of office, New Labour could not afford to fail. This need for greater control was a symptom of wanting to be seen to be delivering on their election promises in this area. As illustrated in Chapter Five, their authority via target setting and Star Ratings tables was felt throughout the NHS. This appeared in the increased levels of monitoring, measuring and quantifying of information, most commonly in a tabularised format.

Surveillance decreased levels of trust over a sustained period and had a detrimental knock-on effect on quality and accountability both in the PCT and the wider NHS, the very areas it had hoped to improve. In Chapter Seven, I revealed that the rationalising nature of performance management was in several respects felt most by the performance managers themselves. A sense of stigma around the work done, demonstrated by a specific performance management language, was the way in which this manifested itself. The surveillance culture led to a loss of professional autonomy, decision-making and trust. I evidenced, in Chapter Six, how performance managers subjected processes, protocols and procedures to increased examination on behalf of the government. However, the technical competence and expertise in understanding the rules and regulations became a skill that needed to be hidden. Proficiency brought greater unwanted external scrutiny and, as shown in Chapter Seven, the exclusive vocabulary, performance-speak, lessened transparency.

During the same period, organisations within the NHS endured constant reorganisation, leading to a loss of organisational memory, history and archive. Organisations experienced trauma; staff felt increasingly undervalued, morale dropped and a strong sense of being under attack from the government as well as the public emerged. Rationalisation of organisations resulted in staff feeling powerless as they lost control over the future direction of their working environments. The reorganisations that the PCT experienced

were mirrored throughout the NHS, change was continuous and yet productivity did not rise in line with streamlining. Many of New Labour's own key markers of success in improving PCT productivity have remained virtually static from 2009 to 2010.⁵⁶³ The process of rationalisation promised increased efficiency and effectiveness for less financial input, but this was not always the outcome. Instead, it appeared that organisations came to a standstill, paralysed by a lack of clear leadership. Communication faltered and staff were stuck in limbo, uncertain of their position as well as the role and future of the organisation for which they worked. It was only with the introduction of Foundation Trusts that power and control were devolved to a more local level, and even then there was an inability to release and relax centralised monitoring systems already in place. There needs to be a recognition by governments of all political persuasions that reorganisation in itself does not bring about reform and can weaken the very systems they are trying to strengthen.

Under the Blair and Brown administrations, performance management became a form of bureaucratic administration and NHS staff undertook anonymous labour. Performance technologies effectively removed the individual, and in so doing removed both responsibility and lessened accountability. Staff working within performance, as well as those at the periphery who felt the impact of arbitrary targets, experienced a sense of alienation. Their autonomy was weakened as they were compelled to both distance themselves from the actual frontline events and to suspend their faculties of judgement and reason. The heuristic approach during New Labour's years in office was one which focused on and gave premium to repositories of fragile facts and figures. There was an over-reliance on tabularised information, from which narratives had been removed from action. The testaments, descriptions and histories given by staff were overridden, sidelined or omitted from official accounts. The absence of critical reflection, while not felt immediately, inevitably made its impact known in due course, as seen in Stoke Mandeville Hospital Trust's thirty three deaths from *Clostridium Difficile*.

This research makes a case for enabling each citizen, member of staff, patient and member of the public to exercise powers of agency, to develop capacities for judgement in order to reinvigorate the NHS and to prevent it from continued self-harm. It is necessary to re-establish within performance management bonds of trust. How is this to be achieved? To quote Arendt, "What I propose, therefore, is very simple: it is nothing more than to think

⁵⁶³ Audit Commission (2010)

what we are doing.”⁵⁶⁴ Staff must be given time and space to think of the consequences of their actions and the purpose of their work, if the NHS is not to leap from one crisis to the next. They need to be empowered to question arbitrary targets and standards that have a negative impact on patient care and the quality of service provided or perhaps have no value at all. Data cannot be collected ad infinitum at huge financial cost with no discernible benefit to patients. Furthermore, the fact that data was used from performance management tools to prop up political posturing was unhelpful to the long-term authority of the staff who worked in this area. Performance management will only regain legitimacy if the public can see the benefit of the work done, whether this is in an improvement in care or making the NHS more financially efficient.

8.2 Performance management post-New Labour

With the medical establishment reasserting its power, the public concerned about ineffective targets, the Coalition government seemingly uncertain about the role of performance, it has to be asked: “Has performance management become a costly ‘comfort blanket’?” Performance management was introduced to re-establish bonds of trust. If this is once again being questioned, where does the future lie for performance management? “The audit society is only superficially a distrusting society. Indeed, auditing is a practice which must be trusted and which is also itself, of necessity, trusting.”⁵⁶⁵ Without trust in the information, performance management is little more than a time-consuming exercise in data collection. The Coalition government has already pledged to remove and reduce targets in recognition that Trusts are best placed to identify how to deliver healthcare to their local populations. Secretary of State for Health, Andrew Lansley,⁵⁶⁶ when addressing parliament on the issue of transparency of outcomes and the future of the NHS stated, “Today marks the beginning of an important shift in focus for the NHS and public health, away from focusing on politically motivated process targets, and towards what matters most: improving quality and delivering health outcomes that are among the best in the world.”⁵⁶⁷ This assertion that attention should no longer be on process but rather health outcomes marked a shift in ideology from the previous government. It remains to be seen how this will be implemented in practice and whether there will be a genuine shift in power from the central to the local.

⁵⁶⁴ Arendt, H., (1998) p5

⁵⁶⁵ Power., M., (1997) p123

⁵⁶⁶ Andrew Lansley, Secretary of State for Health May 2010 – September 2012.

⁵⁶⁷ <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101220/wmstext/101220m0001.htm#1012204000573>

The value of targets is being assessed by the Coalition government. Some may remain will do so if there is sufficient evidence to justify their continued use in improving clinical standards. However targets are just one part of performance management. As I have shown, performance allows information to be amassed on all aspects of the NHS on behalf of the State, providing it with knowledge of areas that had previously remained unseen. The Coalition government has proposed far-reaching reform to the current structure of the NHS; this will have a significant impact on the way information is gathered. The documents '*Equity and excellence: Liberating the NHS*'⁵⁶⁸ in July 2010 and an update in June 2011 proposed three key changes to the structure of the NHS. At first, the Department of Health was to take on a more strategic role, but this was changed by the June 2011 amendment, which stated that the Secretary of State for Health would remain ultimately responsible for Health: a reinstating of the legal responsibility of the Health Secretary for the overall performance of the NHS. The second structural change was with regard to SHA & PCTs. The 10 SHAs and 151 PCTs which were accountable to the communities they serve are to be replaced by 500 consortiums of GPs. Former PCT responsibility for local health improvement will move to local authorities where a ring-fenced budget is to be allocated to public health. GP Consortia will take on the responsibility for much of how the NHS budget is spent.⁵⁶⁹ The final proposed structural change is that all hospitals should seek Foundation Trust status, being encouraged to move outside the NHS to become industries of social enterprise.⁵⁷⁰ The future will see a strengthening of the power of Health and Well-being Boards, which are being set up by councils, to oversee commissioning and give patients a greater role on them. The 2011 update suggested that these boards should retain a lead role for GPs in decision-making, but also boost the roles of other professionals e.g. hospital doctors and nurses.

We are in a period of financial constraint. Public spending is limited and there is no additional funding to support the changes to the NHS; funding is contracting in real terms rather than expanding. The figures show there is room for improvement in all aspects of care and the NHS is expected to find £20 billion of efficiency savings by 2014.⁵⁷¹ Previously, when structures were rearranged in the NHS, it was given additional 'hump' funding to disentangle the existing structure and establish the new structure. Management restructuring will be an integral part of the structural reforms facing the NHS. A level of expertise has developed within the current management, and, as old structures go and new

⁵⁶⁸ Department of Health (2010)

⁵⁶⁹ Department of Health (2010) p28

⁵⁷⁰ Department of Health (2010) p36

⁵⁷¹ Department of Health (2010) p5

structures come into being, the focus for the Coalition government will be on retaining this expertise while promoting greater efficiency and effectiveness. Under the proposed reforms, patients will have more information and choice. This will be with regard to where, when and by whom they are seen.⁵⁷² Patients are already becoming more demanding and this tendency is likely to continue as they seek the best clinical care.

The structural changes proposed in *The Health and Social Care Act 2012*, plus an increasingly demanding public, mean that though specific targets may change, the importance of assessing performance against indicators is expected to remain. Thus, while the future of performance management remains uncertain, its functions look likely to continue. The planned radical reform to the current structure of the NHS and its possible implications for performance management therefore should be investigated further. Since early 2013, a flurry of reports, each intended to have a major impact on NHS conduct, have added weight to my research claims. These are the Francis⁵⁷³, Keogh⁵⁷⁴ and Berwick⁵⁷⁵ reports. Independently each of these reports are intended to make a considerable impression on how performance is implemented and, taken together, they argue for a wide scale re-visioning of performance management culture.

8.2.1 Francis Inquiry

On the 6th February 2013, Robert Francis QC published his final report into failings at Mid-Staffordshire NHS Foundation Trust. It made for uncomfortable reading. The Francis Report reflects on the loss of up to 1,200 patient lives between 2005-2008 at a cost to the public purse of £13,034,300. It corroborates much of my research and vindicates my claim that performance management's sole focus on measuring is detrimental to all. This is a truth that for over a decade during the Labour years, was deeply unfashionable; even until recently it was unpalatable even to the Coalition government. The findings from the Public Inquiry initiated by the former Secretary of State for Health, Andrew Lansley, MP, form the basis for The Francis Report. It took evidence from patients and families, hearing their accounts of appalling suffering. The report describes a closed culture of secrecy and defensiveness. It was endemic throughout the hospital Trust; moreover Francis concludes that the characteristics seen at Mid Staffs were likely to be replicated throughout the NHS. In his letter to Jeremy Hunt, MP, Secretary of State for Health,

⁵⁷² Department of Health (2010) p16-17

⁵⁷³ Francis Inquiry (February 2013)

⁵⁷⁴ Keogh Review (July 2013)

⁵⁷⁵ Berwick Review (August 2013)

given in the first pages of his report, Francis states: “The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed.”⁵⁷⁶ The Francis report blamed no single individual, seeing it instead as a whole-system failure. The checks and balances that should have been in place were ignored. This was in part because of the many reorganisations which unintentionally resulted in a diminution of care towards patients, although their overt aims were to improve the NHS and ensure that patients were treated with dignity and suffered no harm. The weighty 1,782 page report has 290 recommendations which have major implications for all levels of the health service across England.

8.2.2 Francis recommends

In his report, Robert Francis QC calls for a whole-service, patient-centred focus. His detailed recommendations do not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again. A reading of the Francis Report leads me to conclude that implementing 290 recommendations cannot be done cheaply if they are to succeed. The report's conclusion:

“The first inquiry report stated that it should be patients – not numbers – which counted. That remains the view of this Inquiry. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary, but it is not the system itself which will ensure that the patient is put first day in and day out. It is the people working in the health service and those charged with developing healthcare policy that need to ensure that is the case.

The extent of the failure of the system shown in this Inquiry’s report suggests that fundamental culture change is needed. That does not require a root and branch reorganisation– the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it.”⁵⁷⁷

⁵⁷⁶ Francis Inquiry (February 2013) p5

⁵⁷⁷ <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
Francis Inquiry (February 2013) p83

The following themes were focused on:

- a commitment to common values;
- adherence to fundamental standards where non-compliance is unacceptable;
- openness, transparency and candour in work;
- care and compassion at the heart of nursing;
- professionalism to include strong patient-centred leadership;
- information to be accurate, relevant and honest for transparency to flourish;
- boards to publish accessible comparative information and noncompliance against standards aiding public accountability;
- effective health service requires stability; impact assessments undertaken before structural reorganisations occur;
- DH to have a greater understanding of patients' needs and concerns.⁵⁷⁸

Mid-Staffordshire Hospitals were pursuing Foundation status which meant their focus was to achieve key targets, including in finance. The evidence from the Inquiry shows this diverted the Board from the quality of patient care, thereby compromising patient experience and health outcomes. Francis recognises that to some degree the problems seen in Mid-Staffordshire occur in most Trusts, though not to the same scale; my research corroborates these findings. Finally, Francis made clear in his report that cultural change cannot be dependent on government alone and that staff throughout the NHS had a responsibility to change their approach to prevent Mid-Staffordshire-like incidents surfacing again.

8.2.3 Keogh Review

Professor Sir Bruce Keogh's "Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report,"⁵⁷⁹ focused on 14 English hospitals with the worst mortality rates. The report was commissioned in the wake of the second Francis inquiry into Stafford hospital and launched in a period of political recriminations about the way the NHS was managed. On 6th February 2013, the Prime Minister David Cameron announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. The report reflects the growing concern about the capacity of the NHS to deliver high quality, safe

⁵⁷⁸ Francis Inquiry (February 2013) p65-83

⁵⁷⁹<http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>
Keogh Review (July 2013)

and compassionate care. The anxiety arising from the findings of the Francis report was that there might be “more Mid-Staffs” which had gone below the radar of the regulator, that similar crises in care were happening across the country but remaining undetected. The report provided much ammunition for those seeking to gain political points and who sought to discredit the NHS, the regulators, the Coalition government and the previous Labour governments, under both Blair and Brown. Nevertheless, the review itself gave a balanced, thorough and thoughtful appraisal of the 14 hospitals concerned. Unlike the barrage of recommendations made by Francis, Keogh sets out what must happen in order to rectify the low standards of care at the hospital Trusts as well as providing lessons for the wider NHS in the form of eight ambitions.

The report brought no real surprise for me. Keogh showed that warning signs had been missed or in many cases dismissed, and observed that the performance culture was one that exacerbated a multitude of problems. He noted that from junior doctors right up through the NHS hospital hierarchy, there was a culture in which no-one-spoke, no-one asked and no-one heeded warnings.

The lessons from the Keogh review must not be confined only to those hospitals that are currently the subject of special measures. All healthcare organisations, both NHS and non-NHS, need to be alert to problems and concerns. Both clinicians and managers need to be candid, curious and more importantly courageous in asking the awkward questions. Openness and transparency must become a central part of the NHS culture when risks to patients or to organisational governance are exposed, not alien to it. Finding and funding the resources to support the appropriate intervention will be a major challenge in today’s financially-challenged economy, especially in the face of an ever-growing NHS budget deficit and an ageing population. But standards of poor care must be addressed otherwise such scandals as those reported in the Francis and Keogh reports will continue.

Questions initially posed to the Blair government following the scandals of Alder Hey, Bristol and Shipman, discussed in Chapter Two, raised two recurrent questions: “How could this happen?” and “How could such happenings go unnoticed for so long?” These continue to be the same questions that occupy the public. They are perplexed as to why, given the investment in both information technology and performance monitoring better information is not available in order to provide an accurate reflection of how NHS bodies are performing. Moreover, the evidence of poor performance is a source of much anger to the electorate. Politicians of all persuasions know that they are being held responsible for the NHS’s failings. The Keogh report recognises that the hospitals reviewed had suffered

well-documented problems over several years and opines that “these organisations have been trapped in mediocrity.” The implication of this statement is that all performance management systems, such as those discussed in Chapters Five and Six, had no significant benefit to the quality of care received by patients during that those years, thereby supporting my claim that these systems were ineffective in terms of risk reduction.

8.2.4 Berwick Review

Following the Francis Report into the failings of care at Mid-Staffordshire Hospitals, the Prime Minister David Cameron asked Professor Don Berwick to carry out a review into safety in the NHS, an area in which he is an expert. His findings were published in ‘*A promise to learn - a commitment to act: Improving the safety of patients in England*’⁵⁸⁰ (August 2013). Unlike the Francis Review, it did not make hundreds of recommendations. It was a less substantial document whose conclusion was that the focus of the NHS should be putting patient safety and experience at the very heart of the healthcare, meaning that it should be central to all aspects of commissioning and delivery of services.

The report highlights the main problems affecting patient safety in the NHS and makes the following recommendations to address them. It says that the health system must:

- “• recognise with clarity and courage the need for wide systemic change
- abandon blame as a tool
- reassert the primacy of working with patients and carers to achieve health care goals
- use quantitative targets with caution
- recognise that transparency is essential and expect and insist on it at all levels and with regard to all types of information
- ensure that responsibility for functions related to safety and improvement are vested clearly and simply

⁵⁸⁰https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
Berwick review (August 2013)

- give the people of the NHS - top-to-bottom, career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning
- make sure pride and joy in work, not fear, infuse the NHS”⁵⁸¹

Reviews such as those by Francis, Keogh and Berwick have been necessary because the performance systems which I have described in detail are no longer trusted. The culture in place does not deal adequately with persisting poor performance. A key output of the Keogh review is to bequeath a framework and methodology to the NHS. As he says: “I was keen to provide an accurate diagnosis, write the prescription and, most importantly, identify what help and support they needed to assist their recovery or accelerate improvement.”⁵⁸² The Keogh review calls for all the fragmented data about quality in hospitals, both quantitative and qualitative, to be brought together in a useable form, and for trusts to invest in the skills to interpret and use them. It calls for real-time patient feedback and comment to become routine and “reach well beyond the Friends and Family test” that is part of the current assessment. The Keogh report also calls for a comprehensive approach to reviewing Trusts’ performance, and one that relies on data and is transparent as well as multi-disciplinary. The report’s investigation were a tough but fair process which uncovered things previously not revealed - for example, the disparity between reported and actual staffing levels on wards. It was the very antithesis of the tick box, generic approach previously used by the CQC.

The new Chief Inspector of Hospitals at the CQC, Sir Mike Richards, though only recently appointed to the post spoke almost immediately of his desire to see patients and the public being involved in inspections. This reinforces suggestions made in the Keogh’s report that “involving patients and staff was the single most powerful aspect of the review process” and sets out an ambition that “patients, carers and members of the public will increasingly feel that they are being treated as vital and equal partners in the design and assessment of their local NHS”. It also tallies with my research; however, while all three reports state that endless and needless reorganisations were harmful as they moved management’s focus away from patient care, this is not its main claim. The main thrust of the reports is to show that, in striving to meet national targets, patients were and continue to be seen as numbers, not people. Layers of bureaucracy, procedures, process, plans do not give greater understanding of what is happening on the ground. Financial

⁵⁸¹ Berwick Review (August 2013) p10

⁵⁸²<http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>
Keogh Review (July 2013) p3

rationalisation and increased standardisation increase risk of harm. Quantification, in terms of achieving targets is not genuine public accountability. Finally, all NHS staff have been complicit in this culture.

8.3 Future directions of this research

This research has focused solely on performance under New Labour. This is because, during this period, there was a proliferation of this type of management, in part as a means of ensuring manifesto pledges were delivered. When I began my research, there were few studies that looked at the performance management in the NHS. As this research comes to an end, this is beginning to change.^{583, 584, 585, 586} Nevertheless, performance management still needs the rigour of research brought to its activities. The three reports, Francis, Keogh and Berwick, discussed above, push for a new performance culture. Prime Minister David Cameron has called for a zero tolerance to patient harm⁵⁸⁷ while the Secretary of State for Health, Jeremy Hunt, has spoken in parliament about a culture of compassion⁵⁸⁸ being a key marker of NHS success. Both have discussed the distorting impact of targets and the box-ticking performance ethos which led to serious failings of care in the NHS. Nevertheless, how this new performance management framework aids transparency and increases public accountability is yet to be assessed. What is clear is that performance management will need to develop and evolve rapidly, and how this impacts those that work in this area requires much consideration.

This thesis has focused on how performance works in healthcare. Its scope is specific, in that the ethnographic work was done within primary care and Strategic Health Authority settings. Further research should focus on how performance management works in other areas. In recent years, substantial literature on performance in other areas of the public sector has been published; this includes both education and social care. However, it is performance as a process of delivery that needs to be considered. There are three key areas where widening the remit of the research would be beneficial. Firstly, the question of why performance appears to be the preferred tool of choice for policy advisors should be

⁵⁸³ Royal Statistical Society Working Party on Performance Monitoring in the Public Services (Chair: Professor Sheila M. Bird). Performance Indicators: Good, Bad, and Ugly. *Journal of the Royal Statistical Society Series A* 2005; 168: 1 – 27.

⁵⁸⁴ Bevan G, Hood C. Have targets improved performance in the English NHS? *BMJ*, 18 February 2006

⁵⁸⁵ Bevan G, Hood C. What's measured is what matters: targets and gaming in the English public health care system. *Public Administration*, Volume 84, Issue 3, pages 517–538, August 2006

⁵⁸⁶ NHS Institute for Innovation and Improvement (2010) The How-to guide for measurement for improvement. http://www.institute.nhs.uk/qipp/joined_up_care/measuring_the_improvement.html

⁵⁸⁷ <http://www.hsj.co.uk/obama-adviser-to-make-zero-harm-in-the-nhs-a-reality-pledges-pm/5054649.article>

⁵⁸⁸ <http://www.bbc.co.uk/news/health-21922998>

considered. Ashmore *et al* sought the opinion of health economists⁵⁸⁹ while my research has focused on NHS staff. However, policy advisors who are civil servants by training have a huge impact on the creation and implementation of policy, yet their judgements, opinions and reasoning with regard to the NHS are not widely pursued or understood. Hence the need for research in this area.

A second key area of research would be to investigate how performance has developed in private healthcare. New Labour introduced private providers to deliver not only auxiliary services, such as cleaning and IT, but also care, and the Coalition government are keen to extend this further. There has been a greater degree of involvement in delivering NHS care through private companies. It is therefore necessary to understand how performance works in this environment.

Thirdly, it is essential that the role of the healthcare regulator, the Care Quality Commission, (CQC), be examined in greater detail. CQC's role is to ensure that services are as safe as possible so that the best is experienced across the country rather than just in pockets. Nevertheless, though there has been a national regulator throughout the introduction and embedding of performance targets, huge variation amongst providers and services still persists. While targets remain, the Coalition has moved towards outcome measures with a focus on quality standards developed by NICE. The future will see CQC reviewers continuing to note areas of both immediate concern and good practice. However, as the focus will continue to be on compliance with core measures and the role of the regulator is to remedy bad practice, the CQC will come under the greatest scrutiny from parliament, the public and press. Compliance with standards in the NHS, as has already been seen, means that there will be those individuals and Trusts that seek the maximum return for minimum effort to the detriment of patients, and this is where the danger lies. One of the normative accounts of performance was it offered the means by which progress could be measured; the strength of the regulator will determine whether progress made is genuine, and thus there is the need for independent research.

⁵⁸⁹ Ashmore, M., Mulkay, M., and Pinch, T., (1989).

Appendix A

Roles of Staff identified and interviewed

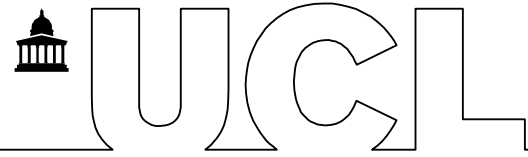
Formal semi-structured interviews were conducted with a total of 17 staff from the Primary Care Trust (PCT) and Strategic Health Authority (SHA). Informal discussions were also held with a number of staff as part of observations.

- Clinical Governance Manager
- Commissioning Manager
- Elderly Care Manager
- Emergency Care Manager
- Finance Manager
- Governance Manager
- Primary Care Manager
- Public Health Manager
- Risk Manager

- SHA Performance Manager 8

Appendix B

UCL SCIENCE & TECHNOLOGY STUDIES



Participant Information Sheet

I (Shana Vijayan), a Graduate Student in the Department of Science and Technology Studies at University College London (UCL), and Head of Performance and Information with PCT, am conducting a social research study of Performance Management in the NHS. This research is toward my doctoral thesis on this subject. You have been selected to participate due to your role in performance and/or your ability to affect performance outcomes and I hope you will be able to assist me in my research.

Why is this study important?

The study will shed light on participants' day to day experiences of life and work in and around performance management in today's NHS. The research aims to provide an account of performance management, which is important because no study or evaluation of performance management has taken place. By asking those dealing directly with performance issues, this research intends to go some way to filling this gap.

What will the study involve?

Participation will involve an oral history interview, lasting approximately one hour, or period of time agreeable to you as the interview subject. There will also be an observational aspect to the study which will be gathered on a day to day basis.

The interview will be audio- taped and transcribed. Your taped and transcribed responses may be quoted though your name will remain anonymous in publications resulting from this research.

The data from the observational study and the interviews will be kept 5 years from the date of PhD completion after which time it will then be destroyed.

The general conclusions of the study will be communicated to ...PCT but this will not affect the anonymity of individuals involved. All personal information will be treated confidentially.

I am happy to answer any questions or research-related problems. You may contact me, Ms Vijayan, on:

You have two weeks in which to decide whether or not you wish to participate. Participation in this research is entirely voluntary. You may refuse to participate at any time without penalty.

What if I change my mind about being involved?

You can decide not be a part of this research at any time without it affecting our professional relationship.

What do I do now?

Let me know whether you would like to take part and when you would like to undertake the interview. If you have any further questions please do not hesitate to contact me on the above number.

Appendix D

Balanced Scorecard - Indicator listings for Primary Care Trusts

Key targets

- Access to a GP
- Access to a primary care professional (PCP)
- Drug misusers accessing treatment
- Elective patients waiting longer than standard
- Financial management
- Four-week smoking quitters
- Outpatients waiting longer than standard
- Total time in A&E: four hours or less

Access to quality services

- Ambulance category A calls meeting 8-minute target
- Commissioning of assertive outreach services
- Commissioning of new mental health workers and crisis resolution services
- Delayed transfers of care
- NHS dentistry
- PCT patient survey: access and waiting
- PCT patient survey: better information, more choice
- PCT patient survey: building closer relationships
- PCT patient survey: clean, comfortable, friendly place to be
- PCT patient survey: safe, high quality, coordinated care
- Sexual health
- Six month inpatient waits
- Thrombolysis - 60 minute call to needle time

Balanced Scorecard - Indicator listings for Primary Care Trusts continued

Improving health

- Cervical screening
- Death rates from cancer, ages under 75 (change in rate)
- Death rates from circulatory diseases, ages under 75 (change in rate)
- Diabetic retinopathy screening
- Flu vaccinations
- Health equity audit
- Immunisation: MMR
- Infant health
- Teenage pregnancy

Service provision

- CAMHS
- Child protection
- Community equipment
- Data quality on ethnic group
- Learning disability: identification in primary care and reducing long-term NHS residence
- Risk management
- Staff opinion survey: health, safety and incidents
- Staff opinion survey: human resource management
- Staff opinion survey: staff attitudes
- Workforce indicator

Appendix E: 18 Weeks Executive Dashboard for NHS Commissioners

18 Weeks : Executive Dashboard for NHS		Commissioners : Nov 07 and W/E 27/01/2008										
Measure	Index	SHA	Trend (Actual vs Plan)	PCT	:PCT	'PCT	PCT	PCT	PCT	PCT	PCT	
A Monthly admitted % treated within 18 weeks	Actual ¹ 61.6% Plan ² 70.1% Index 87.8%	▲		▲	▲	▲	▲	▲	▲	▲	▲	
B Weekly admitted % treated within 18 weeks	Actual ³ 64.8% Prev Mon 61.6% Index 105.3%	▲		▲	▲	▲	▲	▲	▲	▲	▲	
C Monthly admitted % data completeness	Actual ⁴ 70.3% Plan ² 100.0% Index 70.3%	▲		▲	▲	▲	▲	▲	▲	▲	▲	
D Monthly admitted % patients with unknown clock starts	Actual ¹ 21.6% Plan ² 0.0% Index	▲		▲	▲	▲	▲	▲	▲	▲	▲	
E Monthly non-admitted treated % within 18 weeks	Actual ¹ 83.3% Plan ² 84.7% Index 98.4%	▲		▲	▲	▲	▲	▲	▲	▲	▲	
F Monthly non-admitted % patients unknown clock starts	Actual ¹ 9.5% Plan ² 0.0% Index	▲		▲	▲	▲	▲	▲	▲	▲	▲	
G Backlog - patients who have passed breach date (Vol)	Actual ³ 9651	▲		855	1230	926	3650	119	338	1252	446	835
H Untreated patients with unknown clock starts (Vol)	Actual ³ 2169	▲		94	37	23	1512	74	18	14	233	164
I Total planned elective activity to Mar 08 (Vol)	Plan ² 80307			7069	10056	8122	27593	2310	4253	11950	3830	5123
J G and H as proportion of total activity to Mar 08 (%)	Calc 14.7%	▲		13.4%	12.6%	11.7%	18.7%	8.4%	8.4%	10.6%	17.7%	19.5%

Key to Symbols:
 ▲ Increase on previous period
 ▼ Decrease on previous period
 ▲ Static on previous period
 ▼ Static on previous period

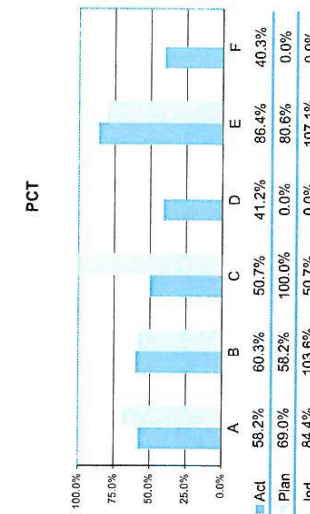
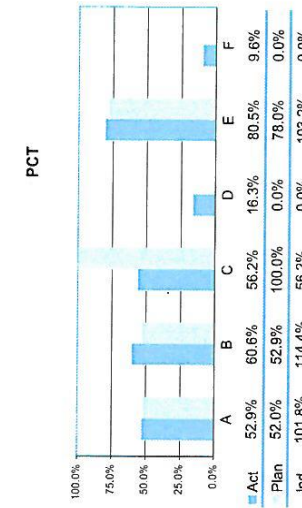
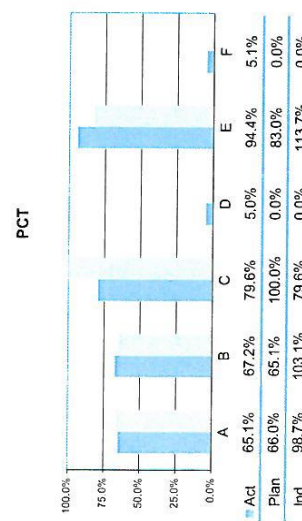
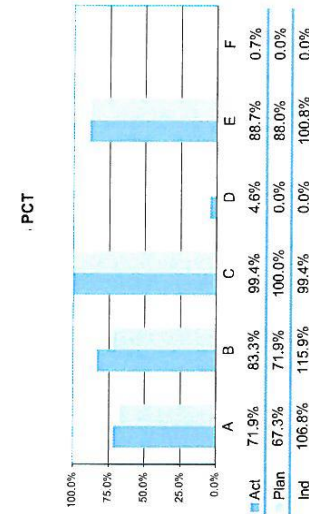
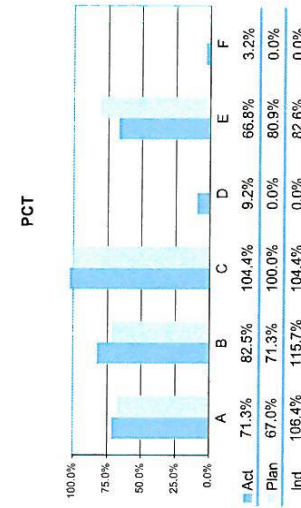
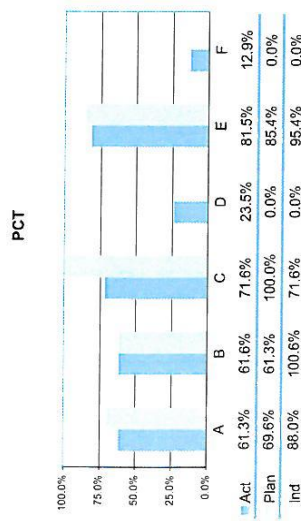
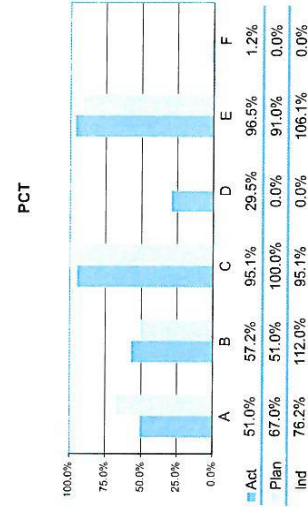
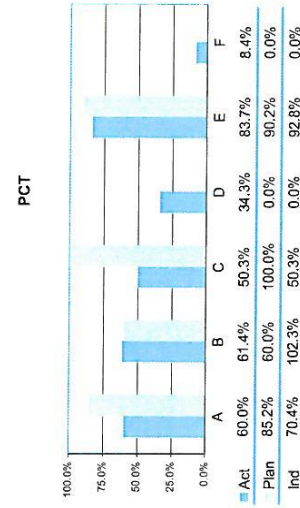
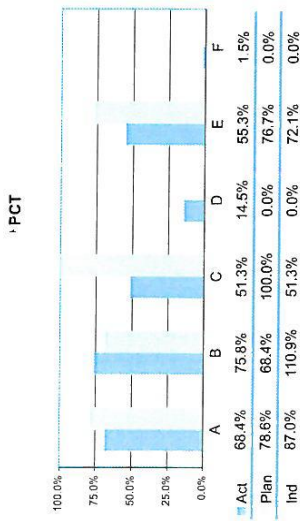
Data Sources:
 1. MAR Comm Return (UNIFY), Monthly Monitoring Database
 2. Further, Faster planned trajectory
 3. Weekly Comm 18 week PTL Returns (Unify)
 4. New Methodology (RTT Total vs MARCOM exc. Diag.)

Appendix E: 18 Weeks - Executive Dashboard for NHS Commissioners

18 Weeks : Executive Dashboard for NHS

Commissioners : Nov 07 and W/E 27/01/2008

Primary Care Trusts - Measures and Indices



Appendix E: 18 Weeks - Executive Dashboard for NHS Providers

18 Weeks : Executive Dashboard for NHS Providers : Nov 07 and W/E 27/01/2008

Measure	Index	Trend (Actual vs Plan)
A Monthly admitted % treated within 18 weeks	Actual ¹ 61.6% Plan ² 53.7% Index 114.6%	
B Weekly admitted % treated within 18 weeks	Actual ³ 64.5% Prev Mon 61.6% Index 104.8%	
C Monthly admitted % data completeness	Actual ⁴ 68.9% Plan ² 100.0% Index 68.9%	
D Monthly admitted % patients with unknown clock starts	Actual ¹ 21.9% Plan ² 0.0% Index	
E Monthly non-admitted treated % within 18 weeks	Actual ¹ 84.0% Plan ² 78.8% Index 106.6%	
F Monthly non-admitted % patients unknown clock starts	Actual ¹ 9.7% Plan ² 0.0% Index	
G Backlog - patients who have passed breach date (Vol)	Actual ³ 9237	
H Untreated patients with unknown clock starts (Vol)	Actual ³ 2138	
	Actual ³ 889	
	Actual ³ 1907	
	Actual ³ 974	
	Actual ³ 1224	
	Actual ³ 266	
	Actual ³ 63	
	Actual ³ 877	
	Actual ³ 75	
	Actual ³ 1164	
	Actual ³ 327	
	Actual ³ 0	
	Actual ³ 0	
	Actual ³ 0	
	Actual ³ 0	
	Actual ³ 664	
	Actual ³ 0	
	Actual ³ 670	
	Actual ³ 718	

Key to Symbols:

- ▲ Increase and on or above plan
- ▶ Static on previous period
- ▼ Decrease on previous period
- ▲ Increase and on or above plan
- ▶ Static and within 5% of plan
- ▼ Decrease and less than 5% of plan
- ▲ Increase and on or above plan
- ▶ Static and within 5% of plan
- ▼ Decrease and less than 5% of plan

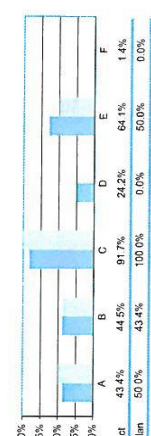
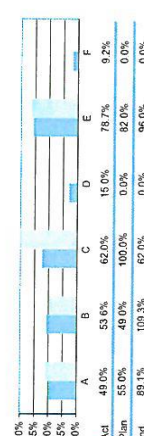
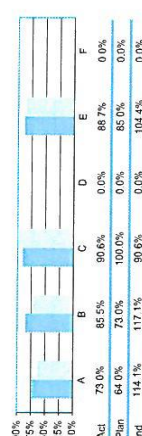
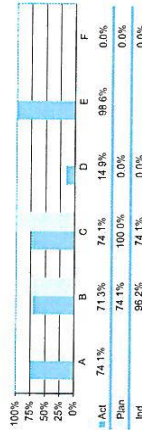
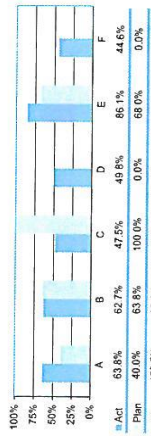
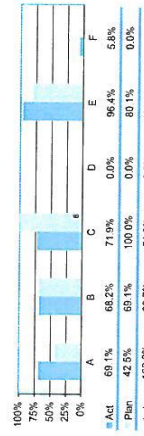
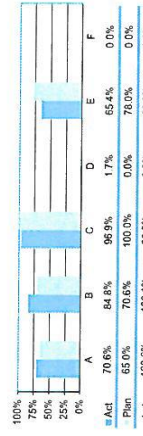
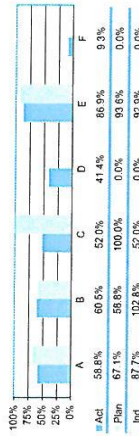
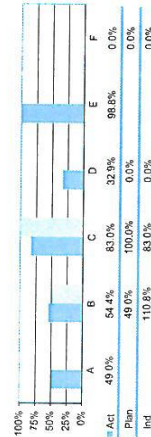
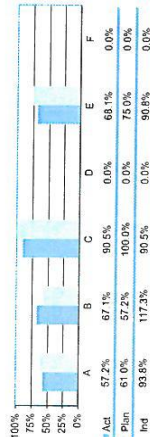
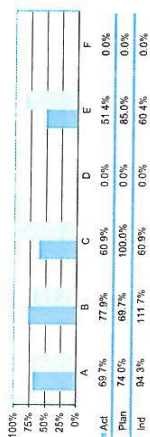
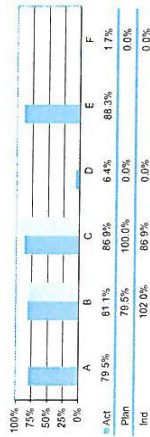
Data Sources:

- MAR Prov Return (UNIFY), Monthly Monitoring Database
- LDP trajectory
- Weekly Comm 18 weeks PTL Returns (Unify)
- New Methodology (RTT Total vs MARCOM exc. Diag.)

Report Printed: 04/02/2008 - 11:10
NP: data for W/E 13/01/08 not available on Unify

Appendix E: 18 Weeks - Executive Dashboard for NHS Providers

Acute and Foundation Trusts - Measures and Indices



Report Printed: 04/02/2008 - 11:10

Data Sources:

- MAR Prov Return (UNIFY), Monthly Monitoring Database
- LDP trajectory

- Weekly Prov 18 week PTL Returns (Unity)
- New Methodology (RTT Total vs MARCOM exc. Diag.)

Appendix F: Glossary of 18 weeks terms

- **Ambushed** - Where the SHA is caught unaware by the DH.
- **Backlog** - Patients, who are in the system, have passed 18 weeks treatment but not had treatment.
- **Bounce back** - Organisations achieve the target at the expected date. However all resources have been employed in attaining the target. The target is no longer as important, it is now yesterday's news. Management become blasé, nonchalant in their attitude and expectations of clinicians ease. It is during this period that waiting times increase, hence the term bounce back.
- **Breach** - The target has been exceeded and the patient waited more than the demarcated period. All patients on entering the system are assigned have a breach date. If the waiting time should go beyond this date then they become a 'breach.'
- **Camouflage** - Where a small issue conceals a more complex problem.
- **Casualties** - 18 weeks is a national priority as such other targets are pushed aside. The achievement of 18 weeks takes precedence over less visible targets.
- **Clearance** - Organisations should be achieving above the target on a weekly basis. This is due to two reasons. Firstly, the thresholds and tolerance for achieving a target can change slightly; Trusts therefore do not want to fail because of one percentage point. Secondly, a Trust's performance varies throughout the year and hence over-performance seeks to compensate for those periods of poor performance.
- **Clock start** - An initial referral by a GP initiates a clock start; this leads to the start of first definitive treatment which is the clock stop.
- **Collateral damage** - Targets that are considered minor which are allowed to be missed in order that the high profile targets may be achieved. A shift in priorities may mean that high profile illness get preference, whereas the Cinderella services suffer further cutbacks. This also can refer to staff dissatisfaction or the loss a senior member of clinical staff due to the change in priorities.

- ***Fit and ready/ fit for action*** - The clock (re-)starts from the date that it is deemed clinically appropriate for the patient to undergo a procedure.
- ***Hollowing out*** - Where there has been a build-up of patients, a backlog develops. At periodic intervals extra capacity is created on a temporary basis and resource is identified to reduce the numbers waiting to be treated. When number of patients not treated in the appropriate timeframe has become significant, scrutiny from the DH or local media leads the executive team to implement remedial action. This short term measure is referred to as hollowing out.
- ***Legacy*** - Patients who are in the system yet not on an 18 weeks pathway. This is because their treatment started before the introduction of the 18 weeks policy.
- ***MIA*** - This is an actually a “did not attend”, DNA. Where a patient fails to attend an appointment/ admission without providing advanced notice to a hospital. Blame for a failure to attend was originally placed with the patient; however on further investigation a batch of appointment letters may have gone missing, making it a hospital administrative error.
- ***Near miss*** - Patients whose treatment fell close to the breach date because, they had fallen outside the system because of a lack of administrative focus on their pathway.
- ***Rallying the troops*** - The SHA’s role is to motivate organisations to continually strive towards the target. Organisations can feel disenchanted, because the target seems out of their reach or unrealistic. Long periods of poor performance can undermine an organisation’s confidence in its ability to achieve.
- ***Regime change*** - A new chief executive appoints new directors for an organisation that had been labelled failing on key targets including 18 weeks.
- ***Run rate*** - The average time it takes for patients to be treated and go through the system. If the run rate is too high it can be unaffordable for the PCT and therefore unsustainable in the long term. On the other hand, if the run rate is too low, it can lead to increased backlog and a breaching of the target.
- ***Smoothing*** - Where a graphical trajectory shows erratic performance, management suggest actions to prevent continued instability in the

system and provide a more sustainable approach. An inconsistent trajectory suggests that staff are on the back foot when problems arise and are not resilience planning. Hence there are no contingency plans in place for a higher volume of patients or an outbreak of illness amongst staff.

- ***Sudden death*** - 1) This is when management suddenly become aware that a specific department is using the old method of measuring, stages of treatment rather than referral to treatment. Stages of Treatment is divided into the time it takes to get a diagnostic appointment, an outpatient appointment and an inpatient appointment. You cannot add up the Stage of Treatment milestones and get a Referral to Treatment time. The total stages of treatment milestones exceed the RTT time. The volume of patients that would have to be seen and treated is too great. This leads to the sudden realisation that the achievement of 18 weeks target is completely out of reach. 2) It can also mean a complete missing of the target, rather than being near the target with the false expectation that you will be able to achieve that target shortly. Sudden death means that there are no unrealistic exceptions of what is feasible.
- ***Surrender*** - Clinicians “capitulate” to management pressure and adopt new ways of working, having previously been vocal and resistant to suggested change.
- ***Tolerance*** - The upper and lower limits of the target.
- ***Watchful waiting*** - This is another term for active monitoring when a waiting time clock is stopped as it is clinically inappropriate to provide treatment to the patient. It may necessary to understand how the illness progresses before ascertaining what would be the most appropriate treatment.

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“Of all creations I am the beginning and the end and also the middle, O Arjuna.”
Bhagavad- Gita: Chapter 10, Text 32.