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THE SOCIAL CONSTRUCTION OF MANAGEMENT INFORMATION SYSTEMS IN A HOSPITAL

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for my parents

Abstract.

This thesis is an exploratory case study of Management Information System (MIS) design and implementation in one large teaching hospital of the National Health Service. Two phases of MIS innovation are investigated. Firstly, the thesis reports on a failed attempt to introduce ward budgeting throughout the hospital. Secondly, the study follows a series of events leading to the creation and subsequent development of a Clinical Information Project (CIP). In particular, proposals aimed at establishing resource management are considered.

Throughout the study, MIS innovation is viewed as an 'organisational' issue rather than a 'technical' matter. In keeping with this organisational approach, a framework is proposed for portraying and analysing social processes in the case setting. This framework is composed of concepts drawn from the dramatic metaphor but extended to a more modern context by using the analogy of the 'soap opera' or continuous serial. The ongoing action at the hospital is divided into four dramatic episodes which forms the main body of the case study.

In addition to analysing the processes surrounding and contributing towards MIS development, the thesis depicts the entire research act. The research uses a qualitative method to investigate how health care professionals interpret and influence the MIS initiatives. A total of 35 unstructured and semi-structured interviews were undertaken with managers, nurses and doctors. These discussions were supplemented by more 'in-depth' fieldwork involving observation and participation during meetings and the analysis of documents.

Having collected a variety of case materials, these were analysed using grounded theory (Glaser and Strauss, 1967: Strauss, 1987) to develop explanations and understandings of why both MIS initiatives were 'rebutted'. A number of the themes emerged including the use of comedy, the politics of language and the manipulation of management structures. These factors all combined to ensure that MIS innovations were socially constructed to maintain rather than transform organisational realities.

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ABBREVIATIONS.

BMA - British Medical Association

CIP - Clinical Information Project

DGM - District General Manager

DIM - Doctors In Management

DHA - District Health Authority

DHSS - Department of Health and Social Security

HCE - Health Care of the Elderly

HISS - Hospital Information Support Systems

MEC - Medical Executive Committee

MIS - Management Information System(s)

MIU - Mental Illness Unit

NHS - National Health Service

OECD - Organisation for Economic Co-operation and Development

OR - Operational Requirement

PAS - Patient Administration System

PCT - Project Coordination Team

PGMEC - Post Graduate Medical Education Centre

PIS - Patient Information System

RCG - Radiology Consultants' Group

RHA - Regional Health Authority

RMI - Resource Management Initiative

RMS - Regional Maternity System

UAB - Unit Advisory Board

UGM - Unit General Manager

The Social Construction of Management Information Systems in a Hospital.

Preface.

The 1980's have been characterised by the search for better information and management in complex organisations. Institutions in the public and private sectors have invested heavily in computer-based information systems in the belief that such technical innovations could lead to improvements in decision making at each level of organisation. According to Morgan (1988), this trend is indicative of an 'information society' eager to digest the latest products available in the microcomputing and electronic communications industries. Economists prefer to locate the diffusion of information technologies in terms of a fifth Kondratiev wave of world economic development characterised by 'information and communication' (Freeman and Perez in Dosi (ed.), 1988).

It is clear that the application of micro-chip technology has the capacity to transform the nature and structure of many organisations. However, it has often been argued that the full potential of information technology has not been realised in organisations (for example, Willcocks and Mason, 1987). Brown (1989:18) concludes from a study on the use of information technology by the Organisation for Economic Co-operation and Development (OECD) that 'the most significant constraints on the use of information technology were not regulatory but organisational'. Such a finding is reflective of the fact that

information systems have too frequently been designed and implemented with little concern for the environmental and organisational contexts in which they are supposed to operate (Hopwood, 1978, 1983: Boland, 1979).

Given the apparent inability of organisations to exploit the full potential of information technologies, there is a need to explore the problems posed by developing MIS in complex organisations. This thesis reports on a detailed case study of the design and implementation of management information systems (MIS) in a large teaching hospital within the National Health Service (NHS). The research was undertaken at Camblewick Hospital, Northtown Health Authority from October 1987 to July 1989. During this period, managers at Camblewick attempted to introduce two MIS, the first being that of ward budgeting whilst the second involved the development of a Clinical Information Project (CIP). Both these initiatives were opposed and resisted by different groups within the organisation. Consequently, this study treats MIS design and implementation as an organizational issue and focusses on the cultural and political processes surrounding and contributing towards these innovations.

In addition to analysing the organisational implications of MIS development, the thesis depicts the process of the entire research act. Having witnessed many of the events leading to a 'rebuttal' of MIS, the author presents a strategy for conducting 'field' research in organisations as well as a reflexive account of the research process in practice. It is hoped that such a discussion not only provides researchers with ideas about how to 'get in, get

on and get out' of organisational settings but also facilitates the reader's attempt to judge the trustworthiness of the research.

The NHS is a particularly appropriate choice of institution for this study given the importance of information systems in the Government's proposals to reform the health service. Throughout the 1980's, the Conservative Government has argued for more health care to be squeezed out of existing resources in the pursuit of greater 'value for money' in the public sector. Information has become the key to this objective, itself a 'resource' that managers, doctors and nurses need to 'manage' if they are to become more efficient (Korner, 1982-84). Increasing amounts of financial support has been provided by the Government to enable administrators to collect the 'minimum' standard of information as defined by Korner for the requirements of the Department of Health.

This emphasis on data collection has been complemented by the Resource Management Initiative (RMI) which aims to operationalise this 'data' into effective management information at the hospital level. The White Paper publication 'Working for Patients' (Department of Health, 1989a) announced the Government's intention to extend the RMI from seven pilot sites to two hundred and sixty by March 1992. Such an information strategy is seen as a catalyst for securing a more dynamic, competitive and 'business-like' market in health care delivery. It is this movement towards information 'use' that provides a context for events at Camblewick Hospital.

It is assumed throughout this study that MIS innovations are complex in nature and present organisational participants with a variety of problems. Hospitals represent complex environments and, as yet, the available information systems are too simple to create adequate pictures of the organisation (Malvey, 1981). Indeed, the worry of many health care professionals is that, through the use of formal data, the work undertaken in the NHS may become pictured in purely economic terms without due attention being paid to the quality of patient care (see Lyall, 1989). Such concerns stress the fact that information system design and implementation is as much a social issue as a technical one.

Throughout this thesis, it will be assumed that the technical features of a MIS only become significant as an *outcome* of numerous rounds of negotiations between different groups of people. These discussions may involve identifying the problems that should be faced, establishing whether computer-based systems can provide data to help understand these problems and deciding how any new systems might be conceptualised. This is the area of ideas, concepts and meanings, the very substance of social activity, rather than the domain of computer hardware and software. Given that certain definitions of a situation may serve the interests of a particular individual or group rather than another, the technical design problem is intertwined with cultural and political considerations (Tichy, 1983: Pettigrew, 1985).

A researcher committed to understanding the meanings associated with designing and implementing MIS becomes interested in the following sort of questions: Who articulated the need to

introduce MIS in the hospital and why? How are these ideas being shaped and transformed by different individuals' interpretations of the initiative? Who supports the initiative and why? Who are the opponents and why? In sum, what are the dynamics of the process which either keep the initiative centre stage or leave it out in the wings?

This thesis contains ten chapters. In chapter one, consideration is given to the centrality of MIS development as a means towards the end of achieving 'better' patient care in the NHS. Such an instrumental view of organisation is contrasted with processual approaches to understanding organisational life rooted in the traditions of phenomenology and contextualism. The chapter is concluded with an analysis of case studies of MIS innovation using the metaphors of politics and culture.

Chapter two is divided into three unequal parts. Firstly, the author's particular methodological commitments are presented. It is these which have guided the entire research act. Secondly, a 'qualitative' research strategy is proposed. This leads the discussion into the third and final section, this being an account of the 'realities' of conducting a detailed case study over an extended period of time.

Chapter three of the thesis is concerned with proposing a conceptual framework for portraying and analysing organisational life. Having outlined the importance of the theatrical metaphor in combining a cultural and political perspective, a more modern form of drama is considered as a guiding analogy.

Chapters four to nine represent the main body of the case study material. Chapter four locates the study within an environmental context; namely, that of the NHS. Particular attention is given to the uniqueness of the health service and the problems associated with resourcing such a large and complex institution. This is followed by an examination of how the Government has sought to intervene in the way the NHS is managed.

The organisational context of the hospital under study (Camblewick Hospital) is given full consideration in chapter five. Camblewick's culture is studied before showing how previous innovations in management and information have been interpreted and understood by key players at the local level.

Chapters six to nine are devoted to an analysis of the process of MIS development within Camblewick Hospital over a twenty-one month period. Chapter six portrays events leading to a proposal to introduce budgeting at the ward level. Chapter seven is concerned with the emergence of a new wave of innovation intended to extend responsibility for the management of resources to clinicians throughout the hospital. The evolution of this Clinical Information Project (CIP) is traced throughout chapter eight as the different stakeholders intervene to shape the meaning of the project. In chapter nine, tensions between different parties reach a climax as proposals for a new organisational reality are presented to senior health care professionals at Camblewick.

Finally, chapter ten pulls together the themes which run through the case study. A secondary analysis of the case material

provides the basis for the final conclusions.

Chapter one: Management Information System Innovation. Organisational Processes and Organisational Contexts .

1.0 Introduction.

This opening chapter is divided into five parts. In section 1.1, consideration is given to the issue which prompted this research inquiry. In short, this is a critical examination of the claim by the Government and health service managers that providing 'better' information for NHS staff will lead to 'better' management of health care resources. In section 1.2, it is argued that a belief in this causal relationship is informed by a 'rational', 'mechanistic' view of 'organisations'. Such an approach takes no account of the experience of individuals and how they singularly and collectively make sense of new initiatives such as information system developments. It is this concentration on 'meanings' which is an essential part of the 'phenomenological' approach taken in this study. Phenomenology is a distinctive tradition in the Social Sciences and given full attention in section 1.3. Whilst the primacy of meanings is stressed in the third subsection, the main concern in the next part of the chapter is that meanings cannot be understood out of context. The main features of a contextualist stance are presented in section 1.4 with the conclusion being that phenomenology and contextualism are complementary approaches. Finally, in section 1.5, the focus switches to the extent to which such an approach has been applied to studies of information system design and implementation.

1.1 The Research Issue: Better Information Leads to Better Management and Better Care?

It was argued in the preface that world economic development in the 1980's has been characterised by a fifth Kondratiev wave of 'information and communication'. In this first section, consideration is given to how the topic of 'information' and associated system developments have become issues of particular significance in the NHS. Having briefly introduced the Conservative Government's 'information' initiatives for the NHS (these are discussed in more detail in chapter four), attention is then given to the causal relationship which underlies these innovations and how this explanation is found to be insufficient.

During the 1980's, information became a topic of considerable interest throughout the NHS. In 1979, the Royal Commission on the NHS identified the need for an 'improvement' in hospital information systems. An investigation into this issue formed the brief of the Korner Steering Group which was set up in 1980 by the Government via the Department of Health and Social Security (DHSS). Six 'Korner' Reports were published by the Group between 1982 and 1984. These reports specified 'minimum data sets' to 'provide...the basic information without which authorities and their officers would not be adequately informed when fulfilling their responsibilities' (Korner, 1984:5). Collection of 'Korner' type data became a requirement for all hospital units in April 1987 and considerable resources were made available by the Government to develop computer systems throughout the service.

Alongside the Korner project, there have been other 'information' related initiatives in the NHS (see chapter four). These include the development of management budgeting as publicised in the Griffith's report (Griffiths, 1983), the subsequent 'Resource Management Initiative' (RMI), the evolution of a National Strategic Framework for Information Development (DHSS, 1986b) and the White Paper 'Working for Patients' (Department of Health, 1989a). Whilst there may be a variety of reasons for the Government's sponsorship of information system developments (eg. providing information for an internal market in health care, introducing competition throughout the service, privatising the NHS, serving the needs of a monetarist philosophy etc), the initiatives have been put forward via the Department of Health with the stated intention of reducing perceived inefficiencies and, more positively, suggesting changes which are intended to ensure that patient care will be improved.

The relationship between information provision and the management of health care is clearly stated in relation to the RMI. In 1986, the NHS Management Board launched resource management in an attempt to provide clinicians and other managers with information combining patient activity data to the costs of running the service at the hospital level. The information system was seen as the 'catalyst' for change, the main objective being to draw clinical practitioners into the management process. With the production of this new information, it was hoped that doctors and nurses (as well as other managers) would start to make 'more informed judgements about how the resources they control could be used to maximum effect' (NHS Management Board Bulletin, August

1987:3).

Since the introduction of the RMI, the Conservative Government has used the initiative to publicise the connection between information provision and improvements in health care. In the Government's White Paper, 'Working for Patients' (Department of Health, 1989a:16), the following case was put forward for developing the RMI in upto two hundred and sixty hospitals by March 1992:

> The Government recognises that managers and professional staff need better information if they are to make the best use of the resources that are available to them

and desire that...

> the new systems are actively used for the benefit of patients.

In desiring the 'best use' of resources, the Government appear to regard information provision as a way of enabling health care professionals to monitor their own activities and improve the way they perform their daily tasks. The computer-based information is the 'means' towards achieving some 'end' such as a tighter relationship between services and their respective costs.

The belief that information system developments lead to an improvement in organisational performance has not been confined to reports from the Department of Health. The connection also permeated through to health service managers. For example, Mike

Fairey (NHS Management Board Director of Planning and Information Technology) stated in a press release in October 1986 that:

> Our joint task is to ensure that the investment being made by the NHS in information and information technology systems not only leads to improvements in the range and quality of data that is collected, but more importantly makes certain that the resulting information assists doctors, nurses and managers at all levels in the NHS in the performance of their duties (DHSS, press release 86/308).

Put simply, the causal link informing much of the debate on 'information' in the NHS has been that 'better information leads to better care'. Indeed, this has been the title for conferences in the NHS. The Health Service Journal set up such a conference in October 1987 at the Kensington Town Hall to discuss such a subject. In a report in Public Finance and Accountancy (6th November, 1987:18), a correspondent suggests that the title for the Conference might better be described in terms of 'better information leads to better management which leads to better care'.

Throughout the thesis, it is argued that the causal link between information provision and 'improvements' in the management of health care is somewhat incomplete. Such a statement can only ever be a partial truth. The position adopted here is that the design and implementation of MIS needs to be understood in relation to the organisation as a whole. This is because technical innovations are intertwined with cultural and political

considerations (Tichy, 1983). Having made this assumption, the provision of 'more' and 'better' information can only be a 'necessary' but not 'sufficient' condition for achieving a more 'efficient' and 'effective' health service.

It should be clear from the last paragraph that understanding the relationship between MIS development and organisational action depends upon how the researcher views the organisational and social world. It is these matters which provide a focus for the next two sections.

1.2 Viewing Organisations.

The development of computer-based information systems and 'better' information does not take place in a vacuum but occurs within 'organisations'. In subsection 1.2.1, the question arises just what is an organisation? In part 1.2.2, a case is made for locating the study within a processual perspective of organisational life. The next two subsections focus on two important process images, these being the metaphors of culture (1.2.3) and politics (1.2.4).

1.2.1 What is an organisation?

Analysts of organisations have tended to use different metaphors to conceptualise organisation. Morgan (1986) undertakes a comprehensive analysis of the various perspectives on organisation in the text 'Images of Organisation'. These include metaphors such as the machine, organism, political system,

theatre, culture, text and prison.

Watson (1986) groups theories of organisation by using the wave metaphor. According to Watson, there have been three successive waves in the evolution of organisational theory and the most up-to-date set of ideas represent the third wave. The first wave of theories views organisations as machines. This grouping represents the classical approaches to administration (Fayol, 1949), scientific management (Taylor, 1911) and theories of bureaucracy (Weber, 1968). The second wave characterises organisations as organisms and includes the human relations school (Mayo, 1949), the systems approach (Katz and Kahn, 1966), sociotechnical systems theory (Trist and Bamforth, 1963) and contingency theory (Woodward, 1965: Burns and Stalker, 1961: Lawrence and Lorsch, 1967). The third wave imagines organisations as social and political processes and covers theories such as the negotiated order approach (Strauss et al, 1963), decision process theory (Cohen, March and Olsen, 1972), cultural and micropolitical perspectives (see below).

The first wave of organisational theory treats organisations as though they can be rationally devised to perform specific tasks in the pursuit of pre-specified ends or goals. People are the cogs in the machine, having clearly defined tasks to perform within a total complex of rules, regulations and procedures. The machine image emphasises conformity, predictability, impersonality and above all, rationality.

The second wave of theories approach organisations as if they are living organisms or natural systems existing in an evolving environment. These systems interact with the environment for their survival and depend on it for their continued existence. The various subsystems of the organism combine in a dynamic living system in a cycle of input-throughput-output sequences. Whilst the relationship between the parts of the organism is significant, it is the 'fit' between the environment and the organism which is of primary importance.

The third and final wave of theories are the processual perspectives on organisational life. In viewing organisations as social, economic and political processes, organisations are less to do with objectivities and organisational goals and more to do with subjectivities and negotiated orientations. The central argument in process theories is the need to view organisations as social entities, characterised by the creation and recreation of social order. Organisations are merely arenas in which 'people act, interact, interpret and make sense of themselves, their actions and their interactions' (Preston, 1987:82). This is a dynamic perspective on organising activity where processes are more important than rigid structures.

The metaphors in each wave represent distinctive yet partial ways of thinking about organisation (Morgan, 1980, 1986). Morgan (1986:16) argues that we should 'use the insights generated by different metaphors to produce a diagnostic reading of the situation being analysed and then move to a critical evaluation of how the various insights relate'. This multiperspectival approach

to the study of organisations is seen as a 'practical tool' for seeking out organisational problems and for the management and design of organisations. This is not the intention here. Such an approach to understanding organisations is in danger of seeing everything and yet, nothing - of creating a mythical monster which is too vividly portrayed. Whilst it is important, if not essential, to remain open to different approaches within a particular wave, to mix metaphors by trying to combine theories from all three waves is to risk plunging into a whirlpool of confusion (see Mangham, 1987).

1.2.2 Locating the research issue within a processual perspective.

Having briefly introduced three waves of organisational theory, it is worth returning to the research issue concerning the relationship between information system design and implementation and ongoing organisational activity. It is clear that the notion that 'better' information leads to 'better' management which leads to 'better' care contains a number of assumptions about the nature of organisational life. Such a causal relationship appears to 'take-for-granted' that the organisation is like a machine or organism rather than a social process. This claim needs further explanation.

When treating organisations as machines, a 'rational' model of human beings is adopted. In metaphorical terms, people are the 'cogs' to service the 'machine-like' organisation. Information systems are part of the infrastructure of the organisational machine and provide the machine with the necessary data to meet

clearly defined objectives. It is assumed that there is no ambiguity and the parts of the machine work together to benefit the organisation as a whole. If a hospital is seen in these terms, then developing MIS and improving formal information flows will be seen as naturally leading to a more 'efficient' and 'effective' organisation.

Similarly, the metaphor of organism can accomodate the 'better' information - 'better' care' link. For example, taking a contingency view of organisation, MIS is one variable to be juggled amongst others in an attempt to find the perfect match of situation and structure for that particular organisation (or organism). Choosing the 'right' information technology for the given situation will presumably enhance organisational performance (albeit that this does depend on other variables, unlike the machine metaphor).

Given that this thesis takes a more critical stance on the relationship between MIS developments and organisation, the first two waves of organisational theory appear to be inappropriate. What is required is an approach to organisation which does not assume a linear relationship between 'variables' but is able to allow for a variety of perspectives and interests in the social world. Whilst human beings can be seen as rational human beings pursuing ends, Weber's (1968) notion of a paradox of consequences suggests that there is no direct relationship between their efforts and the resulting social arrangements. Human actions may have consequences which differ from what was originally intended and even be in direct opposition to it (see Watson, 1986:53).

A more fluid and dynamic perspective which can accomodate the complexity of the social world must start from a position that 'everything depends on everything else' (Mintzberg, 1979). Such a view is accomodated in the process theories of organisation (eg. organisation as cultures or political arenas). Instead of assuming a relationship between 'information' and 'organisation', the status of both these things is questioned. A researcher adopting a processual view of organisational life is wary not to treat organisations as a 'thing' - such reification is, as Watson notes (1986:63) to 'commit the fallacy of misplaced concreteness'. The social scientist pursues a policy of trying to understand the experience of organisational members and how they make sense of initiatives such as MIS development.

Having located this study in the third wave of theories (primarily, organisations as social and political processes), the chapter continues by examining the metaphors of culture and politics.

1.2.3 Organisations as cultures.

The metaphor of culture has been the 'fad' of the 1980's for both the organisational theorist and the practising manager. There has been a proliferation of studies using different conceptions of culture which have been 'taken' from the field of social anthropology (see Smircich, 1983a, Allaire and Firsirotu, 1984). Smircich (1983a) makes a telling distinction between this diverse body of literature; that of using culture as a variable and culture as a metaphor. Using culture as a variable is to treat

the concept instrumentally - it is something an organisation has. For example, Peters and Waterman (1982) use the concept of organisational culture to suggest some basic beliefs or shared values which are meaningful to members. Culture is therefore an integrating device which is part of the internal environment. Managers can shape and manipulate meaning through the use of evocative stories, myths, rituals, specialised language, slogans and other symbolic devices (see Pettigrew, 1979). The implication is that managers should attempt to influence the socialisation of organisational participants so that they come to hold certain values which are believed to be necessary for corporate success (Peters and Waterman, 1982, Deal and Kennedy, 1982). Culture becomes a variable which contributes to organisational effectiveness and therefore, more at home in contingency theories of the second wave of organisational theory.

Culture, when used as a metaphor, is viewed as a form of human expression rather than a purposeful instrument. As Smircich (1983a:353) emphasises:

> ...the social or organisational world exists only as a pattern of symbolic relationships and meanings sustained through the continued processes of human interaction.

When used metaphorically, culture is something an organisation is rather than something it has. The researcher's attention switches from what do organisations accomplish and how can they accomplish it more efficiently, to how is organisation accomplished and what does it mean to be organised (Smircich, 1983a). For those such as

Smircich (1983b) who follow the 'interpretive' anthropology of Geertz (1973), organisations are viewed as 'webs of shared symbols and meanings' which are created and continually recreated by people through their social interaction. Organisations are continually in process and behaviour is found to be meaningful by an act of interpretation: people actively make sense of what they observe. Weick (1979) labels this process through which we shape and structure our realities that of 'enactment'. Organisations are social constructions or social enactments, maintained through symbolic modes (eg. language) that facilitate shared realities or 'intersubjectivity' (Schutz, 1973, 1976).

The studies of organisation mentioned above (ie. Pettigrew, 1979, Peters and Waterman, 1982, Deal and Kennedy, 1982, Smircich, 1983b) tend to treat culture in terms of unity and understanding between people. These rosy pictures of culture gloss over the possibility of conflict, misunderstandings and differentiation that are characteristic of complex institutions (see Frost, 1985). It is important not to treat the sharing of symbols as being equivalent to the sharing of meaning. This point is made forcefully by Cohen (1985:16):

> Culture, constituted by symbols, does not impose itself in such a way as to determine that all its adherents should make the same sense of the world. Rather, it merely gives them the capacity to make sense of the world and, if they tend to make a similar kind of sense it is not because of any deterministic influence but because they are doing so with the same symbols.

As the author has written elsewhere (Munson and McNulty, 1989), the paradox of symbolism is that symbols, such as language, are a commonly available resource to enable people to enter into a discourse and yet the way in which those symbols are interpreted is dependent upon the individual's own mental framework. This recognition of a variety in the sense-making abilities of human beings takes account of organisations as cultural bearing miliuex (Louis, 1983). Furthermore, if the meanings ascribed to symbols cannot be assumed to be shared, this opens up the possibility of viewing organisations as a struggle of competing rationalities; organisations become contests in meaning (Woodward, 1987) as individuals largely interpret symbols to suit their own particular interests at the expense of others' definitions.

1.2.4 Organisations and micropolitics.

Writers such as Burns (1969) have long been aware of the plurality of interests, conflicts and sources of power that shape social systems. Organisational theorists have pursued this basic insight by treating organisations as consisting of individuals and groups, alliances and coalitions, each attempting to gain something from the collectivity by interacting with others and yet each acting to secure its own set of preferences and objectives (Cyert and March, 1963, Pettigrew, 1973, Pfeffer 1978, Mangham, 1979). In short, the metaphor of micropolitics focuses attention on the conflicts of interest between individuals and groups within organisations and the role of power in determining outcomes. The researcher committed to this perspective becomes interested in who is benefiting and who is losing from the activities undertaken

inside the walls of the organisation.

When adopting a micropolitical stance, organisations are not rational decision making mechanisms or adaptive organisms but arenas for internal bargaining. Individuals and groups cooperate and compete with each other, making use of power resources to achieve certain outcomes. The term 'power' is used to refer to the capacity of individuals or groups to affect the outcome of any situation in such a way as to ensure access to valued resources (Watson, 1987). We have already identified the manipulation of symbols as a potential source of power but others have been identified in the literature; for example, the establishment of formal authority, the allocation of scarce resources, use of rules, the control of decision processes and the control of information flows (see Morgan, 1986).

Pfeffer and Salancik (1978) go further than the organisational domain to suggest that organisations are dependent on external constituencies in the environment for their survival. However, the environment is not 'fixed' but can be manipulated through political behaviour to fit the objectives of the dominant coalition. Such a view offers new opportunities for thinking about the context of organisational activity.

To summarise, process metaphors such as culture and politics offer an insight into the fluid and dynamic nature of the organisational world. The researcher adopting these perspectives is able to probe into the complexity of social activity within organisational settings. Organisations are not distinct entities, but treated

as socially constructed phenomena; that is, causal schema collectively produced and reproduced through action and interaction (Dent, 1986:1). Within this context, the relationship between MIS development and organisation is no longer straight forwards. The meanings ascribed to information systems are both constitute and reflect organisational 'reality' (Hopwood, 1983).

Having established an interest in the domain of meanings and organisations as socially constructed realities, the next section of the chapter locates process theories of organisational life within the Social Science tradition of phenomenology.

1.3 Phenomenology and the Social Construction of 'Reality'.

This section begins by considering what is meant by phenomenology and the notion of a socially constructed 'reality'. In 1.3.1, it is argued that there are two traditions within the phenomenological literature, these being the weak and strong forms. However, the author adopts an intermediate position. The remainder of the section is concerned with reinterpreting a processual approach to organisation within 'phenomenological' terms. Three important characteristics of process theories are considered. In 1.3.2, the creative, situational-defining characteristics of individuals is emphasised. Subsection 1.3.3 deals with the formation of alliances and engaging in political activity in 'organisations. Finally, 1.3.4 switches attention towards the important area of enacted environments.

1.3.1 Introducing phenomenology: Weak versus strong forms.

Phenomenology is the investigation of how people individually and collectively isolate, rearrange and make sense of streams of experience (Weick, 1979). Phenomenology embodies the assumption that 'reality' is an ongoing construction, a product of the subjective and intersubjective experience of individuals.

Schutz (1973,1976) is the person who is primarily responsible for developing a phenomenological position within the social sciences. Schutz, takes his departure point from the philosophy of Husserl in being interested in an analysis of the 'natural attitude' - that is the ordinary way that people see things and attain knowledge of the world. For Schutz, the natural attitude can alternatively be described as the commonsense world or the everyday world. These concepts are used to stress how the world is taken-for-granted by its members. The task for the phenomenologist becomes one of suspending the 'natural attitude' and investigating how people create and know the social world.

Schutz explicitly follows Weber (1968) in stating that those interested in studying social behaviour should interpret the actions of individuals in the world and the ways in which individuals give meaning to social phenomena. The emphasis, here, is on what Weber calls 'social action' - the meaningful acts of individuals. However, Schutz argues that Weber stops at this point, taking social 'reality' as given rather than as problematic. Weber, therefore neglects to inquire into how it is possible that people experience and construct a common and

'objective' world. Schutz wishes to understand this very process of experiencing - not amongst isolated individuals but those who interact and share the same assumptions about social 'reality'. As Berger and Luckmann state, 'men *together* produce a human environment' (1967:69). So, what are these shared assumptions that allow people to negotiate 'reality' interpersonally?

According to Schutz, we come to 'know' the world through the accumulation of a shared stock of knowledge. Society provides us with a language which enables us to define the typical features of the social world. We learn to classify the things we experience into types such as 'houses', a 'postman', an 'argument' and so on. These categories or 'typifications' are handed down by our predecessors and comprise our commonsense knowledge. This knowledge provides individuals with a frame of reference to make sense of their own actions and those of others. As Silverman (1975:277) argues:

> Everyday language possesses what Schutz calls a 'treasure house' of ready-made, preconstituted types and inbuilt relevances which constitute the individual's stock of knowledge.

As Berger (1966) has written, 'society makes man' by virtue of providing us with a 'treasure house' of knowledge to organise our streams of experience and render the environment meaningful. But this is not the full story. Berger also makes it very clear that 'man makes society'. In Berger's words, 'our own meaningful acts help to support the edifice of society and may on occasion change

it' (1966:149). Silverman (1970) is equally clear about the status of society, arguing that particular constellations of meaning are only sustained by continual reaffirmation in everyday actions. This leads the argument gently towards the central paradox of the social world that 'society makes man and man makes society'. Berger and Luckman (1967:78) in their major work, 'The Social Construction of Reality', summarise the paradox as follows:

> Man is capable of producing a world that he then experiences as something other than a human product.

This interdependent relationship has long been a central concern for sociological analysis and one which emphasises that the production and reproduction of society should be treated as a skilled performance on the part of its members (Giddens, 1976). Such an approach is important to the research problem because it stresses the importance of the individual's conduct to any understanding of MIS processes in 'organisations'. For the organisational researcher influenced by a phenomenological perspective, the way human beings enact and interpret MIS initiatives is both constitutive and reflective of organisational realities (Dent, 1990: Gray, 1990: Hopwood, 1990).

Schutz's image of social 'reality' is a view based on consensus and understanding between people because it relies upon two main presuppositions - intersubjectivity and reciprocity of perspectives. Intersubjectivity assumes that, for all practical purposes, people inhabit a common and shared world. By the term the reciprocity of perspectives, Schutz refers to the fact that

actors commonly assume that events and actions in the social world are understandable to others in the way that they are understandable to themselves. This harmonious picture suggests that there is an underlying pattern and order within the world to be discovered by people. 'Reality' becomes located in these patterns of interaction and 'constructed' to the extent that individuals interact, negotiate between themselves and seemingly agree (in Schutz's terms at least!) as to what it is 'out there'. This *inter*subjective characterisation of the social world I shall call the 'weak' form of phenomenology.

An alternative to the weak position is that the social world is constructed purely in the heads of individuals. To take this cognitive position is to be an idealist (Clegg, 1983) and represents the 'strong' form of phenomenology in being *entirely* subjective (rather than intersubjective). What is useful about the 'strong' thesis is that it stresses the uniqueness of the individual's interpretation of 'reality' rather than assuming that the only factors which determine what men believe or 'know' are social factors (Radford, 1985:17). As Radford maintains:

> ...sometimes what a man believes and thinks he knows is determined not by what he is taught or the prevailing beliefs to which he is exposed, but by what he perceives or thinks of for himself, about which his fellow men may have no views (1985:17).

Such a position is close to that held by Weick (1979:165) in that he entertains the idea that 'people, often alone, actively *put*

things out there that they then perceive and negotiate about perceiving. For Weick, knowledge does not just flow from objective features of the surroundings to the individual trying to make sense of the world. The additional possibility is that the individual 'partly interacts with and constitutes the object' (Gruber and Voneche quoted in Weick, 1979:165). The environment is seen as an output of the organising work of individuals.

The position adopted in this thesis is similar to that of Silverman (1970) and Jones (1987). In his 'action' framework, Silverman notes several propositions which are essentially 'phenomenological' in nature. Those propositions which are central to the concerns of this chapter are that research should be orientated to understanding 'action', that meanings are given to men by their society and yet, only sustained by being continually reaffirmed by men. Lastly, it is through interaction that men transform social meanings.

This 'phenomenological' orientation is further clarified by drawing from the work of Jones (1987:24) who is careful not to emphasise either the 'strong' or 'weak' form of phenomenology at the expense of the other. Jones is concerned with 'the meanings of action, individuality and multiple meanings'. She summarises her stance as follows:

> The researcher who is rooted in actors' meanings, debates and actions is continually reminded of the multiplicity of perspectives for construing 'reality', of how what is 'given and immutable' is indeed often a matter of interpretation and

human ingenuity, that historical cultural and social structures may define parameters of vision and action but do not totally determine outcomes (1987:28).

Such a perspective holds open the door for both what is 'common' in a situation and also how persons 'differ' in the way they intepret and understand that same situation. It allows for consensus and conflict.

Having introduced a phenomenological approach to understanding the social world, how might a processual perspective on organisations (see section 1.2) be reinterpreted to take account of these ideas? Following Watson (1986:63), three themes are discussed. The first of these is the importance of the individual for understanding conduct in organisations.

1.3.2 The importance of individuals.

Process theories respect the creative potential of the individual by stressing that they are the initiators of action and not just the responder. Returning to the paradox of social life outlined earlier in the chapter, people literally create their own constraints as they are motivated to reduce ambiguity and uncertainty in the world. The individual is seen as an active sense-maker in search of meaning. As Morgan (1980:617) states:

...organisational realities are to be seen as ongoing social constructions, emerging from the skillful

> accomplishments through which organisational members impose themselves upon their world to create meaningful and sensible structure.

In the context of the research problem, MIS initiatives may be prompted by a desire to reduce uncertainty and make sense of the organisational and social world. However, the interpretations that individuals place upon such initiatives is not assumed to be the same. Although people have stocks of knowledge that they share in part, their mental frameworks of beliefs, attitudes, theories, prejudices, expectations, values and objectives are unique (Eden et al., 1983). This is because each one of us has our own particular 'biography' which is the sedimentation of all our previous experience - it is our unique possession (Schutz, 1973:9). Our biography is our life history which is distinctive because each of us has met with a different combination of people and situations. As Mangham (1978:47) notes:

> However common the interpretation, however taken for granted the meaning, it is always and inevitably influenced by the fine gauze of experience.

Natanson, in his introduction to the collected papers of Schutz (1973), suggests that our biography is important given that it defines the way in which organisational participants locate the arena of action, interpret its possibilities, and engage its challenges.

1.3.3 Forming alliances and engaging in political behaviour.

Because individuals have distinct perspectives and particular projects in life, when they come together in any continuing situation, they may not reach agreement about what they are trying to achieve and how they should get there. This diversity of opinion may well be reflected in many strategic issues, including whether to develop MIS or not and, if so, in what way? Such a principle reinforces Thomas's (1923) argument that organisational members are very capable of constructing their own definition of the situation. It is obviously in everyone's interest to get others to accept their version of 'reality' and individuals bargain and compromise, thus forming alliances in order to gain support for their definition (Eden et al., 1983). This is the essence of political behaviour.

However, as Berger and Luckmann (1967) have pointed out, not all constructions of 'reality' carry equal impact in the course of negotiations. Over time, groups and ideas win out over others and these patterns of meaning are often institutionalised (Watson, 1987). People learn to enact and reenact these same definitions for they become taken-for-granted assumptions and part of our stock of knowledge. This is not to lose sight of the fact that these 'enacted environments' can be challenged - they are always open to alteration (Colville, 1981:127).

1.3.4 Enacted environments.

Just as organisations are social enactments and not viewed as distinct from individual's interpretive schema, the wider environment is also considered to be enacted. The 'environment' is not 'external' to the 'organisation' in the sense of individuals having to adapt to it. Rather, people construct and reconstruct the environment in social action. As Knorr-Cetina states (1981:11):

> ...the environment, the context, the setting of social action emerge as something towards which action is directed, which is lived and reflected upon, rather than being 'external' to social action.

For any organisational member, there is an environment 'out there' but it is made up of other organisations whose participants are shaping action in accordance with their favoured interpretive schemes which may have consequences for the way others' view the environment. Organisations shape and respond to the environment according to what their members' perceive and believe about the world. Therefore, the environment is not static but in a state of flux due to this ongoing process of enactment.

Given that the 'environment' only becomes meaningful to people when it is enacted, it is worth spending some more time describing this process. Weick (1979) has written extensively about the enacted environment. 'Enactment' captures the activity involved when individuals bracket some portion of the stream of experience

for further attention. People 'wade in' to a stream of events and make available these segments so that some equivocality can be reduced and a sense of order 'imposed'. This process of interpretation is accomplished through interaction where people engage in collaborative sense-making. The 'selected' interpretations can create a sense of shared 'reality' which contributes to the norms and values which pervade the community.

Products of interpretive acts are 'retained' in the form of 'cause maps'. These cause maps are similar to Schutz's concept of 'stocks of knowledge' or Geertz's 'webs of meaning' which were described earlier. Cause maps are templates of constructs linked together in cause-effect relationships. They are a resource available to organisational members in any future attempts to make their 'environment' meaningful. These retained cause maps determine what parts of the environment are responded to in current situations and what meanings are given to the results of those interactions (Wicker, 1980:715). The 'enacted environment' is, therefore, an output of organising activity and not an input. It is the product of successful sense-making activity on behalf of organisational participants.

In sum, section 1.3 has been concerned with locating the study within a particular tradition of the Social Sciences. It was stressed that a phenomenological research strategy puts the meaning of social conduct at the centre of the analysis. In terms of the present inquiry, it was argued that the researcher should seek to understand how the meaning of organisational 'reality' may both shape and reflect the ongoing process of MIS development.

Complementing this approach is a concern for locating meanings within a particular context. Matters of context are dealt with in the next section.

1.4 Adopting a Contextualist Position.

Having decided to research MIS development as an organisational issue, any such innovations need to be located within an organisational context. But what is meant by taking a contextualist stance? Feldman (1986) suggests that many theorist feel the need to locate their study within a particular context without necessarily knowing what they are expected to do. As a means of clarifying the situation, Feldman (1986:591) suggests that culture is context since 'action is meaningful only in terms of the symbolic context in which it is interpreted'. Having already introduced the topic of 'culture' in section 1.2.3, this understanding appears to be only partial. Context is a broader term to describe the background against which phenomena need to be located if they are to be understood.

Pettigrew (1985, 1987) argues that a contextualist analysis must take account of relations between the 'inner' or micro context and that of the 'outer' or macro context. In this study, the terms organisational context is preferred to inner context. Organisational context includes the cultural and political filters which shape the way members of the organisation understand new innovations such as MIS development. Similarly, the outer context is termed the environmental context and this domain provides individuals with the raw materials for making sense of the world

beyond the organisational setting (Weick, 1979).

The relationship between the organisational and environmental context is often blurred given that people are likely to enact different environments. Indeed, context can be used selectively by individuals to enable or inhibit certain courses of action. Therefore, the way a situation or problem is defined is in itself a political process. There is a need here to analyse how individuals go about attempting to alter social conditions in order to achieve certain goals or ends. Equally, it is important to consider those that feel constrained by the enacted organisational or environmental 'reality'.

Another aspect of a contextualist perspective is to examine the 'interconnectedness' of events over time. According to Pettigrew, it is the historical context of any one particular phenomenon which provides the event with 'form, meaning and substance' (1987:655). Put in simple terms, current events need to be understood in terms of what has happened in the past. Often, members of a particular institution will enact the same stories and dramas as a way of providing the present with meaning.

Mangham (1987:8) does his best to convey the processual nature of a contextualist approach to understanding the social world by describing a number of familiar activities:

> The best way to convey the notion of contextualism is to use verbs. It is...making a boat, running a race, laughing at a joke, persuading an assembly...These acts or events are all

> intrinsically complex composed of interconnected activities with continually changing patterns. They are like incidents in the plot of a novel or a drama. They are literally the incidents of life...What the contextualist seeks to depict is the rich, concrete act in which features interpenetrate and may never be repeated in precisely that configuration. Change and novelty are central features of social life.

In accordance with Pettigrew's understanding of context, Mangham regards events as being 'interconnected'. Life is seen as a fluid stream of ongoing activity. Whilst patterns may be found amidst the process, any one pattern may never be revealed in the same form again. Thus, the task of the researcher is to capture the richness of 'reality in flight', making sure the emphasis is on 'becoming' rather than 'being', of individuals and organisations 'in motion' (see Pettigrew, 1985:36).

To conclude this section, the processes through which the organisation and the environment becomes meaningful to individuals is the major concern of a contextualist perspective. To the extent that the 'corpus of convention' is shaped by the 'interpretive efforts' of particular individuals, the domains of culture and politics are intertwined. Such a position fits well with the processual and phenomenological perspectives outlined above. The next section of the chapter considers the extent to which this broadly social constructionist approach has been applied to case studies of MIS design and implementation in organisations.

1.5 Viewing Management Information Systems in Organisations.

In this part of the chapter, the focus narrows to consider the topic of MIS. In the first subsection (1.5.1), different definitions of MIS are presented. These range from the production orientated view through to a decision process model. An alternative approach to viewing MIS is offered. In 1.5.2, it is argued that MIS should be studied in an organisational context. A number of studies of MIS in organisations have been conducted and these are reviewed in the next three subsections. These case studies are split according to the particular metaphor used. Section 1.5.3 is devoted to culture and MIS, 1.5.4, symbols and MIS, whilst the final section (1.5.5) tackles the area of politics and MIS.

1.5.1 Conceptualising MIS.

What is a Management Information System? According to Lucey (1987:1), many texts treat MIS as largely synonomous with computer data processing:

> ...many books with MIS in the title turn out to be exclusively concerned with topics such as systems analysis, file design and the various other facets of computer-based systems. The emphasis results in a production-orientated definition of MIS.

This production-orientated view of MIS is dominated by the question of how information is produced. In this context,

information is loosely described as processed data. The typical manual on MIS is located in the field of Information Technology, concentrating on the administrative use of computer systems. The question posed is that of how best to collect, store, retrieve, communicate and use data to improve planning and the efficient management of operations within the business.

The logic of this production-based orientation is to concentrate on technical design. Whilst computers are an important aspect of MIS, the single, total integrated MIS computer system is a myth (see Preston, 1982). MIS can only provide materials which may become information once they have been made meaningful through the interpretive acts of individuals. Furthermore, the computer is only one source of raw material. Others might include letters, memos, newspapers, telephone conversations, face to face interactions etc.

Another stream to the MIS literature is that which takes a decision process or communications approach (eg. Ackoff, 1974: McCosh et al., 1981: Davis, 1982: Lucey, 1987). This body of work takes seriously the 'user', aiming to transmit 'useful' information to 'receivers'. User involvement, along with top management support for MIS developments, are considered to be necessities if MIS are to be designed 'effectively'. The effective MIS is one that is congruent with the decisions taken by users (usually thought to be 'managers') in their day-to-day work. This means harnessing the power of the most recent technical innovations to provide regular 'information' flows to supplement more 'informal' (ie. unofficial and unplanned) sources of

information. Those working to a decision process model of MIS also assume that managers do not know what sort of decisions they make or what information they need. The task of the MIS designer is to model how the organisation works in terms of a system of input and output data flows. The model is 'solved' when two conditions have been met:

(1) the goals, tasks and decisions have been defined for 'optimum' performance of the organisation.

(2) the information is available to support the setting of goals, the definition of tasks and decision making.

This concentration on decision processes does not treat the social world as complex and ambiguous but as simple and knowable. The approach represents no more than a 'stimulus - response' model of behaviour. Information is regarded as a stimulus which, for a given problem, will elicit a particular and predictable response (Preston, 1982). The notion of MIS is one of a formal and proceduralised recording, processing and reporting system which is intended to serve purposive, rational and goal directed behaviour (Preston, 1986). In short, this view of MIS reproduces the view of organisations as machines or systems.

Boland (1979:261) calls the decision process perspective on MIS the 'model' based approach. He outlines several problems with this view:

> A basic problem with model based approaches to defining information requirements is that they tend to result in conceptions of the organisation as being in a static equilibrium, interacting with an environment which is effectively knowable, objectively verifiable and inconsequentially affected by the action of managers.

It is perhaps because of these problems that information systems have often been uninformative (Mitroff and Mason, 1983). Traditionally, designers of MIS have tended to forget that the social world is complex and that there can be as many problem definitions within the organisational setting as there are interested parties. As a result of poor attention to multiple realities of different individuals and groups, MIS have tended to produce too much random data for users and not enough information (Wildavsky, 1983). The vogue in the late 1980's in system design is to explore 'soft' methodologies (see Willcocks and Mason, 1987) which put people and their problems firmly at the centre of the model building exercise.

Throughout this thesis, the author's understanding of MIS is rather different to that of the production orientated view or the decision process model. In line with the processual view of organisation, reification of MIS is avoided. Rather, the central topic of interest lies in the process of MIS development and the meanings people associate with MIS. Different parties' definitions of MIS may influence interpretations of organisational 'reality'. Alternatively, constructions of organisational 'reality' may influence how MIS are perceived and understood by

members. This interdependent relationship between conceptions of MIS and organisational action is of central importance to this study.

MIS is, therefore, treated as a matter of definition but the evolving ideas and beliefs surrounding the MIS initiative are no less real in their consequences (Thomas, 1923). In the event of information systems becoming an important topic of conversation within the organisational domain and beyond, these discussions create certain images of organisation for members. It is on the basis of these images that people think and act (Hines, 1988:257, Morgan, 1986). In talking about the need for MIS (or not, as the case may be), organisational members constitute and reflect particular realities for themselves. Researchers can gain an appreciation of the status and purpose of developing MIS by looking at how the initiative becomes intertwined with existing social practices.

1.5.2 Locating MIS development in an organisational context.

Despite many MIS textbooks failing to expose the student to 'the more interesting managerial and political aspects of contemporary technical change' (Buchanan, 1987), there has been a growing body of literature in academic journals (eg. Accounting, Organizations and Society) that has chosen to research information systems as part of a wider organisational and environmental context. In 1978, Hopwood publicised the need to develop an organisational perspective on information systems. This was deemed necessary given that researchers 'still have only the barest understanding

of the factors which shape either the design of information systems or the processes through which they, in turn, influence the consciousness and actions of organisational participants' (1978:10). Knowledge of how information systems operate in practice was particularly scarce at this time.

Since 1978, there has been a growing commitment to undertaking studies of information systems (particularly accounting systems) in their organisational contexts (see the reviews of Hopwood, 1983, 1985: Hopper and Powell, 1985: Chua, 1988a, 1988b: Hines, 1989). The movement has changed the orientation from research operating within the system context to that of studying systems as social phenomena to be understood in relation to organisations and society as a whole. Researchers have started to recognise that developing information systems is 'one of the ways in which a problematic rather than self evident social 'reality'...is constructed rather than merely being a means for its reflection and representation' (Hopwood, 1985:367). Burchell et al (1980) embarked on a pursuit that other researchers soon followed - that of researching the roles accounting (and information systems) play in practice. The mission for academics interested in systems became one of asking:

> Just how...has accounting [and other information systems] become implicated in the functioning of the modern scale, hierarchical organisation? How have particular systems arisen out of organisational processes and actions? What actions have been involved with their design, implementation and operation? And what have been the mechanisms for innovation, change and

diffusion? (Burchell et al, 1980:23).

The approach undertaken in this study is largely sympathetic with such a movement given its central interest in researching the development of MIS within a particular social and political context.

Chua (1988b) has undertaken an extensive review of the roles accounting plays in organisational practice. Such a typology is relevant to this study, given that accounting is often treated as an information system (Davis, 1982). Chua's classification is divided between rational or instrumental roles and other-than-instrumental roles of operative accounting. The latter is made up of symbolic roles (which can include two other of Chua's categories; ritualistic and mythical), political roles, legitimating roles, disciplinary roles and dominating roles. Like Chua, the author is interested in the 'other-than-instrumental' roles of information systems, especially the symbolic and political roles (not that these definitions are unproblematic...see Chua, 1988b:21-23).

Having adopted a processual perspectives of organisation, the next section reviews those case studies which seek to show how systems play a part in the ongoing construction of social 'reality' within organisations. Particular attention is given to those works which use the metaphors of culture and politics.

1.5.3 Case studies: Culture and MIS.

There are very few case studies of system development which have attempted to use culture as a metaphor. Dent (1986:21) claims that there is no empirical work in the literature, prior to his, which 'captures the social processes through which accounting and [information] systems become implicated in the emergence and elaboration of new structures of meaning in organisations'. Dent (1986) adopts the culture metaphor in his case study of a railway organisation. The study shows how Business Directors influence the meaning structures through which organisational members interpret decisions and actions. The traditional 'engineering and production' based culture is replaced by a 'business and economic' based culture. Accounting information systems are implicated in this change; regional budgets are revised by Business Directors into business cost centres so as to influence decision making. Information systems are not treated as problematic by Dent but assumed to be a resource which are available to individuals.

The cultural change of the railway company is illustrated by three symbolic events which embody the new culture rather than the old. The first event tells of how rolling stock is moved on the basis of economic argument put forward by Business Directors rather than bowing to the territorial claims of one Regional Manager. Similarly, the other two events describe how decisions not to renew signalling equipment and changes in timetabling are made by the new Business Directors rather than according to historical arrangements. Dent sees these incidents as evidence of the new business culture where decisions are made on financial grounds.

Dent considers the environment to be a primary trigger for this change in culture. For example, Dent (1986:6) states that 'in response to the environmentally induced resource constraints, the counter-culture emerged'. However, despite its apparent importance, there is little mention of the environment in the paper. The reader is left to speculate about how Dent and organisational members understand the environment.

Although Dent is interested in studying cultural change, change is treated as an irritation to the organisation. It is as if Dent is ultimately more interested in harmony than differentiation; the two do not mix together but lie next to one another. The pattern is one of old culture - problems - new culture. Individuals 'celebrate the new rationale' or else leave the organisation. This seems a rather monolithic treatment of culture despite Dent's usage of concepts such as 'counter-culture'.

Dent's case study suggests that information systems can be used to make visible a particular view of economic order (Hopwood, 1983:294). However, as we shall see later in Preston's work (1986), managers may not use MIS. If an information system is designed to replace rather than complement existing informing processes, then it may threaten existing interdependencies between individuals and groups within the organisation. Consequently, it is possible that groups and alliances may choose to resist or sideline information system developments. Such an example is provided by Berry et al (1985) in their study of an area of the National Coal Board.

Berry and his colleagues (1985) are interested in the significance of culture for an understanding of management control in the National Coal Board. The researchers argue that the historical position of the organisation has been that of not allowing financial controls to intrude on the management of the colliery. The authors use rather organic imagery to demonstrate that different 'parts' of an organisation may be 'loosely-coupled' from each other so that the financial control systems are 'emasculated'. In their words:

> A reasonable way for accounting and accountability systems to operate may be for them not to get 'in the way' of the traditions of production orientation, social cohesion and maintenance of the clan culture (Berry et al., 1985:19).

Interestingly, Berry and his fellow researchers discover that this position is being challenged as actors within the setting respond to an economic recession and changing policies of the Conservative Government. The research traces how there are pressures for change operating through the finance function. The paper concludes by stating that the different philosophies within the organisation - one stressing the logic of production and the other the logic of the market - can 'no longer be kept apart' (1985:25). As members of the colliery near the coal face become less able to resist change towards a market based culture, the organisation is likely to follow similar dynamics to that of the Dent study described earlier.

1.5.4 Case studies: Symbols and MIS.

Using the concept of culture helps researchers to realise that organisations and information systems are symbolic forms (ie. objects, acts, words or ideas). Hayes (1983), for example, has suggested that accounting (and presumably other information systems) provides a language, a mythology, a rationale for action, an image of organisation and a basis for organisational experimentation. Smircich (1985) urges researchers to adopt a cultural analysis of organisational life by focussing on symbols and not culture.

Preston (1986) is one such researcher who prefers to study symbolic interaction rather than culture. Preston follows the introduction of a production information system in a plastics division of a large organisation. Somewhat surprisingly, Preston discovered that managers do not use official documentation. In his own words, 'the official documented information system played little or no role in the manager's process of informing' (1986:535). The process of informing is crucial to Preston's work. It describes the interpretive process whereby managers assign meaning to data. MIS may only constitute a part of the process of informing and not the whole of it. How big a part MIS play in the process of informing depends on the extent to which they are defined as meaningful and relevant by organisational participants.

In discovering that managers do not use formal information systems in a instrumental fashion, Preston goes on to investigate just how

managers do keep informed. Differentiating between the official order and the social order, Preston's thesis is that informal information flows in the social order are dominant; managers keep informed by gathering data from meetings, personal records, observations and particularly interactions. The transmission of information is, therefore, largely governed by taken-for-granted social rules.

Preston's analysis seems inadequate in the sense that he assigns formal information systems to an official order which is not part of the social order. Such a distinction is similar to that made by Boland and Pondy (1983) in their examination of the university budgeting process. Boland and Pondy distinguish between 'rational' and 'natural' orders to show how the budgeting process can take on different meanings depending on how plentiful resources are at any particular time. Rather than suggest systems can serve 'objective' and 'symbolic' functions (Boland and Pondy, 1983:223), the author agrees with Chua (1988a:70) who states that 'both orders are part of a constructed reality' and have symbolic significance through action and interaction.

The theme of instrumental and expressive symbolism is pursued by Nahapiet (1988) in her study of resource allocation within one Region of the NHS. Nahapiet clearly illustrates the paradox of symbolism in her description of the accounting process. She provides an example of a meeting where the Treasurer has great difficulty in getting Authority members to accept revised figures based on new accounting techniques. The logic of accounting conflicts with the logic of the local situation. Such an event

allows the author to conclude that accounting remains ambiguous offering multiple interpretations and yet, is simultaneously imbued with the rhetoric of bureaucratic control. Despite the accounts meaning different things to different people, the rhetoric of accounting symbolises rational action and legitimates administrative behaviour (1988:356).

The usefulness of the above three studies lies in the way each author departs from a view of information systems mirroring and reinforcing the mechanistic model of organisations. Rather, the interdependent link between information systems and organisational 'reality' is treated as a 'complex and intricate web of multiple connections and mutual influence over time' (Nahapiet, 1988:355). MIS is both the producer and product of organisational 'reality' (Burchell et al. 1980: Colville, 1981). This interdependent relationship is clearly illustrated in a later work by Preston and colleagues (1987) into the development of management budgeting in the National Health Service. The authors discuss the introduction of budgeting systems in terms of an interplay between discourse and practice. A discourse is a stylised language and vocabulary which extends beyond dialogue into documentation (Preston et al., 1987:4). In the context of the study, the discourse emerges outside the District Health Authority (DHA) and is shaped and transformed as health care professionals inside the DHA interpret and contribute to it. As Preston et al comment in the abstract:

> The practice of designing and implementing the budgeting system is seen to be informed by the discourse and in turn shapes and informs the discourse such that discourse and practice reflect

and constitute each other.

This research study is working on an aligned agenda to that of Preston and associates. Both studies are interested in why information systems come to be developed in a particular institution and how people's ideas about MIS are constitutive and reflective of organisational 'reality'. Having examined the cultural metaphor in relation to case studies on information systems, attention now switches to the political nature of system development.

1.5.5 Case studies: Politics and MIS.

It has long been established that the 'purposes of budgets are as varied as the purposes of men' (Wildavsky, 1974:4). Budgets are no different from other information systems in that they arise out of the politics of organisational life (Pfeffer, 1978). Systems are social phenomena which help to shape 'what is regarded as problematic, what can be deemed a credible solution and the criteria which are used in their selection' (Burchell et al, 1980:17). What people take as the information system and the product are, therefore, political judgements.

Covaleski and Dirsmith (1986, 1988) look at the use of budgetary symbols in organisations from a political or bargaining perspective. They are particularly interested in how accounting creates organisational 'reality'. In their 1986 study, Covaleski and Dirsmith are attempt to discover the meanings which nurse managers attach to the budgeting process in six different

hospitals. They draw on a bewildering array of previous studies ranging from Mintzberg's functionalist analysis of the manager's job (1973) to Argyris' writings on how people learn (1976). The central theme in the study is to show how organisational members accept, to varying degrees, that the technically, rational image of a budgeting system has a part to play in the internal politics of organisational life. The authors conclude that the symbolic imagery of acting 'rationally' has penetrated and influenced the internal operations of the hospitals - those Nurse Managers who accept the tenets of budgeting have diverted their energies towards it and away from clinical areas.

Covaleski and Dirsmith see the political ramifications of individuals starting to use certain symbols rather than others. This combination of the symbolic and political can be accomodated within yet another image of organisations; that of the theatre. This claim is examined in detail in chapter three. The immediate concern is one of demonstrating the usefulness of the theatrical image for exploring the political nature of organisational life. To achieve this end, references are made to a case study conducted by Ian Colville.

Colville (1989) wishes to see what part accounting plays within organisations. The study describes the process of constructing a budget within a Police Authority and is written in the form of a play. The budget is the focus of the drama because it provides a possibility to observe how accounting operates in organisations; something which has, until very recently, received scant attention. In viewing the story of the budget as a series of

acts in which people make important contributions, Colville is able to show how 'men make their budgets' but not under the conditions of their own choosing.

Colville considers the budget to be a social achievement. Budgeting is as a negotiation and improvisation between organisational members who are searching to tease out the meaning of their own play within the context of a wider environment. Such an approach treats accounting as inextricably intertwined with political and organisational processes (Tomkins, 1989). The dramatic analogy serves as a rich metaphor for understanding how MIS are socially constructed in any particular organisational arena. However, Colville is reluctant to spell out which set of conceptual 'props' he is using to unravel the different sequences of action. This problem is one that the author faces in chapter three when the metaphor of drama is adopted for the purposes of this study.

1.6 Conclusion.

This chapter has outlined the research topic, this being to investigate the interdependent relationship between MIS development and the actions of organisational participants. The next stage was to locate this relationship within a processual perspective of organisational life. In short, a processual analysis regards 'systems' and 'organisations' as the ongoing product of social processes enacted by organisational members. The cultural and political metaphors of organisation were then considered, the emphasis being on the meaning of social action.

Having outlined the bare bones of a perspective, the processual approach was grounded in the more general traditions of phenomenology and contextualism. The chapter was concluded by reviewing a number of published case studies which demonstrated a similar stance to the broadly social constructionist position outlined in this chapter.

Chapter two: Theory and Practice in Case Study Research.

2.0 Introduction.

After locating the study within particular bodies of knowledge, the second chapter switches the focus to the philosophical issues raised by the practice of doing the research. Consequently, matters of methodology and method have to be addressed. Writers often confuse these two terms and mix them up as though they mean the same thing. In this thesis, the term 'methodology' refers to the philosophical issues raised by investigating the world scientifically whilst method describes the research technique. Before describing the research methods used in undertaking this case study, it is considered important to examine the ontological, epistemological and methodological positions that the author, as a researcher, has committed himself to throughout the research period.

In section 2.1, the naturalistic or interpretive paradigm is introduced (Lincoln and Guba, 1985: Burrell and Morgan, 1979). It is within this methodological framework that the practice of undertaking the research should be viewed. Section 2.2 attempts to translate the implications of the naturalistic paradigm into the practice of doing research. A qualitative research strategy is proposed. Finally, section 2.3 presents a 'reflexive' account of conducting research at Camblewick Hospital. The central concern of the account is to make explicit the process by which data and findings were produced.

2.1 Naturalistic paradigm.

In chapter one, a commitment was made to the phenomenology of Schutz (1973, 1976) and Weick (1979) as a basis for understanding the social or organisational world. Phenomenology is located firmly within the interpretive paradigm (Burrell and Morgan, 1979: Halfpenny, 1979). This paradigm or world view has alternatively been described in terms of a naturalistic set of assumptions (Lincoln and Guba, 1985).

Lincoln and Guba list five key principles on which underpin the interpretive or naturalistic paradigm. The first axiom is that multiple realities exist and that they are tied to a particular social context. This is an ontological issue which attempts to answer the question; what is 'reality'? The second principle of the paradigm is that the relationship between knower and known is one of mutual interdependence. Both the 'object' and the 'subject' of the inquiry interact and influence one another. The second axiom tackles an epistemological question concerned with how any researcher can come to know 'reality'. The final three assumptions proposed by Lincoln and Guba can be loosely described as methodological issues. This is the area of how a researcher can discover and validate their claims about the social world. In short, these principles state that only time and context bound interpretations of 'data' are possible, that it is impossible to distinguish between cause and effect and that inquiry is value bound. Given the final assumption that research is laden by the social scientist's values, the researcher needs to make every effort to make explicit their methodological commitments.

Each of the philosophical issues introduced in the above discussion shall be addressed throughout the chapter. In section 2.1.1, ontological questions are raised. In the next subsection (2.1.2), epistemological concerns are discussed. In particular, attention is given to the status of scientists' and lay persons' accounts of social 'reality'. Finally, in 2.1.3, the policy of methodological individualism is advocated.

2.1.1 Ontology: 'Reality' as social construction.

'Reality' is not given but constructed and interpreted. This position has already been made clear in chapter one. Researchers undertaking interpretive research are interested in understanding the multiple meanings current in any social situation and how these meanings are shaped and transformed over time. The emphasis is on the unfolding of social processes and the interpretation of purposive action. It is also assumed that what people say and do is dependent on the social context within which they are situated. The importance of locating social activity within an organisational and environmental context was referred to in section 1.4.

2.1.2 Epistemology: Understanding and interpretation.

How might a researcher go about understanding the social world? This is an epistemological question. Given an ontology which views 'reality' as a social construction, 'reality' can only be known through understanding the social actor's point of view; that is the actor's subjective meanings and definitions of the

situation. It is this empathetic understanding of the individual's standpoint which Weber (1968) described as 'verstehen'.

'Verstehende' sociology seeks an interpretive understanding of the subjective meaning an action has for an individual. In other words, the researcher's task is to grasp the ideas, beliefs, purposes and projects which move people to act in one way rather than another. Schutz (1973:62) argues that verstehen 'are the first level constructs upon which the second level constructs of the Social Sciences have to be erected'. Furthermore, Schutz continues by stating that:

> ...all scientific explanations of the social world can, and for certain purposes must, refer to the subjective meaning of the actions of human beings from which social 'reality' originates.

Following Weber and Schutz, researchers engaged in interpretive style research have the task of building their concepts on the constructs used by actors to make sense of everyday life. Research becomes a matter of producing 'thick' descriptions (Geertz, 1973) of how particular individuals experience, give meaning to, act and interact with respect to particular situations (see Jones, 1987). The researcher has the difficult job of operating between the multiple worlds of the 'subjects' and the world of their own perspective. At this point, it should be made clear that the author does not wish to put too much emphasis on the distinction between lay and scientific 'accounts'.

Interpretive research necessarily involves 'visiting with people, listening, speaking and allowing conversations to proceed as they will [which] means that one's life is implicated in the life of another person' (Cottle, quoted in Bogdan and Taylor, 1975:8). Therefore, 'object' and 'subject' of the inquiry are inseparable and influence one another.

There are definite parallels between social scientists' and lay persons' attempts to render a definitive view of the social world (see Pinch et al, 1989). The researcher draws on the same interpretive procedures to understand the social setting as any other member of that setting. As Watson argues (1977:18) in the context of undertaking sociology:

> Both [layman and sociologist] are concerned with making sense of what goes on around them and both approach the world with sets of preconceptions, typifications, values and indeed theories..[sociologist's descriptions and generalisations are not essentially different from those of the non sociologist.

The central interest in phenomenological inquiry is, therefore, to make an 'account of members' accounts' (Clegg, 1983:119). The status of all accounts (including this thesis) are similar except that the researcher has a 'scientific' project which means that they should approach an analysis of any social situation systematically and with rigour and present findings in such a way that others can judge its trustworthiness. As Silverman (quoted in Clegg, 1983) explains, phenomenology or interpretive type research should oppose the tendency in positivistic sociology to

regard the social scientist's concepts as different from, and superior to, lay constructs.

2.1.3 Methodological Individualism.

The policy of methodological individualism may be conveniently discussed at this point in the argument. It is the author's belief that such a policy lies at the heart of any interpretive work based at the level of the organisation. Methodological individualism argues that statements about wholes (eg organisations) should be analysed, wherever possible, in terms of the situations and beliefs of individuals. This is not to say that social wholes do not exist. As Cuff and Payne (1979:117) claim:

> [Methodological individualism] merely recommends a methodological policy of trying, whenever some social whole is mentioned, to substitute explanations in terms of individual behaviour.

Whilst it is possible here to embark on a discussion of methodological individualism as opposed to methodological collectivism or situationalism (see Knorr-Cetina, 1981), it serves my purpose to adopt the essence of the 'individualism' principle, namely to put individuals at the centre of any analysis. In practice, this means avoiding reification and remembering that concepts are merely analytical devices which 'sensitise' us to the social world (Blumer, 1969).

2.2 A Strategy for Undertaking Qualitative Research.

The second section of chapter two (2.2) attempts to translate the implications of naturalistic paradigm into the practice of doing 'interpretive' research. The approach adopted is essentially qualitative (2.2.1). This is because qualitative materials are thought to be useful for considering the meanings and understandings of the people who have been 'studied'. However, a qualitative approach to research does not just relate to the sort of 'data' obtained. The author argues that conducting qualitative research is a complete research strategy. This involves treating research as a social process (2.2.2), undertaking a 'reflexive' approach (2.2.3), studying the actions of individuals in their 'natural' setting (2.2.4) and using a case study reporting mode (2.2.5). Finally, the topics of theory generation (2.2.6) and the emergent nature of qualitative research (2.2.7) are considered.

2.2.1 The nature of qualitative research.

Different research traditions have their own conception of what is qualitative about social data and what are the problems and possibilities for the analysis of such data (see Halfpenny, 1979). To operationalise interpretive style research with its particular epistemology, qualitative methodologies are usually favoured by researchers. Qualitative research seeks 'to describe, decode, translate and otherwise come to terms with the meaning of certain more or less naturally occuring phenomena in the social world' (Van Maanen, 1979:520). Van Maanen is clear about the close connection between phenomenological analysis (the term is used in

this context to describe a host of interpretive approaches) and qualitative research. In Van Maanen's terms, phenomenology is 'likely to be assumed' by the qualitative researcher since the latter regard phenomena as 'more particular and ambiguous than replicative and clearly defined'.

There is a growing commitment to the practice of qualitative research (eg Glaser and Strauss, 1967: Blumer, 1969: Bogdan & Taylor, 1975: Van Maanen, 1979, (ed.) 1983: Mintzberg, 1983: Fineman and Mangham, 1983: Hari Das, 1983: Bryman (ed.), 1988, 1989: Burgess (ed.), 1988), alternatively known as interpretive research (Weber, 1968: Halfpenny, 1979: Burrell and Morgan, 1979: Morgan, 1980), fieldwork (Burgess, 1982: McKinnon, 1988) or naturalistic inquiry (Lincoln and Guba, 1985). Whilst qualitative approaches to research are diverse, they share similar commitments. For instance Hari Das (1983:301) describes qualitative research methodology as 'combining rational with intuitive approaches to knowledge', interested in the 'unfolding of processes' as well as being 'broad and holistic' and providing 'impressionistic conclusions'. Alternatively, Van Maanen (1979) groups the perspectives in terms of their attempts to reduce the distance between indicated and indicator, between theory and data, and finally between context and action. A number of these themes are revisited later in the section as the main features of qualitative research are discussed.

2.2.2 Research as a social process.

Tomkins, Rosenberg and Colville (1980), have noted that there is a 'considerable discrepancy between how social research has actually been done and what is found in text books'. Traditional texts have tended to describe research methodology as a rational, linear, goal directed activity. Researchers are required to follow formal procedural rules which prescribe a sequence of steps such as the formulation of a priori hypotheses, a period of observation, the testing of propositions under controlled experiments and a statement of the conclusions. This view fails to recognise that researching is a messy social process where a lot depends upon a 'reservoir of unofficial non formalised techniques of inquiry' (Baldamus, quoted in Tomkins et al, 1980).

Qualitative researchers are open about the fact that they utilise these unofficial techniques. When doing qualitative research in organisations, these factors might include such things as negotiating access, finding a role, striking bargains, maintaining a good relationship with others, luck and serendipity and advice from other researchers. These matters cannot be controlled in any formal statement of research design. Often, the researcher has to rely on tacit knowledge in order to establish what feels the 'right' course of action in the setting. Given the mixture of rational and intuitive approaches to knowledge, the researcher is a human instrument whose experiences are key events to be analysed as 'data'.

Having recognised the importance of all these resources in shaping research activity, writers on research methodology are beginning to reflect this understanding by providing 'inside' accounts of researching as a messy and emergent process (see, for example, Bryman (ed), 1988). These accounts are invaluable to other researchers as long as they move beyond the personal experience to the representative experience (Dawe, quoted in Watson, 1977:3). By exposing the research activity 'warts and all', other social scientists are able to learn about the management of research and assess the trustworthiness of the work.

2.2.3 Researching and reflexivity.

In arguing that 'reality' is a social construction, it would be nonsense to assert that this piece of research stands apart from the social construction process. This is the problem of reflexivity in that social science claims of knowledge about the social world are social constructions themselves. For some, it is important to expose the social processes that go into knowledge claims as an end in itself (see Pinch et al, 1989). This perspective has dangers of becoming lost in an infinite regression of thesis and anti-thesis as researchers attempt to avoid imposing their own version of 'reality' on events. This is a rather extreme view within qualitative research methodology and not one the author follows.

Throughout this thesis, a reflexive approach is understood to be one which attempts to render explicit the process by which the 'data' and 'findings' were produced (see Harris, 1987). Inverted

commas are used around the word 'data' to emphasise that in order for data to become data, it needs to be accessed by some theoretical schema. Data does not speak for itself. This is significant because no matter how ill defined a research perspective may be, the research activity is bounded by the researcher's values. The researcher's values impinge on the formation of the research problem, the gathering of data and subsquent analysis and development of theory. Researching is, therefore, governed by the theories or causal maps researchers already hold in their heads.

Such a position is close to that of Weick (1979) who argues that instead of accepting that 'seeing is believing', it might equally be valid to suggest that 'believing is seeing'. Weick casts people as theorists since we all engage in collaborative sense-making. According to Weick, everyone, especially researchers (of all distinctions), should become more self conscious about theorising if we are all to become better theorists and more effective at what we do. This position is clearly reflexive and echoes the debate about the similarity between researchers' and lay persons' accounts.

Van Maanen (1979:520) makes a lucid statement about researching and reflexivity in his paper about qualitative research methods:

> Qualitative data...originate when a researcher figuratively puts brackets around a temporal and spatial domain of the social world. These brackets define the territory about which descriptions are fashioned. These descriptions are essentially

> idiographic maps of the territory which must be read and interpreted by the researcher...but the map cannot be considered the territory simply because the map is a reflexive product of the map maker's invention. The map maker sees himself as much as he sees the territory.

Such a perspective is phenomenological in nature. It deconstructs the myth of a value free, 'objective' methodology and implies that it is important to give the reader an insight into the background assumptions and value basis of the study so that they can assess the research.

2.2.4 Naturalism.

Qualitative research aims to understand social processes rather than structures in the context of particular settings. Therefore, as Atkinson (1979:48) contests, qualitative researchers 'urge that social life be studied as it occurs in natural settings rather than artificial ones created only for the purpose of the research'. Interpretive research is largely 'exploratory' and 'developmental' insofar as such terms describe the process of immersion in a foreign setting in an attempt to identify natives' conceptions of their social world (Halfpenny, 1979). In the context of this particular thesis, this means locating the key actors that may influence the way in which information systems are perceived and understood in the setting. This cannot be done with an 'arms length' research strategy which 'risks the worst kind of subjectivism' according to Blumer (quoted in Bogdan and Taylor, 1975:8):

> In trying to catch the interpretive process by remaining aloof as the so called 'objective' observer and refusing to take the role of the acting unit is to risk the worst kind of subjectivism - the objective observer is likely to fill in the process of interpretation with his own surmises in place of catching the process as it occurs in the experience of the acting unit which uses it.

Blumer is advocating that researchers should study social life as it occurs in natural settings. Tomkins and Groves (1983a:364) pick up this call for 'naturalistic' inquiry and apply it to accounting research. The authors suggest that a more intimate knowledge of the practice of accounting may be achieved by undertaking fieldwork in individual settings:

> ...academics might profitably move more into detailed fieldwork (ie. recording what is happening in the setting within which decisions are made and action occurs) and focus rather more on studying how practitioners perceive their worlds, what issue concern them, why these issues concern them and how they perceive them affecting accounting practices and the influence accounting has.

These propositions might equally have been applied to the process of information system development, in general, rather than concentrating exclusively on accounting practice. The case study is the obvious vehicle for an in-depth exploration of such processes. As Halfpenny (1979:811) emphasises, 'interpretive studies are necessarily case studies - studies of one culture, one

conceptual framework, one frame of meaning'.

2.2.5 Case studies.

The term 'case study' has been used in many different ways by researchers. Chua (1988b), for example, understands the case study to be a research method. It is perhaps more correct to state that the case study stands for a multiplicity of research methods. The researcher has available a number of techniques (eg. surveys, questionnaires and, particularly in relation to this study, interviewing, observation and document analysis) in attempting to collect 'data' relevant to a research problem. The term 'case study' may also describe a distinctive approach to research. Mitchell (1983:191) argues undertaking a case study involves going out into the 'field' and documenting a set of events which a view to drawing theoretical conclusions from such documentation. Quoting Goode and Hart, Mitchell goes on to suggest that case work must attempt to preserve the unitary character of the social objects under study. In what follows, the phrase 'case study' is used to refer to a research approach striving to theorise about complex social processes within a single organisation. Thus, the case study goes beyond the apt illustration, or the analysis of one particular event to consider an extended sequence of events linked through time.

Having established a working definition of the case study approach, just what is it that case studies can do? Kaplan (1986) points to three benefits to the academic community which result from conducting case studies in specific social settings.

First, they provide a firm basis for future research activity such as constructing a taxonomy of models, theory building and hypothesis formulation. Second, they seek out interesting organisations or practices. Finally, they enhance the lecturer's ability to communicate with students about the strengths and limitations of alternative schemes. Platt (1988:19) points to the fact that case studies may be responsible for advances in theory:

> If there is a rich and detailed account of many features of the case, it may be a considerable achievement to devise an interpretation which can deal with all of them, and this may pose a greater challenge than the fitting of superficial generalisations in larger numbers.

A similar point is made by Mitchell (1983:203) who tackles the issue of whether it is possible to generalise from the single case study. Mitchell argues that the relevance of the case study to the wider population 'depends upon the adequacy of the underlying theory and the whole corpus of related knowledge of which the case is analysed rather than on the particular instance itself'. It is the validity of the analysis rather than the representativeness of the events which makes the case study a robust instrument.

2.2.6 Story-telling, description and theory generation.

The movement towards case study work has come at a time when process theories of organisation have pointed to the fact that little is known about the the nature of organising in practice. Rather than design structures to fit with 'science' or situation,

the current vogue is not to be prescriptive and seek to understand the dynamics at work within organisational settings. So, in the context of the information system development, researchers are calling for holistic studies into the 'role information systems currently play in organisations before one starts to prescribe what role it should play' (Laughlin, 1989a). This has led some academics to suggest that, in commenting on organisational life, researchers might be better advised to follow the activities of the novelist or playwright (Mangham, 1978, 1987: Colville, 1981).

Does this mean that writing an account of what is going on in organisations is like story-telling? In many ways it is. For example, Kundera makes the case that the novelist has a lot in common with the researcher. Kundera (1983:237) describes the novelist's desire as being to 'grasp his subject from all sides in the fullest possible completeness' and that:

> A novel does not assert anything: a novel searches and poses questions...it seems to me that all over the world people nowadays prefer to judge rather than to understand, to answer rather than to ask, so that the voice of the novel can hardly be heard over the foolishness of human certainties.

It could be argued that all researchers are essentially performing a similar task to novelists or playwrights because they are also trying to understand and ask questions about the nature of social life. This is one of the reasons for presenting a 'dramatist' model in chapter three. The task for the researcher interested in the social or organisational world thus becomes one of

developing the art of reading and probing social situations within organisational settings (Morgan, 1986).

Fineman and Mangham (1983) state that if behaviour is viewed as situationally specific, idiosyncratic, multivariate or holistic, then a 'richer' or more descriptive analysis may be taken to be more appropriate. However, qualitative research is not just descriptive. As Kant has convincingly argued (quoted in Mangham, 1978:15), 'perception without conception is blind, conception without perception is empty'. Tomkins and Groves (1983a:370) claim that 'one must raise the level of the analysis in an attempt to identify concepts and the establishment of, at least, substantive theories' (ie. context bound theories). Indeed, there are some (eg. Birkett and Chua, 1988) who argue that much 'interpretive story-telling' has been undergeneralised, undertheorised and few conclusions have been drawn out from the analysis. Once more, there is a call for theory which can contain the rich description provided by case materials. How are researchers to develop theory which can cope with the complexity of social phenomena? Grounded theory (Glaser and Strauss, 1967) provides one answer.

According to Strauss (1987), qualitative research is about developing 'effective theory'; that is to say, a theoretical account which is both general and yet, at the same time, 'grounded' in empirical observation or 'data' (Glaser and Strauss, 1967). Theory is 'grounded' in the sense that it is based on or emerges from qualitative data (ie descriptions of events, situations and interactions between people and things). Theory is

to be inductively 'discovered' rather than presupposed by the formation of a priori hypotheses. Jones (1987:25) summarises the position with particular clarity:

> Rather than forcing data within logico-deductively derived assumptions and categories, research should be used to generate grounded theory, which 'fits' and 'works' because it is derived from the concepts and categories used by social actors themselves to interpret and organise their worlds.

Qualitative researchers have to 'get close' or 'live' the 'data' and use their imagination in order to develop analytical, conceptual components of explanation. Inductive research requires both 'detective work' and a 'creative leap' (Mintzberg, 1983).

Grounded theory is not a method or technique but a guide to the generation of theory. 'Data' (ie. descriptions of events, situations and interactions between people and things) is collected using a variety of methods such as interviewing, observation and documentary analysis (see below). The data collection process yields a diverse set of materials which are the raw 'data' for theory generation. These materials may include such things as field observations, notes, interview transcripts, minutes of meetings, reports, letters, newspaper cuttings and other documentation which are filed into chronological order.

Throughout the research process, the researcher asks questions of the 'data'. Notes are made in the margin as the researcher codes the 'data' and sorts it into categories which occur to him/her

when recording or reading through the transcripts. Insights and categories are continually tested as the research proceeds so that the number of categories is cut down to those most capable of ordering the data. Copies of notes and transcripts and documents may then be cut up into segments and filed under each core category. This creates a second file of sorted 'data'. Theory emerges as comparisons are made more general through cross checking of instances illustrative of the concept. This process continues until theoretical saturation is achieved (a more detailed account of how grounded theory may be pursued is given by Martin and Turner, 1986).

Grounded theory provides a rigorous and systematic approach to handling and interpreting 'data'. The approach, however, is in danger of appearing naive for what is the researcher to take as his or her 'data'? 'Data' only becomes such when it is accessed by some prior theoretical schema - data does not speak for itself. The debate has returned to that of reflexivity and how the researcher is part of the data. As Fineman and Mangham (1983:298) note:

> The notion of an empty headed qualitative researcher...is really a rather foolish one; the most collaborative of investigators is unlikely to deny himself or herself in the process of analysis.

Researchers must be honest about the theories or maps that they hold in their heads prior to undertaking the research. In this thesis, a group of 'sensitising' concepts for thinking about

conduct in organisations are soon to be outlined in chapter three. These concepts were already with the author upon undertaking the research, along with a jumble of other theories and concepts. However, sorting out which concepts are going to be useful in a particular analysis is an iterative process throughout the entire research process as the researcher reflects on prior knowledge, immediate experiences in the 'field' and new areas of literature. For pragmatic reasons, if nothing else, the researcher then settles on a skeletal model or conceptual framework which is the basis for deciding what materials are to represent 'data' and which are not.

It is then that the 'grounded' approach to theory generation is most useful. After leaving the field setting, the analyst can concentrate on developing an intimate relationship between the skeletal model and the 'data'. The materials collected whilst in the setting are a resource for fleshing out the 'skeletal model'.

2.2.7 Emergent research design.

An emergent research design is a necessary component of qualitative research (Lincoln and Guba, 1985). The researcher enters the 'field' with half-baked hypotheses about what he or she is interested in. These ideas are likely to change over the course of the research period as the researcher becomes more familiar with the problems of the social actors that he or she is investigating. It is inconceivable to think that forthcoming events and situations could be known in advance to devise the research adequately. Part of the attraction of qualitative

research is that it allows the researcher the flexibility to follow up any new lines of inquiry.

If qualitative can be said to have any pattern, it follows what Blumer (1978) calls the 'exploration' and 'inspection' stages. Tomkins and Groves (1983a:363) describe these two stages as follows:

> Exploration involves gaining a clear understanding of how to pose the problem, what data are relevant and how to identify significant lines of relationships for closer inspection... inspection involves a gradual deepening of the enquiry following themes which emerge from flexible, but close, observations of specific decision contexts.

The exploratory stage of research is, therefore, like a pilot study whereby the social scientist experiences the organisation as a culture. Whilst this stage is never complete, inspection chases problems which are posed in culturally competent ways.

The emergent and unfolding nature of the research process should become clear as the author describes something of his own experiences of managing research. Readers should beware the orderly gloss of the following passages (as with all text). As Rosenberg (quoted in Tomkins, 1985) has written, 'neatness has its own logic whereby a finished product denies its origins and history'.

2.3 A Reflexive Account of the Research Process.

In this section, my own experiences of conducting research at the Camblewick Hospital are presented to the reader in the form of a reflexive account. Throughout this section, the first person singular (I) is utilised to emphasise that the researcher is not divorced from the research process. Indeed, all researchers influence what is 'studied' and what is 'found out'. This thesis is just one account of proceedings at Camblewick (not 'the' account!).

The account is composed of several subsections. In 2.3.1, attention is focussed on how I inherited a research setting and a research problem. The latter was redefined to fit with my own particular theoretical commitments. Subsection 2.3.2 reveals how the problem of negotiating access featured strongly throughout the research process. In the next part (2.3.3), the first 'exploratory' stage of the research is outlined. Attention is given to interviewing and making use of transcript materials. Subsection 2.3.4 indicates how the research became more 'action' orientated after an initial period of interviewing. Stage two of research process (the 'inspection' phase) is presented in 2.3.5. Finally, the chapter concludes with a note on 'data' sources (2.3.6).

2.3.1 Inheriting a setting and redefining the research problem according to biography.

I came to this project in September 1987 having completed my undergraduate studies in Business Administration at Bath University. It was during my degree that I was exposed to organisational theory and the areas of culture, micropolitics and decision process theory. The philosophy pervading the Management School was that of the 'social construction of organisational behaviour' (see the recently published Bath text - organisational Analysis and Development, Mangham (ed.), 1987). 'Reality' as social construction was the basic ontology that I felt happy with upon arriving at Nottingham Polytechnic.

I joined a research team based in the Department of Accounting and Finance of the Nottingham Business School. Two of the members of the team (Senior Lecturers in Accounting) were undertaking consultancy work for a local hospital in association with the accountant at the site. The consultants' project consisted of developing specialty costs in an attempt to improve financial information systems at the hospital. However, part of the contract with the senior management team at the unit (ie hospital) was that research could be carried out within the setting. I had the task of undertaking the research and did not get involved in the consultancy work for fear of compromising my research position by being 'hired' by unit management. I was particularly fortunate to have a setting already available for research where access seemed probable.

I had inherited a setting but what was the research problem? The research problem had already been outlined by the two Polytechnic lecturers when I arrived in September, 1987. This was clearly stated in a research brief, this being to:

> Observe the extent to which the power structures and the culture of the organisation together with other internal and external variables, influence the characteristics of the MIS, and conversely, how the production of new accounting information affects managerial behaviour.

I have already argued that particular underlying assumptions inform the framing of a research problem. The above problem is framed in terms of contingency theory. Given that the lecturers were familiar with contingency theories of organisation at the time of writing the research brief, power and culture are assumed to be variables that organisations 'have' and that these variables influence the development of systems. Furthermore, the authors' consider organisations to have clear boundaries which separate the internal world from the external. These second wave assumptions (ie of organisational theory) appeared inappropriate to me, given the problem at hand; that of studying the dynamic, interdependent relationship between features of an organisation in its environment and the development and production of information. Following insights from my own biographical experience and recently read articles by Colville (1981) and Tomkins and Groves (1983a,b), I saw the potential in a study which looked at how the meanings attached to information systems are constitutive and reflective of organisational 'reality'. Thus, there was a healthy

tension between the problem definition offered by the accountants and the definition offered by the student of management (ie myself).

This tension in views was worked through in numerous rounds of meetings between the three members of the team. We had in common the fact that we saw the importance of locating the technical practice of developing accounting information systems in a wider organisational context (Hopwood, 1983). The outcome of these discussions was that the accountants became interested in processual approaches to organisation and supported my enthusiasm rather than trying to curb it. As if to symbolise this meeting of minds, a paper was written by the three researchers which explored the accountants' experiences in the hospital prior to my arrival (see Munson, Murphy and Taylor, 1988). The analysis was worked through using the garbage can perspective on organisations (Cohen, March and Olsen, 1972). The research team then sought to recruit a Professor in the Business School with knowledge of Sociology and Organisational Theory in order to strengthen what was clearly a multi-disciplinary project. This done, the research problem was recast in processual and contextual terms; namely, to understand the social and political processes involved in the ongoing construction of information systems within one particular organisational context.

2.3.2 Negotiating access.

I used my colleagues contacts with the unit accountant (Paul Hart) at the hospital to make my entry into the setting. The first task

I had was to decouple myself from the activities of the Polytechnic consultants. After being introduced to Paul Hart by my colleagues in October 1987, I met with him on three occasions before Christmas of that year. For credibility with such a gatekeeper, I opted to wear a suit at the site. This made me feel more confident that I would fit in with health care professionals at the hospital. The early meetings with Hart were early explorations into what I could research that would be of interest to both the 'hospital' and myself. He was keen for me to do something that was 'of use' to the unit. Since in this instance 'the hospital' was being represented by an accountant and not, for example a doctor or a nurse, I was directed into projects which the accountant thought were important - namely, to develop an information strategy within the unit. Paul Hart wanted the proliferation of 'data' collected within the hospital to be used by doctors, nurses and managers. I was eager to 'get my foot in the door' and this practical problem seemed relevant to my project - that of watching the development of information systems.

Paul Hart and I negotiated that I conduct a number of interviews (about twenty-five in total) with a variety of health service professionals (ie managers, doctors and nurses) in order to investigate the sources of 'information' they use from day to day and what their future needs might be. I would then write a report on any general themes that were emerging. A list of candidates for interview was produced by the Unit Accountant. To make sure I was not unduly biased towards management, I made sure that there were representatives of clinical professions included in the list of twenty-five interviewees (see appendix 1). It remained for me

to draw up a research proposal which included a hospital task (investigating information sources, uses and needs within the unit) and a research proposal. The latter I broadly described in terms of the interdependent relationship between information use and culture (see appendix 2). This proposal went to the management committee in January 1988 and was accepted on the proviso that there were some 'practical benefits' accruing to the hospital.

So far, the description of negotiating access has been concerned with building trust with a gatekeeper and preparing the ground for future 'data' collection at the site. However, I would not like to suggest that the problem of access ends after the researcher has been granted 'permission' to conduct research within the organisational setting. Whilst gaining approval for research from some higher authority is essential, this is only the start of a recurrent problem; that of maintaining access to documents, people and events within the field throughout the duration of the research.

In the next two sections of this reflexive account of the research process, I describe the exploration and inspection stages of the research. In doing so, I intend to show how the whole research act can be understood in terms of managing threats to validity and reliability. I use the terms validity and reliability in the same way as McKinnon (1988) in her excellent article about improving the trustworthiness of field research. Mckinnon conveys the idea of validity in terms of 'the achievement of consistent results from repeated measures, using maximally similar methods' whilst

reliability is 'the achievement of agreement on the phenomenon of interest using maximally different methods' (1988:42). McKinnon suggests that there are three strategies for reducing threats to validity and reliability resulting from the researcher's presence at the research site, observer bias and any imposed access restrictions. These research strategies are to spend a substantial time in the field, use multiple methods and adopt sensitive social behaviour. My experience of conducting qualitative research has been very much in accordance with these strategies. I shall support this claim and allow other related issues to emerge throughout the remainder of the chapter.

2.3.3 Stage one of the research process: Exploration.

The twenty-five interviews that I had arranged with Paul Hart and approved through the management board were 'exploratory' in nature and took place between January 1988 and September 1988. One of the most significant issues to emerge during this period was that of gaining access to medical staff. I was conscious of the fact that I had used the Unit Accountant as a gatekeeper. Was I now Hart's man or a management spy when talking to other personnel? Would staff be too busy to bother to talk to me? Or had Hart picked a list of his allies for interviewees and ignored those which would not support this exploration? As it turned out, in using the Accountant's secretary to arrange meetings with the interviewees, my particular project was not seen to be independent but part of the work of the Accountant's department.

My research proposal was sent out to all interviewees and filtered through the hospital network as one of Hart's memos might have been. In using Hart's secretary as a resource, I learned that the Accounting Department had little influence with medical secretaries who were reluctant to give the Accountant's secretary a slot in the diary for my visit. Contrary to my expectations, I discovered that it was difficult to get to see medics from the 'management' side by using the 'normal' (ie. in-house) channels of communication. It was not until the second stage of the research (the 'inspection' stage) that I was able to overcome this restriction in access.

The use of the interview as a research method is well established in field research. For example, Hickson et al (1986:25) suggest that:

> It was found that essentials of problems, interests, processes could be gathered by interview in an outline narrative of main events and participants and by the answers to a series of questions about what happened...without it being necessary to discover every incident...The hindsight story that is forthcoming in interview is the same in main events and characteristics, just less cluttered with detail.

Having chosen the interview method, it was necessary to think carefully about how to conduct myself during each interview. Throughout the interviews, I adopted an informal, 'chatty' style attempting to relax the interviewee. I found this particularly important given that I intended to use a tape recorder at every

opportunity. It proved a useful tactic to mention the tape recorder at the start of the interview rather than try to hide it away. I would always ask the person's permission whether I could tape the conversation and allow them the opportunity to switch it off at any time if they so desired. Just giving the interviewee this kind of control meant that the option was rarely exercised. In all but one instance, the tape recorder ran for the complete duration of the interview (usually between one and two hours).

The interviews were in fact more like discussions or 'speech events' constructed jointly by interviewer and respondents in specific contexts (see Mishler, 1986). As interviewer, I played the role of the 'naive' researcher, allowing the respondent every opportunity to pass on their experience and ramble around topics which they considered to be important. This description of my interviewing technique could largely be described as 'unstructured' and 'open-ended'. Such an approach contrasts with the 'structured' interviewing approach which entails using a standardised list of questions to 'stimulate' a 'response' from interviewees. However, it would not be correct to suggest that I approached the interviews without any guidelines. Typically, I made a mental note of steering the conversation around the following sorts of areas:

What is their role?
What are their responsibilities?
What 'information' do they have?
What 'information' do they use to carry out their activities?
What are their 'information' needs?

I was surprised to find that most interviewees seemed very willing to talk about their experiences of working at the hospital without knowing much about me. Indeed, at times, my presence allowed staff to 'let off steam' and rid themselves of some current frustrations. On such occasions, the ethical question of how the tape material should be used comes into play. One senior nurse was so anxious about having criticised the Unit Management Team during the interview that she contacted me afterwards to find out what I was going to do with the tape. Such an example illustrates the point that the researcher's role can be a powerful one. Apart from having the confidence of a number of people who were not sure how I intended to use the material, other interviewees were keen for me to act as a postman and pass on their opinions to others in the organisation. The tactic I adopted throughout the research period was to be discrete and not pass on messages from one person to another.

After each interview, I made sure to write to each interviewee to thank them for their assistance. This was a common courtesy but also helped me to get a good name around the hospital and leave open the possibility of meeting people once again in the inspection stage of the research process.

In sum, the main purpose of the interviews was to allow ample opportunity for professionals from different professions to tell me what part they played in the 'whole', how they kept informed on a daily basis and whether there were any shortfalls in this informing process. In doing so, I hoped to learn something of 'how individuals perceive, give meaning to and express their

understandings of themselves, their experiences and their worlds' (Mishler, 1986:ix).

Throughout the interviewing period, I was conscious of two pressures upon me. The first pressure was the need to 'produce' something for the management board as a gesture of goodwill. A research contract had been drawn up between us and I saw the submission of a report to the management committee as a passport to further, and more detailed, research work. The second pressure stemmed from a need to become culturally competent in the setting. Both these influences became manageable as a consequence of conducting a 'grounded' analysis of case materials early in the research process.

I have already given a description of grounded theory earlier in the chapter. At this exploratory stage in the research, I was concerned with transcribing interviews as soon after the event as I could (the next day if I had no other commitments). Transcribing the tapes helped me to reflect upon my experiences in the field. Any interpretations that occured to me whilst typing out the conversations were either put in separate asides (see appendix 3) or else written up in a field diary (see appendix 4). It was through this combination of listening to tapes and reflecting upon my experiences that I started to notice themes within and across transcripts. After I had typed out about ten transcripts, I started to compare the texts more formally, looking for illustrations of the themes as indicators of particular cultural traits. Whilst this process was time consuming, the analysis helped me to learn something of the

organisational culture as well as providing me with ideas for the report I had to write for the management committee (see appendix 5).

It is important to stress the 'looseness' of the grounded approach during the exploratory phase of research. There is a temptation with grounded theory to seek interpretations and meanings immediately after entering the setting. Such a policy can lead to the researcher filling in the interpretive gaps of the theory very early in the research process and seeking 'evidence' to support a particular view. During the first few months of researching the setting, I was particularly sceptical of my understanding of events. To confront the bias in my interpretations of case materials, I took every opportunity to feed back my account of what was going on to other members of the Polytechnic research team who had a prior knowledge of the site. It was through this process of checking my interpretation with others and going back to experience more events in the field that I grew to be more confident that my analysis of 'data' was a reasonable one.

2.3.4 Towards action research.

Whilst preparing the report for the Management Board during the first week of November 1988, I met with Hart who told me of the White Hart Plan which aimed to develop resource management on site. This plan was later renamed the Clinical Information Project (CIP) (see appendix 6 for the structure of the CIP). Such an initiative had come just at the right time. This seemed an ideal project to become involved in if I was to spend more time at

the site and move into the inspection phase of the work. I used my connections with Paul Hart to arrange a meeting with Simon Toms, the CIP Project Manager. My intention was to obtain a place on the project team so that I could carry out action orientated research.

Action research involves the researcher collaborating in solving problems of the organisation in such a way that problem solving and knowledge acquisition gain from one another. In a sense I had already been conducting action research given that my presence in the setting was inevitably disturbing it. For example, by conducting interviews, I was in effect publicising 'information' related issues which interviewees may not have otherwise thought about (see Sims in Reason & Rowan, 1981). As it turned out, observer caused effects diminished as the commitment to develop information systems escalated in the last quarter of 1988. Information related issues were no longer an artificial subject for the majority but of topical interest throughout the hospital.

Upon meeting Simon Toms on the 15th November, 1988, he agreed in principle that I could be a participant in the CIP. I presented this proposal in my report to the management committee on 8th December 1988 and it was accepted without reservations. I had managed to manipulate the committee mechanism to obtain opportunities for research that I wanted. Apart from keeping the access problem temporarily at bay, feeding back my analysis of the interview material to organisational members allowed me to check the validity of my observations. For the most part, my understanding was thought to be a reasonable one. This reaction

made my work seem more meaningful for I had now reached a level of cultural competence in the setting to allow me to 'get by'. Therefore, this meeting marked the end of the exploratory stage and the beginning of the inspection stage of research.

2.3.5 Stage two of the research process: Inspection.

The inspection stage of the research process began in December 1988 and lasted until July 1989. Rather than maintaining the rather 'marginal' role of the interviewer, I spent more time at the hospital and began to adopt different roles in the field. These roles varied between complete observer to complete participant. As Fairhurst argues (1983:320):

> Rather than fieldwork requiring a linear progression from observer to participant, there occurs a constant interplay between the two.

At first, I became a member of the Support Group of the CIP (see appendix 7 for a list of all Support Group members). This group met every week and my role consisted of observing the process at the meetings. I intervened rarely apart from leading the discussion on one occasion to present a paper (see below). The others in the groups saw me a some sort of 'external adviser', a name given to me and two other members of the group (Tracey Tandy, the District Health Authority Training Manager and Carl Carter, a trainee manager from a neighbouring unit) because we were members of other organisations, coming to the hospital as outsiders. I assumed that Toms had given me this elevated status (ie. from a

researcher) on the strength of the report I had just submitted to the management committee.

Throughout the Support Group meetings, I made notes mapping out the basic thread of the debate. Wherever possible, my notes were composed of the words of those contributing to the discussion in order to reduce observer bias. After the meeting, I would type up my notes within twenty-four hours so that the notes would jog my memory of the events that had transpired. With practice, I could recall an hour's meetings with virtually no significant omissions (see appendix 8). In many ways, I found note taking to be preferable to tape recording. Taping would most certainly have not been allowed in a meeting for it could have inhibited interaction. In addition, transcribing from tapes takes a lot more time than transcribing from notes. Given that I was spending three days a week at the field site, I did not want to waste any time by producing more voluminous notes. Furthermore, I am in agreement with Foote Whyte (1960) who argues that tape recorders can fail to develop the memory and sensitivity of the researcher if they are relied on too often.

The choice of direct observation as a method was extended to other arenas such as Task Group meetings (see appendix 9 for a list of Task Groups with members). Toms was keen for the 'external advisers' to sit in on Task Group meetings as observers so that the three of us could comment on the progress of Task Groups in Support Group meetings. By gaining access to Task Group meetings, I was able to observe 'medical' reaction to the information system development. I took notes at these meetings,

but because of the numbers present, (three rather than the twelve for Support Group meetings) I had to be more discrete about note taking and often contributed to the debates.

During the course of the inspection stage, I attended three different Task Groups, two on more than one occasion. This left four Task Groups that I could not attend because other 'advisers' were allocated to them (see appendix 9). In order to understand what had transpired in these four Task Groups, I had to rely on another method; that of a content analysis of documents that these groups produced. This method was supported by other secondary sources of data, namely 'hearsay' from members of the Support Group who had attended those Task Group meetings that I had not been able to be present at.

Despite describing the use of such methods as observation and content analysis of documents, I also continued to do some semi-structured interviewing. After about four weeks of meetings, Toms wanted me to assess the reaction of senior managers to the formation of the CIP and how their roles would change if Clinical Directors were established throughout the hospital. I said I would write a report based on the interviews and feed it back to the Support Group. Access presented no problems here for I was working under the instructions of Toms. Simon Toms had provided me with a valid 'excuse' for contacting many of the managers that I had met during the exploration stage of the research. Taking on this task gave me some more credibility with Support Group members and I felt a more legitimate part of the project team because I had something to do.

During February and March 1989, I embarked on ten interviews which lasted about one hour each with senior managers on the Unit Advisory Board (see appendix 10). The interviews were more structured than my earlier ones, largely because I was following Simon Toms' brief. I also wanted to chase earlier themes in relation to this new project...How would senior managers understand and explain this new initiative? What would it mean for them? Feeling comfortable with note taking, I continued this practice in the interviews. This speeded up my analysis and the report was finished in the first week of April, 1989 and presented to the Support Group on 25th of the month (see appendix 11). Once more, I had the chance to check my understanding of events with those of members of the organisation.

The final tier of the CIP structure that I needed to cover was that of the Steering Group (see appendix 12 for a list of members). I asked the Project Manager if I could attend the first meeting but he refused, rather anxious not to disturb his previous arrangements. Once more I had to rely on 'hearsay' for this meeting plus an analysis of committee minutes. The second Steering Group meeting was scheduled for the 24th July 1989 when I was about to withdraw from the field. I was determined to attend this meeting in an observing role and decided to write to the Unit General Manager (UGM) asking for his permission to attend. Permission was granted by the UGM and I had managed to bypass Simon Toms to a higher authority.

The Steering Group meeting was particularly significant in the sense that Toms chose this occasion to propose changes in the

management of the hospital. I was able to observe how senior medical representatives reacted to these proposals. To fit with the influence of drama in my work, I wrote up the notes of the meeting in the form of a script. This is reproduced in chapter nine. Fittingly, this Steering Group meeting marked the end of my field research at the site (except for the odd phone call!).

2.3.6 A note on sources of 'data'.

Throughout the exploration and inspection stages, events were happening beyond the organisational context in the environmental context. The most notable example of this was the publication of the White Paper 'Working for Patients' (Department of Health, 1989a). Apart from using such documents as valuable sources of 'data', I collected a large number of newspaper articles from various newspapers (eg. Times, Guardian and Independent). These articles, like Government publications, are accounts which contribute to the environmental context. On numerous occasions, actors within the setting under study made reference to such documents and articles - these referents helped to structure the organisational context and vice versa. Throughout this thesis, I describe my account of the environmental context by also making reference to newspaper articles, Government publications etc. In selecting newspaper material, I decided to use cuttings from the Independent newspaper. I chose this paper for a number of reasons. The four most important factors in making this choice were as follows:

(1) The Independent is read by a number of key actors in the setting.

(2) The Independent is not affiliated to any political party.

(3) I wanted to be consistent in primarily using one source of this type of 'data' rather than a diverse number of sources.

(4) I wanted to reduce the number of newspaper clippings to a manageable amount.

2.4 Conclusion.

This chapter has set out for inspection the methodological commitments that have guided the whole research act. Initially, this research study was located within a naturalistic or interpretive paradigm. The implications of this decision were traced through in relation to ontology, epistemology and methodology. The actual practice of doing research was then considered. A qualitative research strategy was proposed. In the final part of the chapter, a reflexive account of conducting research at Camblewick Hospital was presented. This section made sure to outline the particular research techniques that were adopted throughout the research period. It is hoped that such an honest account of the research process adds to the trustworthiness of the work by uncovering the paths the author (as a social scientist) went down in researching MIS development as a social process.

Chapter three: Metaphors and Model Building.

3.0 Introduction.

In this chapter, a framework or model is presented for examining and analysing social conduct in organisations. Throughout chapter three, parallels are made between life in organisations and the staging of drama. Traditionally, the home of drama is in the theatre. Indeed, the domain of the theatre provides a rich selection of concepts for thinking creatively and consistently about sequences of 'action' in the case setting. However, rather than retrace the steps of others who have used the theatrical metaphor to frame their inquiries (for example, Mangham, 1979, 1986, 1987 (ed.), 1988: Colville, 1989: Pinch et al, 1989), this study sets organisational life within a more modern and distinctive dramatic context; that of the continuous television serial or 'soap opera'.

In section 3.1, life and drama are considered to be intertwined. The theatrical metaphor and the Social Science tradition of dramaturgy are given some consideration. In accordance with these traditions, the research act is also considered one part to be performed amongst many. The next section (3.2) argues that the dramatic metaphor is consonant with the social constructionist perspective adopted in chapter one. Connections are made between dramaturgy and the processual metaphors of culture and politics. In part 3.3, the metaphor of drama is extended beyond the theatre to include the domain of television. The 'soap opera' is offered as a new image for portraying and analysing social processes. In

section 3.4, the focus of the chapter switches to the development of a model for viewing organisational life as a continuous serial or 'soap'. The key elements of the conceptual framework are presented. Finally, in section 3.5, attention is given to how the model shall be used in later chapters to illuminate the case study material.

3.1 Drama, 'Reality' and Illusion.

This section is divided into two parts. The first part (3.1.1) examines the interconnection between life and theatre whilst the second (3.1.2) explores the nature of dramatic illusion. It is proposed that the illusion of drama needs to be 'bracketed' by the audience if they are to 'critique' the perfomance and tease out the meaning the organisational drama has for their own lives.

3.1.1 Theatre as life, life as theatre.

The theatrical nature of everyday life is often alluded to in our conversations with others. As Mangham and Overington (1987:27) put it, 'we dress up and make up to go out, we play roles, we stage parties, we entertain friends'. In such circumstances, the theatrical metaphor is often used without reflection. However, Lyman and Scott (1975:110) argue that people can glimpse the theatrical in life 'when they suspect that the persons before them are merely acting', or 'when they suffer from stage fright before or during an important occasion'. It seems that people have the facility to regard theatre as part of, and yet sometimes distinct from, their daily lives.

Apart from theatrical metaphor being found in daily conversations, everyday life can be viewed in terms of the theatre. Of course, such an idea is not new. Shakespeare gave expression to the notion that 'all the world's a stage' in his play, 'As You Like It'. In sociological circles, this imagery has been adopted and developed in what has come to be known as the 'dramaturgical' approach (see, for example, Goffman, 1959: Berger, 1966: Brissett and Edgley (eds.) 1975: Mangham, 1978, 1986, 1987 (ed.): Mangham and Overington 1983, 1987: Harre, 1979: Hare 1985: Colville, 1981, 1989). In brief, the 'dramaturgical' perspective is interested in the study of meaningful behaviour, how the individuality of each person is established through interaction and how situations are defined (Brissett and Edgley (eds.), 1975:2).

Dramaturgy has much in common with the symbolic interactionist school of thought. In a clear statement of the guiding principles of 'interactionism', Blumer (1969) argues that individuals act toward things on the basis meanings have for them. Furthermore, these meanings are products of human interaction and handled and modified through an interpretation process used by the person in dealing with the 'things' he or she encounters. Dramaturgy and interactionism are similar, therefore, to the extent that they both focus on an analysis of how meanings are created, maintained and changed by individuals interacting with others in specific situations. However, dramaturgical writers such as Goffman (1959), have tended to depart from Blumer's interactionism by concentrating on the way people are skilled performers who attempt to manage the impressions that others form of them.

It is not the intention here to follow Goffman's line of enquiry and explore the rules which govern social encounters. The theme of this chapter is to explore how life can be conceptualised by the dramatic metaphor. So how have social scientists understood theatre? Goffman (1959:246) uses the following concepts:

> In developing the conceptual framework employed in this report, some language of the stage was used. I spoke of performers and audiences; of routines and parts; of performances coming off or falling flat; of cues, stage settings and backstage.

Whilst providing a rich assortment of concepts, Goffman's view of theatre is a rather restricted one. As Mangham (1986:57) notes:

> In Goffman's theatrical frame, social actors perform, for the most part, within well-understood, well-rehearsed scripts which they have little or no part in creating. His image of theatre is that found in textbooks and more often than not referred to as 'classical' or 'traditional'.

Mangham continues his criticism of Goffman by arguing that the latter views theatre in terms of the 'polished performance'. Scant attention is paid to the way social life is put together (as a play is put together). According to Mangham, this means an exploration of the period of 'rehearsal' and 'improvisation' which can take place both prior to and during the public performance. Mangham's view of theatre is informed by an appreciation of the Renaissance Comedy, the Commedia dell'arte. In this Italian

tradition, players improvised around a scenario. The scenario is a summarised description of the plot in terms of the nature of the predicament, the parts to be played and the resolution (Harre, 1979:192). It is the scenario which provides the actors with themes to deviate from and to return to. Such a view of theatre is not a constraining one, but suggestive of spontaneity where actors are able to fashion their own parts. Having alluded to a theatrical tradition, Mangham uses the analogy by conceiving what goes on in organisations to be similar to the Commedia dell'arte. An examination of executive process then follows.

Mangham's treatment of theatre is a useful one for the purposes of this study. He shows that theatre is not just a place where actors play parts by religiously following a script, but can be a place where actors have intentions of their own and choice in the parts they play. Theatre is, therefore, a metaphor which can be used to explore how organisational reality is constructed and reconstructed by actors as an ongoing process. The paper by Colville (1989) discussed in chapter one (1.5.5) is an example of this approach.

So far, the connection between life and drama has been thought of in terms of the theatrical metaphor. This is not the understanding of all 'dramaturgical' writers. Those such as Burke (in Brissett and Edgley (eds.), 1975) and Lyman and Scott (1975) argue that drama is not a metaphor but a literal model for social interaction. Indeed, Lyman and Scott (1975:3) argue that 'reality is a drama, life is theatre, and the social world is inherently dramatic'. Others such as Perinbanayagum (quoted in

Mangham, 1978:24) puts the case more strongly:

> ...critics of the dramaturgical perspective err in supposing that the drama of social life is a mere metaphor; it is rather the stuff and fibre of social relations, and the very substance of the sociological perspective invites consideration in dramatic terms.

The author considers Perinbanayagum's position to be extreme one. Hare (1985:146) presents an alternative case which accommodates both the drama as 'real' and drama as 'metaphor' perspectives:

> ...we take the view that there is a continuum ranging from everyday activities that do not have a dramatic quality, through social events that are consciously staged, to theatre productions. In every case, the same social psychological variables are at work. However, the playwrights, directors, actors and critics involved with the theatre have paid considerable attention to some of the processes involved in presenting an idea to an audience. We can therefore turn to them as a source of concepts...

In line with Hare, this study takes the view that the domain of theatre can provide useful concepts for understanding how organisational life is constructed. However, as Goffman (1959:246) notes, the analogy of life as theatre should 'not be taken too seriously'. There are obvious differences between 'real' life and stage drama. Harre (1979:191), clarifies these differences between social life and theatre:

> Stage drama selects from, simplifies and heightens the act / action sequences and personal presentations of real life. Time is foreshortened. Only a few of the many threads of everyday life are followed. Resolutions are frequently achieved in contrast to the endless postponements of the daily round. Issues are faced rather than dodged; lies are discovered and so on.

In sum, any comparisons between life and drama remain metaphorical.

3.1.2 Illusion versus 'reality'.

The debate about whether drama is a literal model for life or just a metaphor is not confined to the Social Sciences. Literary critics are also interested in what they call dramatic 'illusion'. Dawson (1970:7) explains:

> Aristotle's placing of drama among the initiative arts gave rise to the idea that an audience was in some sense deluded or deceived into believing that what happened on the stage (ie. that action) was 'really' happening and that drama should be limited as far as practicable by the possibilities and probabilities of 'real life'.

This convention was replaced in the twentieth century by playwrights keen to show that it was false for the audience to submit unwittingly to the contrieved illusion of the stage by mistaking 'representation' for 'reality'. For example, in his

1919 play 'Six Characters in Search of an Author', Pirendello creates a play within a play. Whilst the opening of 'Six Characters in Search of an Author' is about a collection of actors and a director putting on a Pirendello play, it is not long before the audience is presented with a fantastical scenario; six characters from another play enter the theatre. The characters are 'created realities' that have been rejected by their author. In protest, the characters have jumped up from the script and gone in search of an audience. Within the play, the actors and the director provide such an audience.

The characters feel a passion to play out the drama because it is 'within' them and persuade the company that their story has dramatic potential. Ironically, when the actors attempt to portray the six characters, they are incapable of characterising them as they 'really' are. Consequently, Pirendello's play demystifies the nature of drama in the drama itself. The audience has to think very carefully about what they normally take for granted; that is, the nature of theatre itself. In being directed by the playwright towards reflecting on the nature of theatre, the audience are no longer victims of dramatic 'illusion'.

What is significant about the demystification of drama is the fact that the likes of Pirendello have made it possible for the audience to take a 'critical' attitude towards the performance whilst it is still going on. In order to tease out the meaning of the play for their own lives, the audience has to suspend belief in the authenticity of the performance. As the audience 'brackets out' what has hitherto been considered normal, they

approach a phenomenological understanding of the play. Therefore, the theatrical metaphor is an attractive proposition for researchers influenced by the phenomenological tradition (as the author is, see chapter one). The metaphor of drama offers researchers both an opportunity to demystify the nature of organisational life (as Pirendello demystifies the theatre) and understand the research act (Harre, 1979). The latter is made possible by the researcher of organisational life participating 'in' and acting as audience 'to' the 'action' which is unfolding in front of them (see section 3.4).

Researchers such as Mangham and Overington (1983, 1987) have noted the possibilities for demystifying the nature of organisational life. In thinking about interventions by consultants in organisations, Mangham and Overington (1983) pursue a policy of 'startlement'. By this, the authors mean that they wish to subject the accounts of organisational members to a 'critical' reading of the situation which the members themselves may not have considered. This approach moves away from the process of mystification by offering a more 'rounded' explanation rather than relying on one or two elements of the 'pentad' of dramatism. The 'pentad' of dramatism is derived from Burke's work (see Brissett and Edgley (eds.), 1975) and offers an approach to understanding the who, what, where, how and why of social action. Burke's formulation is used as a basis for model building in section 3.3.

3.2 Drama, Culture and Politics.

In the last subsection, the author linked the notion of dramatic illusion to a phenomenological understanding of social action. There are obvious connections to be made between a dramaturgical analysis and the broadly social constructionist stance adopted in the opening chapter. It was Berger (1966) and Berger and Luckman (1967) who exploited the metaphor of drama in relation to writings on the social construction of reality. The following passage by Berger and Luckman (1967:92) demonstrates the metaphor at work in relation to institutional analysis:

> The institution with its assemblege of 'programmed' actions, is like the unwritten libretto of a drama. The realisation of the drama depends upon the reiterated performance of its prescribed roles by living actors. The actors embody the roles and actualise the drama by representing it on a given stage. Neither the drama nor the institution exists empirically apart from this recurrent realisation.

The theatrical analogy can, therefore, enable a researcher to discover the social arrangements that make the staging of organisational realities possible. Similarly, the processual metaphors of culture and politics introduced in chapter one can be combined within the metaphor of drama to provide a powerful analysis of organisational processes.

Mangham (1978:26) illustrates the intersection between a dramaturgical approach to understanding the social world and the

metaphors of culture and politics in the following passage:

> The dramaturgical perspective assumes that society can only be realised, that microscopic and episodic action can only occur, and that individual purposes can only be achieved through the sharing of meaning about particular events, situations and relationships and that such sharing is realised symbolically, rhetorically and dramatically.

The references to 'shared meanings' and 'symbols' fall conveniently within the domain of the cultural metaphor. The image presented is harmonious, it is one where each person contributes to the routine of the everyday world by enacting 'tried and trusted' understandings of the environment. In short, culture and dramaturgy intersect when actors stage realities which are in accordance with the 'corpus of convention'.

Behaviour becomes political when individuals come to disagree with these enacted environments and seek support from others to bring about a new version of reality. Political activity involves paying attention to different events than before, defining situations in alternative ways and forming new relationships to achieve one's personal projects in life. Politics and dramaturgy intersect when key actors are able to shape and influence the activities of other actors. Furthermore, the metaphor of politics assumes that conflict is an inescapable feature of organisational life. Similarly, conflict is the essence of dramatic action (see section 3.3).

In short, the metaphorical nature of organisational life as drama have been shown to be consonant with the theoretical commitments made in the first chapter. With this in mind, the next section of this chapter seeks to demonstrate the utility of the dramatic domain by moving out of the theatre towards the province of another artistic medium; that of the television.

3.3 Organisational Life as a 'Soap Opera'.

In this section, the characteristics of the 'soap opera' are defined. Through such an analysis, the case is made for adopting the 'soap opera' as a metaphor for organisational life.

The term 'soap opera' originated in the USA in the 1930's. It was originally adopted to describe radio serials which were used as an advertising vehicle to promote the products of multinational companies such as Proctor and Gamble. Since the 1960's, the 'soap opera' has been successfully transferred from the radio to the television. In Britain, the longest running 'soap opera' is Coronation Street which was first broadcast on the 9th December 1960. This programme still enjoys tremendous popularity with the general public. For the week ending the 11th February 1990, Coronation Street was at the top of the national television ratings. The Wednesday edition of Coronation Street was watched by twenty-two million people. Four other 'soaps' were also well represented at the top of the television ratings, these being Eastenders, Neighbours, Home and Away and Brookside.

The immense popularity of the 'soap opera' was an initial reason for considering this form of drama as a metaphor for understanding conduct in organisations. The 'soap opera' is significant as part of our popular culture and is much more modern and accessible than plays staged in the theatre. Self (1984) makes the point that the broadcasting of one of Shakespeare's plays would yield an audience of approximately four million people. This is a fifth of the audience for a typical episode of Coronation Street. Somewhat more surprising is the fact that it would take the Royal Shakespeare Company five years of theatrical performances to amass an audience of twenty-two million people compared to one night for the makers of Coronation Street.

The main characteristics of the 'soap opera' provide further reasons for taking the metaphor seriously. Geraghty (1981) conceptualises 'soaps' in terms of the 'continuous serial'. According to Geraghty, the continuous serial has three main characteristics. The first relates to the organisation of time. The 'soap' is broadcast regularly at the same spot every week of the year and the time appears to pass at a similar rate as the outside world. Indeed, 'real time' intrudes into the drama so that occasions such as Christmas or Valentine's Day are interwoven into the plot to coincide with the event itself. To add to this sense of 'realism', the continuous serial has restricted itself to a portrayal of 'everyday life'. The drama portrays 'a slice of life' which takes place within a strong central location. As Hobson (1982:33) has written in relation to the television drama, Crossroads:

> Soap operas are designed specifically to connect with everyday life and aim to reflect reality. They are about people and the problems of their everyday lives.

As such, 'soaps' often comment on social problems of the times such as homelessness, child abuse and divorce.

Geraghty's second characteristic of the continous serial is the ongoing nature of the drama. The serial is differentiated from other forms of drama (including theatre) because it does not have a beginning, middle and end but is characterised by a sense of future. Geraghty (1981:11) makes this point in relation to the television series:

> Unlike the series which is advertised as having a specific number of episodes, the serial is endless. The apparent multifariousness of the plots, their inextricability from each other, the everyday quality of narrative time and events, all encourage us to believe that this is a narrative whose future is not yet written.

The final characteristic of the serial is that of the 'interweaving of stories' which make up the plot. Two or three stories are often intertwined within the structure of one episode and continue over from one episode to another. As one story ends another begins. The endless variety of stories provide the audience with a mix of the 'dramatic with the everyday, the tragic with the comic and the romantic with the mundane' (Geraghty, 1981:12).

Each of these three elements of the continuous serial are pertinent to this case study. In seeking to reflect community life without recourse to parody or satire, the 'soap opera' metaphor provides a model for understanding everyday life in a specific organisational setting. Furthermore, by concentrating on the ordinary and mundane nature of life as well as generic problems, the 'soap opera' analogy provides a link back to the sociology of everyday life and the phenomenology of Schutz (see section 1.3). Equally important to this study is the processual nature of organisational life which is captured by the 'soap opera's sense of future. In both the 'soap opera' and the organisational drama, life is ongoing and seemingly endless. The last factor which distinguishes the 'soap opera' as a useful metaphor for analysing conduct in organisations is that storylines are interwoven to reflect the complexity and richness of social life. This basic movement provides a relief from the tediousness of viewing established characters in familiar settings.

Having introduced the 'soap opera' metaphor, the next section of the chapter uses this image to develop a coherent conceptual framework.

3.4 A Framework for Understanding Conduct in Organisations.

This section presents the main elements of the 'soap opera' model which shall be used in the case study to illuminate social conduct in organisations. After a brief introduction on model building (3.4.1), seven concepts are developed in turn (3.4.2).

3.4.1 The 'soap opera' model: Model building.

This thesis has already used concepts which are used in both the theatre and in television drama without making any formal definitions. These include terms such as 'actor', 'performance', 'part', 'stage' and 'scenario'. In view of this, just what are the key terms for building a model suitable for viewing organisational dramas? In his treatment of dramatism, Burke (in Brisset and Edgley (eds.), 1975:370) suggests that the minimum is five - act, scene, agent, agency and purpose. According to Burke, these correspond to the what, where or when, who, how and why of social action respectively.

The author considers Burke's five terms to be a useful starting point for model building. Burke presents the social scientist with a group of concepts that enable questions to be asked about some social reality. A similar selection of concepts are presented below. In keeping with the theoretical traditions in chapter one, the 'soap opera' model consists of concepts familiar to sociologists as well as dramatists. Thus, a sociological understanding of the world underlies and informs the development of the 'soap opera' model.

Whilst developing a conceptual framework for understanding conduct in organisations, it is important to remember the model is not the thing it is trying to represent; life in an organisation is not a play or a television serial and it is not the intention here to build a model which restricts thinking to the world of the thespian rather than the world of the organisational

participant. The framework is purely a 'means' towards the 'end' of explaining and analysing social action in organisations. The model guides in such a way as to allow flexibility in thinking. This having been said, the key building blocks of the model are as follows:

- actors.
- projects.
- alliances.
- stage setting
- action.
- dramatic episodes.
- scenario.

These elements shall now be considered in turn.

3.4.2 The 'soap opera' model: Concepts.

Actor (or player).

Individuals are seen as unique and self-aware actors who seek to endow their own lives with meaning. Each actor has the ability to create and develop a range of parts for different social situations (in the author's case, a number of characters apply such as researcher, teacher, husband, father, son and friend etc). The actor chooses to play these parts and characterises each according to the fine gauze of experience. Within the context of the organisational 'soap opera', there will be a wide variation amongst the characters in terms of age, relationships

and attitudes. However, there will be a number of core characters who appear regularly and may be distinguished in terms of a particular trait such as being ambitious. Equally, certain characters are shaped by type and may perform within the constraints of a 'stock' part. For example, the academic context would yield the the eccentric professor or the lethargic student.

For simplicity, it will be assumed that a character can perform one of four different functions at any one time within the drama. These functions range from the protagonist to the antagonist, the supporting cast to the part of audience. Hare (1985:20) argues that the protagonist 'presents images, themes, plots or scripts that guide group activity' whose part is central in the play. Of course, there may be opponents to any such schemes and these are the antagonists. Meanwhile, those actors who make up the supporting cast complement the protagonists or antagonists. There may also be other actors present 'on stage' at any one time. These actors play the part of the audience and may verify the meaning of an event at a later time by providing accounts of the action.

The function that a character fulfills in an episode will depend on the storyline and the extent to which an actor's projects in life are engaged.

Projects.

Each actor possesses a unique mental framework which is used to define and interpret the world. This framework is made up of

concepts or ideas which are linked together as the actor learns about the world. Much of this knowledge is given to us by our predecessors and checked through daily interactions with others. As they go about their daily lives, actors become aware of some sense of a desired end to be served. In phantasising about some future state of affairs, each of us produce what Schutz (1976:20) calls our 'projects' in life. These projects of our 'forthcoming acts' are based on our current stocks of experience. Projects are rehearsed in our minds as a pre-text to action. This is what Mead (1962) calls the 'theatre of the mind'. Projects are only transformed into action when actors have the intention or purpose to bring about the projected state of affairs.

In any particular drama, actors' projects in life shadow the characters that they play. When actor's projects are engaged, characters are likely to become involved in the unfolding narrative and try to direct and influence others so that events unfold according to their expectations. In such circumstances, actor's play the part of a protagonist. If an actor can see the opportunity to create a different sort of drama based on their particular projects, they may play the antagonist. Other actors may have projects which are similar to the protagonist and antagonist and, therefore, support such characterisations. Any actors watching these performances may have a completely different set of projects altogether.

Alliances.

It is assumed that every actor has a unique biography which is the sedimentation of all their experiences. Our projects in life may reflect this individuality which means that actors define situations differently and are unable to always agree about ends and means. At such times, protagonists will attempt to gain support from other like-minded players by forming groups or cohorts so that their projects may be realised. These agreements reduce uncertainty for actors and the relationships can become relatively stable so long as each actor's projects can be sufficiently accomodated. On occasions, it may be in a group of actors' interests to make alliances with other groups by forming coalitions. In such circumstances, 'compromises will be negotiated, bargains struck and favours exchanged' (Eden et al, 1983). Where agreements cannot be made, a stalemate position may occur leading to the suspension of interaction.

Stage Setting.

In theatrical circles, the setting is the place of action in a play and includes furniture, decor, physical layout which supply the scenery and stage props for the action played out before, within, or upon it (Goffman, 1959). All social activity takes place within the 'spatial and temporal confines of a particular social setting' (Preston, 1987:81). It provides a background to any sequence of action. Writers often use the concept of setting as synonomous with the term 'scene' (as in the physical surroundings of the stage rather than a subsection of an

Act). Burke (1975) uses the term 'scene' rather than 'setting' to denote the background to any act...the 'when' or 'where' of dramatism. As Brockett (in Hare, 1985:48) argues, the setting is an 'aid to audience understanding...defining the time and place of the action and clarifying the relationship between the offstage and onstage space.' The setting, therefore, limits or constrains action in some way.

For the 'soap opera', the stage setting consists of a central location such as a particular street, close, square, hotel, hospital or ranch where the filming is undertaken. This setting becomes familiar to the audience and the action never strays far from this place. When the action takes place within the confines of these well-known surroundings, the action can be said to be located 'on set' or 'frontstage'. When the action relates to events beyond the normal boundaries of the community, the narrative has moved 'off-set' or 'backstage'.

Action.

From a sociological perspective, Weber (1968) considers action to be subjectively meaningful behaviour. Similarly, Schutz (1973, 1976) argues that action is conduct based upon a preconceived project. Both these conceptions point to the importance of understanding the subjective intentions of actors. As Silverman (1970:129) states, 'the action of men stems from a network of meanings which they themselves construct and of which they are conscious'. Action arises out of meaning and it is the patterns of meaning as reenacted and confirmed by the

use of actor's stocks of knowledge which constitute 'social reality'. Action is an ongoing process; it is a stream of happenings which is bracketed, interpreted and added to current stocks of experience by actors seeking to make meaning of their worlds.

Action is considered 'social' when actors take account of the behaviour of 'others' (Weber, 1968). This is the proper area of inter-action, the latter being concerned with interpersonal contacts and the extent to which actors align their courses of action as they gather together in social settings. Silverman (1970) stresses the importance of interaction in that it is through this process of face-to-face contact that actors modify, change and transform social meanings.

When applied to a 'soap opera', action is something continuous and ongoing thoughout the serial. It is in the drama and not behind it (as in a story). Action moves forward in time. As Morgan (1987:103) argues:

> ...each present moment continually presses forward into the future, with a sense of purposive direction or evolution.

Of course, not all action can be termed 'dramatic'. It has already been argued in section 3.1.1 that there is a continuum of activities that are more or less 'dramatic' (Hare, 1985). According to Morgan (1987:10), dramatic qualities are those of 'tension, suspense and surprise', there is a 'build-up in the action' leading to a 'climax', a 'change of direction' and a

'gradual resolution'. Similarly, Dawson (1970) argues that, for drama, there has to be tension, a demand for sustained attention, irony and action. In Dawson's words (1970:14), a dramatic sequence of action must 'embrace a series of situations which compel our attention; each situation arises out of what has preceded it, and gives rise to expectation of further change until the end of action, which is the end of expectation'.

Whilst Dawson's definition of dramatic action may be appropriate for a theatrical production, the need for a final resolution of the storyline is not a component of the 'soap opera'. As explained in section 3.3, the action is ongoing from episode to episode and the serial may provide only moments of temporary resolution. As such, the continuous serial has a similar structure to that of everyday life in organisations. Problems are not finished on time, tensions are not always resolved and life remains messy.

Dramatic Episodes.

According to Foote (1975:25), 'living gets organised like conversation into sentences, paragraphs and whole stories, of diverse length, complexity and intercontingency'. This metaphor captures how the processual nature of social activity can be organised into units of action. These units, the sentences of life, are the building blocks from which narratives are fashioned. In this account, units of action are called 'events'. It is the flow of interdependent events and practices that are the irreducible 'reality' of the 'soap opera' and organisational life

(see, Roberts and Scapens, 1985). Events are threaded into 'episodes' which correspond to the 'paragraphs' of living in Foote's analogy. They are a meaningfully bounded interaction (Harre and Secord, 1972: Harre, 1979). Within the 'soap' metaphor, an episode may contain two or three stories which are woven together and presented to the audience over a number of episodes.

In this case study, it is not just the researcher's judgment that pinpoints events and episodes. If episodes are considered as particular social dramas, each of these dramas must be sufficiently engaging in the minds and actions of the people in the organisation to be regarded as critical occurences (Pettigrew, 1979). This means that the main drama creates tension between protagonists which is then isolated by all of the actors as a major occurence and discussed in the ongoing situation. These accounts of sequences of action are commentaries which are produced for the purpose of 'justification, explanation or excuse' (Harre and Secord, 1972:166).

Scenario.

It was suggested in section 3.1.1 that a scenario is a description of the play or performance in terms of the actor's parts and the stages the actors must go through from predicament to resolution. A scenario may be 'thematic' and just suggestive of particular parts or more 'scripted' where specific directions of social behaviour are presented (Hare, 1985). In the context of this study, the scenario is not tightly scripted. Its function is to

allow the author (as narrator) to introduce to the reader the main themes of the dramatic episode under consideration. Consequently, the scenario is a summary of past action selected by the narrator who considers it worthy of portrayal and interpretation.

It is all very well to argue that the scenario is a reflection of past actions but how did these dramatic episodes come about? Who directed events so that a scenario could be narrated? Given the phenomenological stance taken in this thesis, the author does not consider that there is some extraneous scriptwriter who is able to determine the parts that actors play. The plot does not exist outside of situations but is found through situations. It is the actors themselves who create their own parts and guide the direction of events. This is compatible with the experience of actors in 'soaps' who often feel that they know better than anyone else how 'their' character would behave in a certain circumstances and influence the narrative. As Colville (1989:105) puts it, the actor's performance is 'not just about style but one of strategic intent to affect how the play turns out'. To place this 'strategic' project within the framework as outlined, such a part would be played out by protagonists and antagonists. As key actors, the protagonists and antagonists enact context selectively to define situations for others and attempt to bring about a favoured state of affairs (rather than another). Improvisation occurs around these enacted themes.

Given this processual stance which emphasises movement and flux, there appears to be little in the way of structure to keep 'chaos' at bay (Berger, 1966). However, structure does evolve out of

social process as actors align their courses of action (see Elger, 1975: Giddens, 1981). In situations where actors enact and reenact the same definitions and these are accepted by everyone, the situation can become routine; the actors know their parts and understand what is to happen. Little improvisation takes place. Actors may even lose sight of how their parts were conceived and run off the performance without questioning why they do what they do. In such circumstances, there may seem to be a script which achieves a kind of objectivity and confronts actors as 'reality'. In fact, the case study presented in thesis is concerned with actors who are in search of a new script, trying to find appropriate ways of behaving when faced with a novel situation; that of developing information systems within the hospital.

Having introduced the seven elements which make up the 'soap opera' model, the case study is the vehicle for illustrating how the concepts can work together to provide a thorough portrayal and analysis of different organisational dramas. Before introducing the environmental context of the study (chapter four), the final section of the chapter is concerned with how the 'soap opera' is to be applied to case materials in practice.

3.5 Applying the Model to Sequences of Action.

This final section of the chapter is concerned with how to apply the 'soap opera' model to a stream of events that the author has observed (and participated in) within the case setting of Camblewick Hospital. Particular attention is given to the way

dramatic episodes are portrayed and interpreted in the following chapters.

In metaphorical terms, the author has been to watch the making of an organisational 'soap opera'. The writer has spent two years observing and taking part in attempts by protagonists to develop information-based systems. The author has, therefore, taken the part of the audience (in observing the action) and also that of supporting cast (in aiding protagonists' attempts to introduce the MIS...see chapter two). Having been to the Camblewick drama, how might the myriad of events be portrayed? It would seem appropriate for the author to play the part of narrator now that, for the researcher, the drama can be considered to be 'over'. The narrator's role is to select dramatic episodes, present a scenario of 'what happened' to the reader (the narrator's audience) and then 'round this out' by relaying each stage of the action in more detail. In undertaking this task, the narrator is not neutral but attempts to demystify the 'drama'. This means acting as a television 'critic' and providing 'informed commentary upon the action, upon the players and their performances, upon the scene and the scenario' (Harre, 1979:192).

It is important to emphasise that the intention of the author is not to write a 'soap opera'. If this was undertaken, the metaphorical nature of the comparison between organisational life and the continuous serial may well be obscured. The 'soap' metaphor is merely a vehicle for thinking about the staging of organisational realities. The elements described in the model perform a function in providing the narrator with a pool of

concepts with which to fashion an interpretation or critique of the Camblewick drama. The concepts are the tools which enable the narrator to characterise the different parts played by actors within the setting and, to some extent, let the actors 'speak for themselves' by using their words in the text. Of course, these members' accounts of action need to be situated in terms of the actors' reasons for making them such as justification or explanation. These accounts are also introduced by the narrator for a purpose, this being to facilitate a particular project - that of providing the reader (and the wider academic audience) with a 'scientific' and trustworthy account of the drama.

The 'soap opera' model is not fully introduced until chapter six. This is because chapters four and five are concerned with 'setting the scene' by describing the context for action at Camblewick hospital. The four dramatic episodes which are presented in chapters six to nine are not as distinct as they may first appear. The first episode provides themes which are subsequently developed in later episodes. In terms of the structuring of each chapter, the format of chapters six to eight is similar. Each chapter begins with a scenario of the episode under consideration. The episode is then portrayed by the narrator in a number of parts. As a way of extending the 'soap opera' metaphor, analysis of the ongoing action is interwoven into the drama through the use of commercial breaks which are renamed 'conceptual breaks' to befit their purpose. These are to be found at the end of each part of the serial. Finally, each chapter is concluded with a summary of the main themes. In order to increase the dramatic tension, chapter nine is presented in terms of a dialogue between actors.

In keeping with the earlier chapters, this drama is also analysed by the narrator using 'conceptual breaks'.

3.6 Conclusion.

In this chapter, a distinctive model based on the continuous serial or 'soap opera' was introduced and developed. Initially, a case was made for using theatrical terminology as a resource for a collection of concepts. Connections between everyday life and the theatre were investigated with particular reference to the writings of those working in the 'dramaturgical' tradition. The dramatic metaphor was considered a useful analogy for investigating how organisational realities are 'staged' or 'constructed' as well as being consistent with the processual metaphors of culture and politics.

The author's own particular 'soap opera' model was then proposed. By using the continuous serial as a metaphor for organisational life, the utility of drama as a 'way of seeing' was extended beyond the domain of the theatre. The 'soap opera' framework was also unusual in the sense that the concepts were gathered from a variety of sources (not just 'soap operas'!). For example, Schutz' concept of 'project' was taken from phenomenological writings and 'alliance' from the micropolitics literature. Both terms were given particular prominence in the 'soap opera' model. Concepts such as 'scenario' were included because they have tended to be used implicitly rather than explicitly by field researchers working in the dramaturgical and interactionist traditions. In short, the seven concepts presented were thought to be a

sufficient set of tools for analysing and interpreting social conduct in organisations.

In the last part of the chapter, attention was given to the how the model could be applied to sequences of action enacted within the case setting. It was argued that the author would play the part of narrator in presenting his account of 'what happened' to the reader. This would allow the narrator, as one actor present at Camblewick, to act as a 'critic' and demystify his account of the drama.

Chapter four: The Environmental Context of the Study.

4.0 Introduction.

In the last chapter, a 'soap opera' model for analysing conduct in organisations was proposed. Before using the model to portray and interpret four dramatic episodes in the case setting, this chapter and the next are concerned with 'setting the scene' before the serial begins. This is considered an important task given the narrator's commitment to studying social phenomena in their context. The actions of individuals are motivated by events within the larger whole and cannot be understood apart from it.

This chapter locates the case study of information system developments at one hospital within the environmental context; namely the characteristics of the NHS as a backstage area. Chapter five narrows the focus by examining the organisational context of the case setting. Thus, the scene is set in the frontstage as well as the backstage. Chapters four and five are vital to this thesis as a way of introducing significant themes. It is these themes which are continually played out in the dramatic episodes which make up the body of the case study in chapters six to nine. 'Setting the scene', therefore, provides a historical canvas against which to interpret these successive episodes.

The first part of this chapter (section 4.1) is concerned with identifying what is distinctive about the NHS as a complex form of 'organisation'. The hospital is introduced in terms of the

professional bureaucratic configuration (Mintzberg, 1979). However, rather than concentrate on structures (as Mintzberg tends to do), section 4.1 examines the tensions that exist between the different groups of actors that have a stake in running the service. In section 4.2, the focus shifts to the problems the NHS faces in the late 1980's. One example of the problems experienced within a cardiac unit is given to highlight the conflicting demands upon the service. Tracing the NHS back to its founding assumptions, it is shown how the changing political and economic contexts have merged to produce difficult operating conditions for those running the service at the unit level.

Finally, section 4.3 attends to the NHS projects of successive Conservative Governments that have attempted to alter the balance between professional and managerial action in hospitals. It is claimed that projects such as general management and information system development have striven to strengthen managerial action throughout the service. Whilst such Government initiatives are intended to enable managers, doctors and nurses make more informed decisions about allocating and consuming resources, these developments have not been well synchronised. In practice, management of the service remains reactive, leaving health care 'professionals' the unenviable task of rationing care at the local level.

4.1 The NHS as a Distinctive Organisation.

In this section, the NHS is treated as a unique and distinctive 'organisation'. In subsection 4.1.1, the NHS is presented as a

large and complex institution that has enjoyed massive public support over the last forty years. Section 4.1.2 argues that hospitals are often understood by theorists as professional bureaucracies. However, this conceptualisation is considered insufficient because it neglects the processual nature of organisational life. This subsection supports the view of the NHS as composed of a number of competing coalitions (Thompson, 1986, 1987). It is in the final part of the section (4.1.3) that attention is given to the tensions that exist between the three major coalitions.

4.1.1 The NHS as a friend to the nation.

The NHS was created in 1948 during the first term of a Labour Government following the second world war. Aneurin Bevan, Minister of Health (1945-1950) is the man who is regarded as the founder of the NHS. Bevan (1952:92) argues that the NHS makes a 'massive contribution to the equipment of a civilised society' and is 'part of the texture of our national life'. Bevan's statement still has relevance today given that the NHS has survived forty years and enjoys massive public support.

The founding assumption that the NHS should provide a tax funded system of health care delivery free at the point of need has largely been protected. Bevan argued in his text 'In Place of Fear' that 'no political party would survive that tried to destroy [the NHS]' (1952:92). This comment has particular relevance in the late 1980's as a third successive Conservative Government sets out to reform the NHS with the publication of the White Paper

'Working for Patients' (Department of Health, 1989a). Whilst the details of this report are introduced in chapter eight, the point made here is that the Government's paper has evoked a strong desire on behalf of the public to preserve the NHS. For example, a poll conducted by Gallup in the first week of October 1989 for BBC1 coverage of the Conservative Party conference (10/10/1989) suggested that 83% disapprove of the Government's plans for the NHS.

The NHS is a large organisation with a current annual expenditure in 1989 of £26 billion and approximately one million staff. Only the Red Army and the Indian railways are larger organisations. The NHS is a complex organisation but can most easily be understood in terms of four tiers (see appendix 13). At the bottom, there are the units of management (ie. the hospitals and community services). Collections of units are grouped within districts and these in turn are arranged into regions. At the top is the national level (the Department of Health). These tiers are not mutually exclusive but are intertwined through the movement of personnel from one tier to another. For example, a Unit Accountant at one unit may also be the Deputy Treasurer of the District Health Authority.

So far, the NHS has been referred to as though it were a monolith. This is very misleading given the author's dislike for reifying organisations. To avoid confusion, the term the NHS is used throughout this account as a short hand notation for a number of different settings in which people enact and reenact distinctive histories and traditions. This case study is concerned with one

such organisational arena but is placed within the context of the other tiers of the service.

4.1.2 Conceptualising the NHS: Structure versus process.

Given the researcher's interest in hospitals as the basic unit of management in the NHS, how might these 'organisations' be understood? Mintzberg (1979) conceptualises organisations as complex entities whose elements of structure, strategy and environment have a natural tendency to gather into configurations. Mintzberg suggests there are five such configurations which have relevance to a large fraction of organisations. Hospitals are thought to fall most naturally under the professional bureaucratic configuration. The key groups within this configuration are the trained 'professionals' (in this case, the medical and nursing staff) who must be given considerable control over their own work. According to Mintzberg, operating and strategic decisions flow downwards to the professionals in the operating core. Coordination is achieved between the 'professionals' because of the standardisation of skills. In the hospital, clinical practitioners work independently and this means that only a few middle managers are needed to protect the 'experts' from unwelcome intrusions from the 'environment'.

The support staff for these clinical 'experts' is very large in the professional bureaucracy. General servics such as laundry, catering, domestics and portering provide jobs which are simpler to perform than the trained 'professionals' and more amenable to top-down management. Thus, 'parallel hierarchies emerge in the

professional bureaucracy - one democratic with bottom-up power for the professionals, a second autocratic with top-down control for the support staff' (Mintzberg, 1981:109). Mintzberg warns that 'this is not a structure to innovate' and operates most successfully in complex and stable environments where the 'professionals' can perfect their craft.

This conceptualisation of hospitals raises the whole question of the tension between the stock characterics of the professional expert and the bureaucratic expert. Sociologists, in particular, have been keen to expose the conflict between professionalism and bureaucracy. The analysis of Scott in Davies (1983) is typical in that it treats representations of bureaucracy and profession as immanent and diametrically opposed structures (see figure 1).

This bureaucratic - professional split has been used in analyses of the NHS. Hunter (1980:11) suggests that what is unique about the NHS is that 'it is a split organisation with a bureaucratic component and a professional component' and that 'it is the nature of this split organisation which underlies many of the management problems and tensions in the NHS'. The rigid 'conflict' thesis that is behind the analysis of Scott and, to a lesser extent Hunter, seems to deny the fact that Mintzberg considers the two influences can be accomodated within the professional bureaucratic configuration and are, to some extent, complementary. Furthermore, actors within hospitals have managed to combine professional and bureaucratic parts (as in doctors who take management positions but still continue to treat patients).

A Model of Professional / Bureaucracy Conflict.

	Bureaucracy	Professionalism
task	partial, interdependent with others	complete, sole work
training	short, within the organisation, a specialised skill	long, outside the organisation, a total skill
legitimation for act	is following rules	is doing what is to the best of his knowledge correct
compliance	is supervised	is socialised
loyalty	to the organisation	to the profession
career	ascent in the organisational hierarchy	often no further career steps in the organisation

Figure 1. Source: Scott in Davies (1983:178)

The foregoing analysis has tended to favour structural analysis rather than that of organisational processes. The stance taken in this thesis is more closely affiliated to the position taken by Davies (1983:192) who argues for work organisations to be conceptualised as 'everchanging and emergent social forms'. It was argued in the last chapter that this processual view needs to take account of groupings of people and how their actions are guided by specific projects. The NHS is particularly distinctive in that 'professional' and 'managerial' groups have to work together throughout the different tiers of the service. The term 'management' is preferred to 'bureaucratic' or 'administrative' because it fits the context of the NHS in the late 1980's following the introduction of general management in 1984 (see section 4.3.2). Whether management itself is successfully following a professionalising strategy is of some current debate but will not concern me here (see Watson, 1986:187-192 for a discussion of this issue). It is sufficient to state that the medical groups, in particular, have been very successful at using the concept of a 'profession' as one means to construct a reality in line with their own particular projects in life.

Thompson (1986, 1987) suggests that there are three alliances which dominate the NHS. These are the political, practitioner and administrative coalitions. The diagram below illustrates the key features of Thompson's analysis (see figure 2). Two boxes in Thompson's scheme have been altered; the administrative coalition becomes the managerial coalition whilst the natural power base of the District Administrator has been replaced by the District General Manager (DGM) and the Unit General Manager (UGM). This

does not preclude the possibility of an administered rather than a managed service.

The Characteristics of the Coalitions.

	Political	Practitioner	Managerial
Belief	Parliamentary accountability	Clinical autonomy	Social Services and equity in meeting patient needs
Source of power	The law	Technology	Information networks
Power base	Authority Chairman	Medical Executive Co.	DGM, UGM
Recipient of health care	Consumer voter, taxpayer	Patient	Patient groups, defined communities

Figure 2. Source: Thompson, (1986, 1987).

Thompson's analysis is useful to this study in that it recognises that the NHS is a pluralistic 'organisation' and that different groups may have conflicting 'beliefs'. However, the way Thompson presents his analysis is somewhat static and needs to be reinterpreted in terms of dynamic action as different parties pursue their projects in life. The term 'project' is preferred to 'belief' in that 'accountability', 'autonomy' and 'equity' may be future states of affairs that provide guidance and meaning for the everyday actions of individuals and groups. Therefore, projects are strategies but can also be viewed as symbolic resources when used by actors to further one course of action rather than another (Watson, 1977). In this case study, of particular interest is the tension between the activities of the clinical practitioners (professional action) and those of managers (managerial action).

For any particular ongoing situation, whether one group's projects are pursued at the expense of others is largely dependent on the claims that groups and individuals put forward to defend or further particular ends. According to Thompson (1987), the political coalition has an arena in the meetings of health authority members. During these meetings, actors may 'draw their power from the majesty of the law and a belief in democracy to formulate the policies and set the financial and organisational framework within which the NHS operates' (Thompson, 1987:132).

As the focus reaches the level of the district, and more specifically the unit, local politics may diverge from national politics allowing the practitioner and managerial alliances some

influence. The practitioner coalition is made up of medical and nursing groups who may mobilise their claims to technical knowledge and expertise to legitimise their professional acts on behalf of the individual patient. Whilst Thompson stresses the importance of 'autonomy' to a maintenance of professional action, this project is increasingly under challenge from Ministers in the Government who are stressing the importance of utility (see section 4.3). Utility is concerned with the maximisation of output, that is to say with 'efficiency and output'. According to Fisher (1990), the utility heuristic takes into account the 'common good' of customers rather than the 'individual need' of patients.

The managerial coalition may also be able to secure some influence at the hospital level by controlling information flows and administrative structures and procedures. 'Objective' information and 'rational' argument in the pursuit of a fair treatment to all patient groups are claims that managers may use to counter the arguments of the clinical practitioner. The case material presented in chapters five to nine investigates this area of potential influence as managers attempt to develop formal information systems.

As a final note of interest, Thompson's analysis is valuable because it suggests how each actor or group of actors can claim some service or benefit to the tax-paying customer, patient or local community regardless of which coalition they are located in and the projects they are pursuing.

4.1.3 Tensions between the clinical practitioner, managerial and political coalitions.

The above analysis points to a number of groups operating within the broad context of the NHS. Understandably, there is likely to be an element of tension within and between different coalitions. These tensions provide the basis for treating organisational life as if it were a drama. One such tension exists between actors belonging to the political and managerial based groups. It is clear from the conceptualisation of the NHS as having a national tier that the service operates within a 'politicised' context. At the national level, the Policy Board (which has replaced the Supervisory Board following the White Paper, 'Working for Patients', 1989a) is chaired by the Secretary of State for Health and is the top level body which sets policy, decides finance and monitors performance. The Management Executive (which has been replaced by the Management Board in accordance with the White Paper) is meant to implement the policies of the Supervisory Board and is chaired by the Chief Executive (appointed by the Secretary of State).

The tensions between national politics and management of the health service are perhaps most vividly portrayed in the resignation of a key player in the NHS; the former Chairman of the Management Board, Victor Paige. In an interview for a BBC1 programme, 'A Picture of Health' (September, 1988), Paige commented that he resigned because 'the politicians were doing the management' and that the politicians never said that 'that is a matter for the Management Board'. For Victor Paige, managers had

become the agents of the political coalition, a view supported by Harrison (1988). This view is further articulated in the next section of the chapter.

Other tensions exist between the political and practitioner coalitions and the practitioner and managerial coalitions. Taking the first of these relationships, the most striking example of conflict between the Government and the medical profession was at the birth of the NHS. In his original plans for the creation of the NHS, Aneurin Bevan (Health Minister, 1945-1950) intended that general practitioners be paid, in part, by salary rather than capitation and local health centres provide the front line health care provision with the hospital service in reserve. The British Medical Association (BMA) resisted these plans fearing 'the socialist principles of state ownership of hospitals, direction of doctors and basic salaries for doctors' (Guy Dain of the BMA quoted in Chalmers, 1988:5). In a poll reported in the Evening Standard in February 1948, 89 per cent of doctors were against the Labour Government's plans for the service. Bevan had to compromise the principle of a whole time salaried service to the BMA in order for the NHS to start the service on the appointed day (5th July 1948). The BMA negotiated favourable contracts of employment with the right of practitioners to define and implement clinical decisions and play a significant part in policy formation.

According to Klein (1983:24), this episode established the power of the medical veto as a natural and legitimate characteristic of the NHS. Medics were neither part of, or divorced from the

organisation. The situation is still very much the same in the late 1980's. Medical and nursing groups aligned to the practitioner coalition can still be seen to be resisting Government plans to reform the way the NHS is managed and organised as outlined in the White Paper, 'Working for Patients' (Department of Health, 1989a). This Government project is discussed in detail in chapter eight.

The final relationship not yet considered is that between the practitioner and managerial coalitions. Tension between these two alliances is readily available in the NHS literature. For example, Nairne (1988:1520) argues that:

> ...the difficulties of the NHS have never seemed to me an adequate explanation of its flair for 'rubbishing' itself in public. Clinicians openly criticise the numbers of administrators; administrators respond by criticising waste by clinicians.

Nairne is suggesting that open criticism is a cultural phenomenon. The apparent conflict between doctors and managers is summed up by Klein (1983:160) who argues that:

> the paradox of the NHS is that while it is the professional expert who decides which patient gets what in the way of treatment, the machinery of accountability is designed only to make the bureaucratic expert answerable for what he or she does.

Likewise, Scrivens (1988:1754) suggests that:

> Doctors complain that they cannot treat as many patients as well as they wish; managers complain that they cannot manage because the invocation of clinical freedom means that they have no control over doctors' use of resources.

In Scrivens suggesting that coalitions are inhibited due to resourcing constraints, this comment introduces the economic context of health care delivery. In the next section, consideration is given to the problems the NHS faces in the late 1980's, operating as it does in a complex political and economic context. One example is taken which highlights the dynamics between actors aligned to the three coalitions 'within' the service and other 'outside' parties; namely the public and the media.

4.2 Problems of Resourcing the NHS.

In such a large and complex organisation as the NHS, problems are part of the status quo rather than the exception. Poor management of the service has been a common complaint throughout the 1970's and 1980's and one of the reasons that there have been three reorganisations of the service between 1974 and 1984. The cycle of 'management' trends has gone from one of advocating 'consensus management' at the hospital level (whereby a triad of a doctor, nurse and administrator all had to agree on what decisions should be taken) through a philosophy of management teams and, ultimately, to the appointment of general managers at each level

of the service. Each of these reorganisations have aimed to make improvements in the way the health service is run and yet the media claimed that the NHS was in 'crisis' during the Winter of 1987 / 1988. In section 4.2.1, consideration is given to a well publicised example of insufficient resourcing of the health service, this being the case of David Barber at the Birmingham Children's Hospital. Spokespersons from the three competing coalitions offer different understandings of the Barber incident. This analysis is followed by an investigation into the apparent lack of resources for the health service and how the economic and political contexts of the NHS are inextricably intertwined.

4.2.1 The Baby Barber episode.

The particular event of interest occured in November 1987. It was the case of David Barber, a six week old baby with cardiac abnormalities (a 'hole in the heart') and waiting for an operation at the Birmingham Children's Hospital. According to press reports, the baby's operation had been postponed five times because of a shortage of specially trained nurses. The number of beds at the intensive care unit had been cut from six to four as a result of these staff shortages. David Barber's parents sought an injunction compelling the Health Authority to perform the operation but this was turned down in the courts. David later died eleven days after receiving the operation.

This drama evoked responses from various parties. In the context of Prime Minister's question time in the House of Commons on the 24th of November 1987, actors from the Labour Party and the

Conservative Party 'played' politics in the following manner:

David Nellis (Lab): If there are any deaths in these cancelled heart operations the Government won't be able to pass them off as accidents - that will be murder!

Tony Newton (Cons): The main problem is the shortage of intensive care nurses and the situation is now improved. We have to recognise that in the end, clinicians have to decide the order in which patients are treated according to the urgency of their case.

Whilst the Labour spokesman's language is emotive, his project is to blame the Government for the current situation. The Conservative Minister's project is to deny that the postponements of operations is a Government responsibility. He does this by refering to the shortage of nurses as being behind the problem and that this has been contained (without Government action). Newton's second task is to further disown responsibility for the case by suggesting that the Government should not interfere in the clinical judgements of doctors.

Newton's first statement about the nursing shortage was scrutinised by newspapers offering an alternative opinion to the Government of the day. In The Guardian, Phillips (1987) makes the case that there is a shortage of specialist nurses because they are not paid enough and this is a Government matter. However, she speculates that any pay awards would not be funded by the Government and have to be met within the present health authority budget. This could not be done without squeezing services.

Phillips sums up by saying:

> Without pay rises, the nursing catastrophe will accelerate. With them, it is likely that services will be cut again.

Turning to the Health Minister's second point in the common's debate, Tony Newton argues that the Government should not interfere in the clinical judgements of doctors. This point of view is supported in the courts for the judge does not instruct the surgeon to operate. Thus, parties aligned to the political coalition support a major project of the practitioner coalition - that of autonomy or clinical freedom. The consultant in the Barber case is aligned to the practitioner coalition in wanting to be left alone to practice his craft. Barber's surgeon, Mr Sethia, is reported as saying:

> Each week we should do seven to ten operations and we are lucky if we do one. (The Guardian, 25/11/87:2)

This consultant does not have freedom without the resources he needs. He is forced into making decisions about patient priorities that he hitherto did not have to. The responsibility for priority of care flows from the Government to the consultant because of a lack of resourcing of the service.

Meanwhile, what of the managerial coalition? The General Manager of the Birmingham Children's Unit seems powerless and is left to state the obvious:

> Mrs Jean Rigby, General Manager of the Children's Hospital, said it was not possible for David's operation to be performed yesterday because all the beds were full. David remained stable (The Guardian, 25/11/87:2).

The manager is left to argue that the hospital is running to capacity within the resources it has. The implication here is that management are not discriminating against Baby Barber because there are other worthy cases being treated. Equity is maintained.

The Barber episode sparked a number of reports of similar cases in December 1987 eg. Matthew Collier, a four year old heart patient at the Birmingham Unit. The problems of the NHS were further publicised when the presidents of the three senior Royal Colleges (the surgeons, physicians and gyneacologists) issued an unprecedented statement on the 6th December warning that the NHS had 'almost reached breaking point'. The president of the Royal College of Physicians is reported as saying that 'we are trying to run [the health service] too cheaply' (see Timmins, 1988:44). In the face of this lobbying for extra resources for the health service, the media started to look at problems, such as bed closures, in more detail. Under the heading 'Crisis in the NHS', the following report was made by Timmins (The Independent, 9/12/87):

> According to the figures, which are far from comprehensive, more than 3200 beds are temporarily closed [by health authorities in England]. The total does not include short-term closures of beds, for perhaps a month, planned by some

authorities later in the financial year, which ends in April. Nor does it include those who will not take effect until the next financial year; nor delays in opening new facilities to save money, outside London. The closures from shortages of nurses, which make up less than half the total, go up and down as recruitment waxes and wanes. But some districts, with beds already closed for financial reasons, say that they could not afford to reopen them this year even if they could recruit the nurses.

This article constructs reality in publicising the 'crisis' to a wider audience. The problems for the NHS had become not only staff shortages but funding shortages. Numerous articles were written of this type in December 1987 influencing the public's perception as to the state of the NHS. The public were polled for their opinions in a Daily Telegraph Gallup Poll on 14th December. It was argued on page one of the Telegraph that 'twenty-two per cent see the health service as the country's most pressing problem' and, in relation to a Government proposal to charge for medical check-ups, that '88 per cent opposed the scrapping of free dental checks and 89 per cent opposed charging for eye tests'. The publics commitment to the founding principle of a free health service at the point of need appeared robust.

Pressure mounted on the Government to act and they did so on the 17th December 1987. Tony Newton, the Health Minister, announced £101.8 million to ease the pressure on the NHS in the current financial year. The Government had finally accepted that there were problems in the NHS and that they should act to help the

service and pacify their critics. However, as the case study reveals in chapters six to nine, this 'one-off' payment to health authorities did not end the matter.

The case being made in relation to the Barber incident is that the NHS is constrained by the political and economic context in which it operates. The financial 'reality' is that the NHS depends on central Government funding for its survival and how much it receives is largely a political decision. Economic and political contexts are inextricably intertwined and can produce difficult environments for those health care 'professionals' working at the unit level. However, the relationship is not one of hospital actors purely reacting to Government scripts. Actors can reject a particular characterisation and lobby the Government to win concessions (as in the episode above when Barber case stimulated interest in the problems of the NHS leading to an extra payment being made to the service). The remainder of the section is devoted to understanding something of the widening gap between health care demand and health care supply.

4.2.2 Investigating the resourcing shortage.

In understanding something of the debate over the appropriate levels of resourcing for the NHS, it is important to return to some of the founding principles behind the formation of the NHS and how they turned out to be very naive. As has been made clear in the section above, the major principle behind the creation of the NHS was that of a tax funded health service free at the point of need and available from the 'cradle to the grave'. In Bevan's

words (1952:77):

> The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not a disadvantage.

The boldly stated ideal was that the service should be free but could the nation afford it? Assumptions put forward by Beveridge prior to the formation of the health service took the view that development of the service would be offset by the fall in demand after the initial backlog of need had been wiped out and the population became healthier as a result of better medical treatments. In economic terms, the introduction of a nation health care service would produce more fit people who would be able to return to work. This in turn which would mean greater wealth for the nation and enough money to fund the NHS. Despite this optimistic thinking, events did not turn out as expected.

Bevan's principle of a free health service did not last long. Bevan resigned from the cabinet in 1951 because of the introduction of health charges for drugs, dentures and spectacles. The Treasury view was that 'charges were necessary both to offset some of the cost and to curb a tendency to prescribe medicines, spectacles and dentures too freely' (Watkin, 1978:29). Since the 1950's, the amount of volume spending on hospital and community health services (what health authorities can buy with the money after pay and price rises) has increased until the beginning of the 1980's. However, despite increases in annual expenditure on the NHS from eight billion in 1978-1979 to twenty-six billion in

1988-1989, the BMA's view is that volume spending has remained fairly static since 1982 (see figure 3 below).

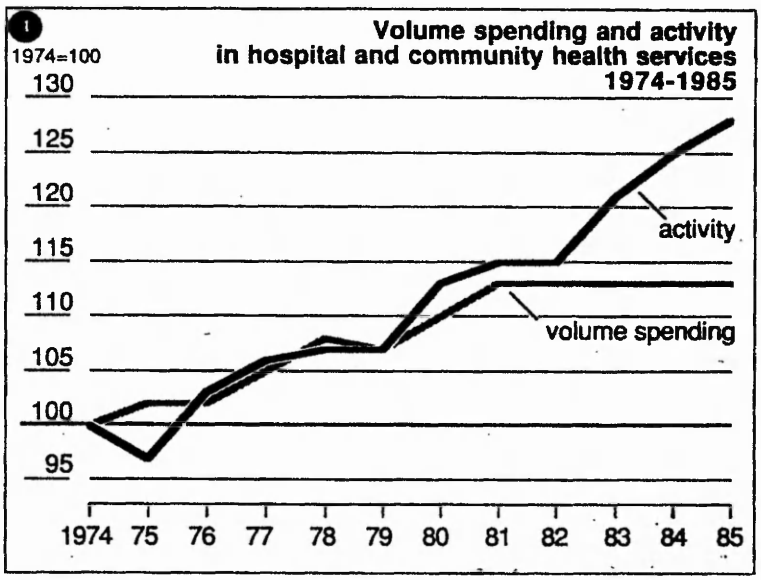


Figure 3. Source: BMA in Timmins (1988:7).

Assuming that this chart is indicative of a trend and not purely an artificial 'prop' for the BMA's lobbying activites, it can be argued that volume spending cannot afford to stay still in the NHS for a number of reasons. These are:

(1) the increasing demands of a population which is living longer.
(2) the challenges and opportunities presented by advances in medical science.
(3) Department of Health demanding improvements in priority areas eg mental handicapped and family practitioner services.
(4) the public are committed to a tax funded health service and yet their expectations of what the service should achieve is increasing.

The increasing cost of looking after an ageing population, the high expense of sophisticated medical technologies and a switch of funds to the community sector has meant that spending on the acute hospitals (ie medical and surgical treatment and not long stay care) has been squeezed. In crude terms, services would need to expand by two per cent a year to cope with these developments (see Timmins, 1988) but this has not happened. The forecasts of a decreasing burden of financing for the NHS made in the 1940's have been proved to be hopelessly mistaken. Demand for health care is outstripping supply.

During the 1980's, the pressures on the service have been increased due to a political decision by the Government to spend less of the gross national product (GNP) on health care than other countries. Ironically, this is at a time when the public are

demanding more from a health service and yet expect the NHS to be largely funded through central taxation. The figures are as follows; in 1987, the UK spent 6.2 per cent of GNP on health compared with 10.8 per cent in the United States, 9.6 per cent in Sweden, 9.3 per cent in France, 8.8 per cent in the Netherlands and 8.2 per cent in West Germany (see figure 4 below).

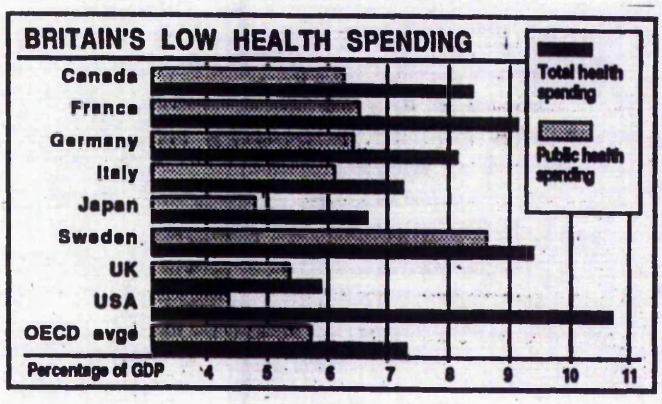


Figure 4. Source: OECD in The Guardian (20/1/1988:16)

Whilst league tables do not always compare precisely the same kinds of service provision, the overall pattern suggests that the NHS is a relatively cheap method of delivering health care. Successive Thatcher Governments have not pursued an 'open bag of money' policy towards health care provision and accepted that some rationing of care must take place. However, rationing of care has taken a 'backdoor' route because of the sensitivity of the subject with the voting public. The lesson of the Winter of 1987 is that as resources become short, managers have had to close beds and operating theatres and leave doctors with the difficult task of deciding which are the most needy cases. As shall become clear in the final part of the chapter, these decisions have not necessarily been 'rational' decisions because of the lack of formal information available in the NHS.

4.3 Government Projects in the NHS.

This section of the chapter considers Government projects for the NHS in the 1980's which have emerged from the top tier (ie the Department of Health). These have concentrated on strengthening managerial action within the service. It will be shown in section 4.3.1 that the Government have taken an interest in cutting out waste and tracing how resources are used at the unit level. In the next part (4.3.2), attention is given to a particular Government project, that of general management. This project was intended to change the way the service was organised and managed by creating a system of accountability throughout the service. The appointment of general managers was to be complemented through various information system developments which are still being

developed in 1990. It is these information-based projects which are considered in subsection 4.3.3. Throughout section 4.3, my argument is that the implementation of successive Government proposals threatens to disturb the relationship between professional and managerial action within units. It is this duality which is crucial to the running of the service at the operational level.

4.3.1 Value-for-money.

When the Government came into office in 1979, a number of criticisms were aimed at the NHS by the Public Accounts Committee in terms of its lack of efficiency. This sparked the DHSS to look into the whole question of what savings could be made in the NHS. From 1981, the NHS was expected to make 'efficiency savings' and these amounted to as much as half a percentage point in 1983-1984. Furthermore, health authorities were cash limited since 1978 and legally obliged to stay within their budget. To complement these requirements, the Secretary of State, Norman Fowler, announced two measures to improve accountability throughout the service. These were the introduction of a review process involving regions and districts and the development of performance indicators. Harrison (1988:57) argues that the review process was an attempt to 'secure greater adherence to national policies' whilst according to Birch and Maynard (quoted in Maxwell, 1988), developing performance indicators was a way of asking questions about atypical performance. Resource-rich units or programmes could be easily spotted 'without asking too many questions about quality of care' (Maxwell, 1988:6).

Other strategies followed these measures. The Government's project was based on the concept of economic utility; that is to say, improving the 'efficiency and effectiveness' of health care delivery. This idea was restated in terms of the NHS providing 'value-for-money'. Better value-for-money was to be achieved through such mechanisms as targeting the ancillary services (eg. laundry, catering and domestics) for competitive tendering. The idea here was for private contractors to be given the chance for delivering the ancilliary service at a cheaper price than 'in-house' staff could manage. In the event, the vast majority of bids were won by 'in-house' bids but pay rates of ancilliary staff were cut in order to do so. Competitive tendering was indicative of a Government keen to 'tone-up' the NHS rather than radically change it. As Pike (1988) argues:

> It would have been unthinkable that the NHS could have completely escaped the attention of a Government committed to market forces, privatisation, tight control of public spending, improved efficiency in the public sector and reducing the dependence of the individual on the state.

Any 'hands off' approach to running the service that had hitherto prevailed was abandoned in 1983 when an inquiry was set up by the Prime Minister to investigate the effective use and management of manpower and related resources. General 'management' had arrived in the NHS (as opposed to 'administration') and it is to this subject that the chapter now turns.

4.3.2 General management.

Roy Griffiths, Managing Director of Sainsbury's, was asked to head the inquiry team set up to study the management of the health service. In late 1983, Griffiths reported his team's findings in an extended letter to the Secretary of State. His argument hinged around the observation that 'consensus' management within an organisation arranged primarily around the medical and nursing functions had produced the 'lowest common denomonator' decisions in the health service. The NHS could apparently learn from the management practices of the private sector. In an attempt to reduce the significance of differences between the private and public sector, Griffiths (1983:10) argued that:

> We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important.

Having asserted the similarities between the sectors, Griffiths' 'diagnosis' and 'prescription' for the NHS are described by Harrison et al. (1988:27-28) in terms of five points (see figure 5).

General Management.

Diagnosis:	Prescription:
(1) Lack of strategic direction.	Create a Health Service Supervisory Board and Management Board.
(2) Lack of individual managerial responsibility.	Appoint general managers in regions, districts and units.
(3) Failure to use objectives as a guide to managerial action and the implementation of plans.	Extension of the review process to units and incentives for managers.
(4) Little orientation towards performance.	Doctors to become more involved in management through management budgeting.
(5) Lack of an orientation towards the consumer.	More attention to be paid to the patient and public opinion.

Figure 5. Source: Harrison et al., (1988)

In sum, the above ideas add up to a much more mechanistic and 'rational' script for players with the unenviable task of organising and managing the NHS. Griffiths was acting as though he was a script writer, recharacterising the part of the administrator in terms of a 'manager'. Direction of the service would flow downwards to units from the top. Managers would be appointed to create a chain of accountability running through the service and their performance reviewed. To support management, improved budgeting techniques were favoured. The emergence of information systems onto the agenda can also be noted, seen here as an essential mechanism to support managers and health practitioners in their decision making.

Following publication of the Griffiths' report, eight hundred managers were appointed in 1984 to manage regions, districts and units. The Government project had become one of shifting the organisation from a professional bureaucratic configuration to a more 'managed' and 'business-like' organisation modelled on the private sector. The Government hoped that the introduction of clear lines of responsibility throughout the service would allow a rapid implementation of many of the initiatives it planned for the NHS. As Harrison argues (1988:119), the general theme is one of central control over local managers by members of the Government. In dramatic terms, managers were expected to make excellent understudies for the characters created by script writers allied to the political coalition.

Griffiths' proposals were introduced amidst a host of reaction from health service personnel which added up to a claim that the

service was unique and not like Sainsbury's (see McNulty and Filby, 1988). The clinical practitioners were worried about what the implementation of Griffiths' ideas would mean for the relationship between these new managers and their 'profession'. Medical groups feared that the balance would be tipped away from a service 'administered' for the needs of the clinical practitioner to one of the manager shaping and directing the actions of medical and nursing staff. In the Hospital and Health Services Review (1984:94-97), the BMA reaction to Griffiths' proposals is reported as one of caution:

> ...the council hope and believe that it is not intended that there should be a somewhat autocratic executive manager who can take make major decisions against the advice of the profession.

From a vantage point in the late 1980's, these fears of autocratic control of doctors and nurses have largely been illfounded. At the unit level, management action in the NHS is much more about building and preserving social networks (see Kotter, 1982) rather than discovering and developing a 'rational' and 'functional' management practice. Relationships have still remained collaborative between coalitions (Banyard, 1988:917). As Banyard comments;

> ...it is illusory to pretend that significant constraints have been placed on professional clinical freedom in the NHS following the introduction of general management.

Harrison (1988:120) also admits that defeats for the medical profession are ones of form rather than substance. The relationship between professional and managerial action will be further investigated throughout the case study.

4.3.3 Developing information systems.

Alongside the movement towards general management in the health service was that of an increasing Government interest in the development of hospital information systems. The call for improved information in the NHS is not new. In 1978, the Royal Commission identified the need for better information in the following terms:

> The marshalling of information could much be improved to allow the monitoring of activities which have been delegated by higher authorities, to give a quick flow of financial information so that the accounting system is applied efficiently to management purposes, and to bring together financial and non-financial information so that costs and efficiencies can be measured in time for managers to take the necessary information. Major computing developments are required, and the quality of routine information produced by hospitals must be improved (Warwick University, 1978).

In response to the Royal Commission report, a Steering Group on Health Service Information was set up by the DHSS in February 1980 to be chaired by Edith Korner. Its terms of reference were as follows (see Earlam, 1988):

(1) to agree implement and keep under review principles and procedures to guide future developments in health service information services.
(2) identify a coordinated approach to health service information.
(3) review existing health service information.
(4) consider proposals for change in health service information services.

Every effort was directed towards developing scientifically measurable criteria for decision-making. Between 1982-1984, six reports were published by the Korner team and a series of minimum data sets were proposed, 'without which authorities and their officers will not be adequately informed when fulfilling their responsibilities' (Korner, 1984:5). The main orientation of the reports of the Steering Group was towards management information at the local level rather than as an accountability exercise to the supervisory bodies. Consequently, all the reports emphasised the need for data disaggregated by specialty or even consultant. Health authorities were expected to have the systems for collecting the Korner data sets by April 1987. To prevent a plethora of non-standardised, incompatible information systems, the NHS Management Board published the National Strategic Framework for Information Management in the Hospital and Community Health Services (DHSS, 1986b). This document complemented the Korner initiative by giving health authorities some direction to their information policies.

Despite the original intention that information should be a 'resource to be managed' and used at the unit level (Korner,

1982-4), the emphasis in the NHS during the 1980's has been on data collection rather than use (West, 1987: Merry, 1988). McClenahan et al (1986:1258) argue that 'units see Korner as being driven by the centre for the use of DHSS and regions'. Black (1989:586) echoes this point in the following statement:

> ...the hospital activity analysis was devised as part of an information technology strategy which had at its key feature the centralisation of data for administrative purposes. Instead of starting with an information strategy based on the needs of those who directly provided health care, systems were designed by information technologists and imposed from the centre.

It is this 'use' of information by central administration that units are beginning to question more and more. Those providing the information at the local level could be penalised for doing so if it is used by Department of Health officers to compare performance across units and districts (see Bourne, 1987:120-121). Given these possibilities for survelliance, the movement towards information system developments in hospitals could be forcing information onto organisations of people that are not prepared to accomodate it. The point to make here is that information use (and what counts as information) is constrained by organisational and environmental context. This is borne out throughout the case study.

The 'rational', 'mechanistic' orientation of Korner is comparable to that which was behind the Griffiths' report (Griffiths, 1983).

In fact, both initiatives complemented each other in the sense that they called for the adoption of more sophisticated budgeting techniques throughout the service. The traditional budgeting arrangements in the NHS can be categorised under the term 'functional' budgeting which involved allocating expenditure to hospital departments. Cook (1988) summarises the criticisms that health service managers have made in relation to functional budgeting:

(1) It provides no analysis of expenditure by health care category.
(2) Doctors' clinical decisions commit resources for which they are not the budget holders.
(3) Budget holders, such as the Pharmacy manager, have to live within a predetermined budget, although the level of activity is outside their control.

In response to such limitations, the sixth Korner report (Korner, 1984) called for the widespread adoption of specialty costing, a system aggregating hospital expenditures into hospital groups. Griffiths, meanwhile, publicised the need for units to 'develop management budgets which involve clinicians and relate work-load and service objectives to financial and manpower allocations so as to sharpen up the questioning of overhead costs' (1983:7). Griffiths actually announced something that was already being piloted in the NHS. Six pilot sites had been established in September 1983 to test clinical budgeting as a clinical tool and develop diagnostically related costing.

Management budgeting differed from specialty costing in terms of emphasising that clinicians 'participate fully in decisions about priorities in the use of resources' (Griffiths, 1983:6). It was management budgeting that became the vogue in the NHS in the mid-1980's as the DHSS acted on the recommendations of the Griffiths' report. It was clear that the success of attempts to move from a specialty costing system to management budgeting was largely dependent on clinical practitioner support. Griffiths saw no obstacles to recharacterising the doctors' parts in terms of management responsibilities. Indeed, Griffiths (1983:18) type cast medics as 'natural managers' who should be accountable for the resources they use:

> Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of resources. The nearer that management gets to the patient, the more important it becomes for the doctors to be looked at as 'natural managers'.

This emphasis on the 'effective' management of resources reinstated the concept of economic utility as the correct and proper project of all health care professionals. As Pinch and his colleagues (1989:278) argue, management budgeting represented a 'strong' programme of reform being held to be a way of 'a more rational and efficient distribution of scarce resources such that ultimately patient care will be improved'.

The management budgeting script was further elaborated and publicised throughout the NHS in a DHSS health notice 85(3). Again, clinical involvement in the management process was considered primary:

> When the system is fully established it should:
>
> (a) give individual clinicians a key role in influencing the content and level of functional and facility budgets for the unit based on the assessment of clinical workload for the year ahead;
> (b) devolve control as far as possible to clinicians and other budget holders over the use of resources which can be varied within the year and
> (c) reflect agreed district priorities in allocating resources between budgets (DHSS, HN 85(3):3).

However, as Scrivens (1988) argues, it was never made clear how to engage clinicians interest so that they might participate in the management process. It was merely assumed that management budgeting would be the special technique to 'involve clinicians more closely in the management process consistent with clinical freedom for clinical practice' (Griffiths, 1983:6).

The difficulties associated with developing and implementing management budgeting had been overlooked by the DHSS and the NHS Management Board. There was growing resistance to the scheme from clinicians in the original pilot sites and the subsequent fourteen 'second generation' sites established in 1985. It was

claimed in the British Medical Journal (17/5/1986:1345) that doctors were not able to see the relevance of the information to their treatment of the patient and budgeting seemed to have been 'taking place in isolation from the management and organisation process'. The main protagonist with responsibility for developing the management budgeting initiative in the NHS was the Financial Director of the NHS Management Board, Ian Mills. Mills summarised the growing difficulties associated with management budgeting in a speech to the members of the Central Committee for the Hospital Medical Services in May, 1986:

> Increasing numbers of consultants in the pilot districts and opinion formers within the BMA have become convinced that management budgeting was at best a costly irrelevance and at worst an attempt to challenge responsible clinical sovereignty by trying to make clinicians financially accountable for a great deal and managerially responsible for very little (BMJ, 17/5/86:1345).

In contrast to the philosophy behind involving doctors in budgeting, clinical practitioners were being urged by their 'trade union' spokespersons to stand 'outside' of the management process rather than be a part of it. The BMA were, in effect, providing clinical practitioners with an alternative script to that feeding through the DHSS and the NHS Management Board. Rather than learning a new part, doctors had a representative body within the political coalition to challenge the characterisation of doctor as natural manager. Management budgeting was never to recover from the what were termed the 'fundamental problems

affecting the management dimension' (DHSS, 1986a).

In order to reclaim the initiative from being thought of as purely an accounting exercise, a new wave of pilot studies were launched by the NHS Management Board in November 1986 in association with the BMA's Joint Consultants Committee and the Royal College of Nursing. The new schemes were not management budgeting sites but Resource Management Initiatives (RMI). The change of name reflected the initiative was not a costing system or accountancy system but about management and managing resources. The emphasis was on using information to help practitioners solve practical problems. As Perrin (1988:111) put it, whereas management budgeting had largely been 'information system' driven, the new approach was to be 'information user driven'.

The main aims of the new resource management project were made clear by the Financial Director of the NHS Management Board in the NHS Management Bulletin (NHS Management Board, 1987:3):

> Resource management is a way of organising and managing the resources of a unit by increasing the involvement of all types of clinical staff in its management. It gives them more accurate and useful information about their clinical practice and its costs compared with colleagues in the same hospital, district or region...At the heart of the initiative lies the need to link and relate patient activity data to the costs of running the service at hospital level and to involve doctors, nurses and paramedics in designing the periodic reports and making use of the resultant information.

The RMI represented a movement away from the 'strong' version of management budgeting towards what Pinch et al (1989:280) suggest is a 'weaker' form of budgeting. Rather than stress a radical economic rationale of managing resources 'efficiently' and 'effectively', resource management was about 'trying to help clinicians and attending to their misconceptions about budgeting systems'.

Despite the RMI's concern for helping clinicians (and managers) understand and 'own' management problems, the original resource management sites have not been without their difficulties. Whilst sites had been picked where relations between the doctors and management were thought to be good, Brindle (1988:25) reported that the new pilot sites were encountering difficulties similar to those experienced in the management budgeting pilot sites:

> It is no secret in the NHS that another Wirral hospital, Clatterbridge, failed to get a trial off the ground after being announced as one of the first six sites. The word is that managers and consultants could not come to terms.

Furthermore, an interim evaluation of resource management commissioned by the Department of Health and undertaken by members of the Health Economic Research Group at Brunel University also adopts a cautious stance. In the report, it is argued that 'resource management in its entirety is still an aspiration and its benefits for patient care still have to be shown' (Packwood, et al., 1989:275). This assessment has not stopped the Government writing resource management into its script for reforming the NHS.

Indeed, the White Paper 'Working for Patients' (Department of Health, 1989a) publicised the Government's intention to 'roll out' resource management before the Brunel team had published their report on the initial pilot sites. The Government's drive to general implementation appears overwhelming.

From this brief history, it is clear that information system development is still in its infancy and has yet to 'bed down' in the political and cultural context of the NHS. Indeed, this case study is devoted to understanding how health care professionals are facing up to the task of making information 'work' at the local level. Before portraying and analysing the dramatic episodes at Camblewick Hospital, the next chapter switches attention away from the environmental context towards the organisational context of the setting.

4.4 Conclusion.

In this chapter, the case study was located in the environmental context (in broad terms, the NHS). In dramatic terminology, the 'backstage' areas of the case setting were investigated. A number of themes were introduced. The first of these was that the NHS is a complex and distinctive organisation which cannot be divorced from social, political and economic considerations. The Baby Barber episode provided a good illustration of how these contexts are intertwined.

Another essential idea established during the chapter was the fact that the health service is composed of different occupational

groups that have to work together and that this can often lead to problematic relationships. In particular, the tension between managers and clinical practitioners was highlighted and conceptualised in terms of the delicate balance between managerial and professional action. In an attempt to develop this theme, it was argued that the Government have attempted to strengthen managerial action throughout the health service. Most notably, protagonists such as Roy Griffiths have striven to change policy in relation to the management of health care. In terms of the 'soap opera' metaphor, Griffiths was conceptualised as a script writer for the NHS, creating a typical or 'stock' manager who would take responsibility for resource consumption and value economic utility. This characterisation has yet to be considered an acceptable interpretation of the manager's part by many actors within the service.

Finally, the theme of information system development was introduced and understood in terms of innovation seeking to complement the introduction of general management. The rationale behind such a development is that providing 'better' information should allow managers and clinical practitioners to make more informed choices about resource allocation and consumption. In practice, the systems have yet to deliver information of 'real value' to health service staff. As the Barber episode emphasised, the rationing of care at the unit level has often been reactive (in terms of bed closures) rather than a planned and 'rational' activity.

THE STORY OF CAMBLEWICK HOSPITAL.

Chapter five: The Organisational Context of the Study.

5.0 Introduction.

In the spirit of the 'soap opera' model, this chapter 'sets the scene' by moving from the backstage to the frontstage to consider the organisational context of the case setting. The main concern here is to examine how different actors construct and make sense of organisational 'reality'. Earlier in chapter one, it was made clear that constellations of meaning are enacted and reenacted on an ongoing basis through action and interaction. Once learned by organisational actors, these meanings are available as a resource for interpreting and understanding new developments. They are a background of expectations which create a 'corpus of convention'. It is against this background knowledge that the 'on stage' action has to be viewed. In this study, the action focusses on the meanings that become associated with the development of information systems. The dramas associated with such innovation are presented in chapters six to nine.

This chapter is divided into two parts. In the first part of the chapter, section 5.1, Camblewick Hospital is treated as if it were a distinct culture. Three main themes are developed, these being the sense of community and 'togetherness' at the hospital, the informal relationships between groups of people at Camblewick and the predominance of professional action over managerial action (see chapter four). Throughout section 5.1, attention is given to the manner in which the historical context of the hospital plays a significant part in the way key actors interpret and define

current situations. In section 5.2, the chapter is concluded by outlining how recent Government projects such as general management (Griffiths, 1983) and specialty costing (Korner, 1982-1984) have been interpreted and understood by actors at the site. The political nature of organisational life is clearly demonstrated in the way that the Government's initiatives were deflected away from clinical core of the hospital.

Throughout this chapter, the materials used are those collected from the researcher's initial round of interviewing in the setting. Whilst these interviews took place between January 1988 and September 1988, chapter five is concerned with actors' accounts of Camblewick rather than 'events' at the hospital. A ward budgeting initiative was proposed at the site during this nine month period but this sequence of 'events' is taken to be an 'episode' of 'on stage' action in chapter six.

5.1 The Cultural Context of Camblewick Hospital.

Throughout section 5.1, various cultural themes specific to Camblewick Unit are considered. In 5.1.1, a brief history of the hospital is given. This leads into a discussion of how actors at Camblewick use the recently built Grand Hospital as a reference point. The next subsection, 5.1.2, is devoted to actors' understandings of Camblewick as a friendly, happy family that patients prefer to the Grand. In 5.1.3, the informal social network at Camblewick is introduced as a significant feature of daily life. This informality is largely seen to be an outcome of historic relationships at the site. Relationships between doctors

and administrators (lately renamed managers), doctors and nurses and nurses and managers, makes up the next three subsections (5.1.4 to 5.1.6). The final part of section 5.2, is concerned with Camblewick as a medically led unit.

5.1.1 The historical context of the setting.

The foundation-stone of the present Camblewick Hospital was laid in 1899 and the buildings opened as the Baggerton workhouse in 1903. The Baggerton Institute was established for the sick and aged poor and continued in this 'caring' work until 1930 when it became a municipal hospital. In 1930, the hospital relied on only five medical staff and four visiting medical specialists. The recruitment of nurses was slow but improved with the establishment of a nursing home in 1939 which allowed all nursing staff to live in. Despite these early developments, expansion of the hospital occurred only steadily. When the hospital was nationalised in 1948, the numbers of full-time medical staff had grown to twenty-two with a similar number visiting from the nearby general hospital. It was not until 1970 that the hospital's capital development accelerated. At this time, Camblewick Hospital was designated a teaching hospital for Northtown's new teaching hospital and medical centre (the Grand). A programme of upgrading medical and surgical wards and the opening of new clinical departments followed this decision.

At the time of the present study, Camblewick Hospital is a large and complex organisation, treating acute medical and surgical cases, the long stay geriatric and mentally ill patients in

different buildings around the campus. The campus is located within an attractive setting of lawns and trees which span some eighty acres. In July 1988, Camblewick's annual budget was thirty-seven million pounds with a staff of four thousand and a bed allocation of fifteen hundred. Whilst these 'facts' are informative, they only provide a thumbnail sketch of the hospital and do not provide a rich picture of what it is like to experience organisational life at Camblewick. For this, it is necessary to make use of actor's accounts of Camblewick, making sure to situate these statements in terms of people's projects or purposes in life. These accounts shall be considered shortly. Of immediate concern is the significance of the Grand Hospital to actors at Camblewick.

In looking at the cultural context of Camblewick Hospital, constant references were made by actors to the Grand Hospital. The Grand is of a similar size to the Camblewick Hospital with approximately thirteen hundred beds and is located within the same District Health Authority (Northtown). In purely physical terms, the hospitals are very different. Camblewick is an old red brick construction on a grassland site, with the main medical and surgical specialties housed off one long corridor. In complete contrast, the Grand is a modern, regular, multi-storey construction built on the outskirts of the city of Northtown.

Rivalry between the two hospitals is intense since they compete for resources and public attention. More of the District's budget goes to the Grand...twenty-eight per cent of the budget in the year to April 1988 (£43 million) as opposed to twenty-three per

cent for Camblewick (£37 million). As shall become clear in section 5.2, Camblewick staff feel aggrieved at this situation for they believe that as much patient activity as the Grand flows through Camblewick. In relation to the issue of media coverage, the Grand tends to get more media attention than Camblewick (this is supported in the case study...see chapter eight). This is largely because the Grand is perceived as a modern, prestiguous hospital thought by many to be a centre for teaching excellence because of its close links with the local university.

It will become clear throughout the chapter that the contrast between the Camblewick and the Grand does not end with the physical differences between the buildings. The social climate within the two hospitals is also perceived as being very different by Camblewick's actors. The Grand represents a reference point for staff at Camblewick which helps them define and maintain particular understandings of organisational life within the setting. These interpretations are considered throughout the remainder of section 5.1.

5.1.2 Camblewick Hospital as a friendly, happy family that patients prefer to the Grand.

In medical, nursing and management circles, one of the noticeable aspects of life at Camblewick is that those in the senior positions are often people that have been at the hospital twenty years or more. For example, Tony Raymond, a Divisional Manager, was a nurse on night duty for seventeen years before moving into nurse management. He had the following to say about Camblewick:

> Talk to patients and they like it here better than the Grand because its a bit more homely. There's not so many floors, it's got a nicer, friendly atmosphere and you can do all your business on the one corridor and you're not likely to get lost and people will tend to help you more here. People will show you if you look lost here but at the Grand you can literally walk around and have to ask. The unfriendliness at the Grand is no fault of the people. It's the floors and it's a bit impersonal and will take years and years to get a reputation. I'm sure the standards of nursing are the same but people like Camblewick, it's been here a long time.

Immediately, Camblewick is projected as being a warm, friendly and caring institution that patients prefer to the impersonal climate of the Grand. The differences in the design of the two hospital buildings seems to symbolise the apparent differences in attitude between those working at each institution.

This 'friendly' and 'caring' tradition is an indication of Raymond's loyalty to the Camblewick but is not specific to him alone. A much younger nurse, Senior Sister Thomas, uses very similar language to Raymond in describing Camblewick:

> Camblewick is more close knit than the Grand. It has got character, everybody knows who works here...the patients are quite happy here and say the Grand hasn't quite got the atmosphere of Camblewick because it's been around for donkey's years and the Grand is a relatively new place.

Again, Camblewick is contrasted with the Grand and the notion that 'patients like it better' at Camblewick is an important cultural assumption which distinguishes the two hospitals in the minds of Camblewick staff. Whether such a statement is justified is not of concern here. What is significant is that both actors refer to the hospital's past to explain and justify ways of behaving for the present time.

Whilst the patients are said to like the friendly atmosphere of Camblewick, managers, nurses and medics also emphasised the strong 'community' spirit amongst Camblewick staff. For example, in a newssheet article, Colin Peterson (UGM), argues that Camblewick is like a large family:

> The Camblewick Hospital...resembles a small village. We are very proud that despite our size we have managed to retain a friendly, family atmosphere, and will strive to preserve this even as we continue to grow (Northtown Health, July, 1988).

This 'public' statement to those outside the hospital was reiterated throughout my interviews within the setting. Matron, who has worked at the hospital since the 1950's, promoted Camblewick to me in the following terms:

> There is an informal climate...it's a super place to work, you get a lot of cooperation and a lot of staff feel that they belong to Camblewick. It's fantastic...a big family atmosphere.

Similarly, Sally Martin, Medical Records manager, explained the sense of community feeling at the Camblewick:

> Poeple stay here a long time which is true and it has got a community feel and I think that has been accentuated by the development of the gin palace [the Grand] and I think that has reinforced that feeling at Camblewick as a sort of defence mechanism...Oh yes, they might have gold plated service but you all know Camblewick is best, you know they might have all the money, all the fancy this and that, they might have the headlines in the Post, which they always do, but good old Camblewick soldiers on making purses out of sows' ears.

Many jealous reactions to the development of the Grand are contained within this single statement. The 'gin palace' is a reference to the Grand's many windows. The Grand is seen as a 'flashy' and 'gold plated' 'palace' which is rich in resources whilst Camblewick is the Cinderella sister who has yet to go to the ball. However, the sense of hardship at being underfunded and overlooked compared to the Grand has been turned around by Camblewick members into something more positive. The Camblewick 'family' will not become bitter but go on caring for patients despite these setbacks. Not to be outdone by the material advantages which staff at the Grand appear to enjoy, people at Camblewick emphasise the more intangible, interpersonal features of life at the hospital.

5.1.3 Camblewick and informal working practices.

The friendly atmosphere which is said to pervade Camblewick must not be considered purely as a 'myth'. The researcher's experiences at the setting were very positive. As a visitor to the hospital, I found that I was particularly welcomed by all those I interviewed and there was always somebody keen to direct me when I looked lost. According to one cleaning lady, Camblwick staff were encouraged to 'do their good deed for the day' by directing members of the public. This 'friendliness' was, therefore, supported through purposeful action from day-to-day. Apart from this welcoming atmosphere, what struck the author as particularly important was the apparent informality between members of staff. As Jill Dukes, a long standing manager of Para-medical services, explained:

> ...particularly on this site, its always been a very friendly hospital and it has relied more on the informal than the formal network because its been a friendly chatty organisation.

Much like the 'street' in Coronation Street, much of this 'chatter' or 'gossip' was to be found on the main corridor of the hospital linking medical and surgical wards. Senior managers such as Steve Gilbert (Out-Patients Manager) admitted that much of his work was 'done on the corridor', 'chatting-up' and trying to influence key players. Another place where actors gathered in small groups was the dining room. This applied particularly to members of the Unit Team (see appendix 14). Harriet Elms,

Personnel Manager at Camblewick, remarked upon the possibile existence of a 'luncheon club' for senior managers:

> There is an in-crowd that meets at an informal luncheon club in the waitress service station of the dining room on an ongoing basis which may or may not be the hidden management structure of the unit.

It seemed generally acceptable that senior managers, such as Kathy Silver, General Services Manager, could be contacted via informal means rather than by arranging a formal meeting. As David Lewis, the Catering Manager, admitted:

> There is an opportunity to for us to have contact regularly, and she [Kathy Silver] often has lunch in the restaurant and quite often, if necessary, I can have lunch with her.

Somewhat unsurprisingly, the informal working practices of Camblewick were contrasted with those at the Grand. Paul Hart, the Unit Accountant said:

> I was at a meeting this morning with a chap from the Grand who was talking about Camblewick as though he couldn't organise anything here. Anything that required a decision and there wasn't anybody to make a decision. To me that was a typical Grand approach. When they have to decide anything, they have to have a meeting and bring everybody to a meeting and somebody takes notes and publishes them but nothing like that happens here at all. Here, the general manager goes to

> see somebody and says we need to do this because of so and so, the reasons are... They will speak to Arthur or Jack and say 'Can you do this?', and it will happen. So it is a different culture altogether but I think our way works just as well.

This 'cultural' difference is not confined to management circles but extends throughout the campus. As Professor Bolton, a senior Pathologist at Camblewick, explained:

> Now I think that there is a big difference in attitudes between Camblewick and the Grand...I am not saying that the Grand is not as good but they are different. We work in a very cooperative way and I think they work in a very regimented way at the Grand through a formal committee structure and as a result, I think we make more use of the resources and more advances in provisions of facilities.

In this statement, Professor Bolton is quick to point out that Camblewick does not use the same formal structures as the Grand. The latter uses the cogwheel arrangement for medical representation which is based upon elected representatives from particular specialties. Camblewick is rather different because it has a medical committee meeting once a month open to all medical staff. From this committee, eight consultants (from any specialty) go forward to Medical Executive Committee. However, these more formal arrangements only serve to supplement what is essentially an informal process. As Bolton remarked:

> People on the Medical Executive Committee (MEC) are not in this unit as representatives of a particular specialty. They happen to be broadly representative as 'good men and true' and we find this very helpful because they are not obliged to produce the hard-line tailored view of a particular specialty...they do act much better by being broadly representative and this helps to maintain the cooperative attitude. What is interesting is that one or two consultants have come in from elsewhere and been used to a more formalised structure. They have come in and thought that they could do the same here and throw their weight around and in fact they have realised its not the way to do it and things aren't done that way here.

The principle of 'trusted' medical colleagues acting as 'good men and true' is a reference to the 'glorious' past when, allegedly, 'a gentleman's word was his bond'. Whilst representatives on the MEC may represent the mood of the majority of the ninety consultants on site, there are always going to be deviants. Such deviants can often expose particular conventions of the majority and this was certainly the case with Dr Marshall, a Cardiologist at Camblewick. Dr Marshall used to be a medical representative on the cogwheel structure at the Grand before moving to the Camblewick Hospital. We shall see in chapter eight that Marshall remains an advocator of the formal, cogwheel system and, therefore, at odds with the informal arrangements of Camblewick. Jill Dukes was one person to identify him as a 'misfit' long before the author was introduced to him:

> Dr Marshall does not like the system on this site because it can actually make a decision on the corridor and that is not the way to do it if you want to have structure. I think what he is saying is that he hasn't found his way into the informal bit. Nobody takes any notice of him here because he's made himself so difficult.

Camblewick's informal network for managing its daily affairs appears to be favoured to the formal committee meeting structure. It will be shown in the next subsection of the chapter that this preference is one which is rooted in past relationships between different groups of staff at the hospital.

5.1.4 Alliances at Camblewick: Doctors and administrators.

The relationship between medical groups and management groups at Camblewick has to be located in the context of the previous relationships between medics and administrators. In the 1970's, the management style was 'relaxed' because cash limits had not been imposed at the hospital. As Steve Gilbert (previously the Pharmacy Manager and now the Out-Patients Manager) explained:

> Before 1982, the District Pharmacist used to ring me up two months after the year end and say you are overspent. I would say, 'Are we, how much?

Overspending was not a problem to departmental managers at the unit level because 'balancing the books' was seen as the task of the Hospital Secretary and the District Treasurer. Colin Peterson

recalled the way the hospital used to be run:

> Ray Burton [Hospital Secretary] ran the place beautifully as a non medic because he had the confidence of the medical staff who are very suspicious of managers because managers tend to restrict their activities. Our predecessors here, the Hospital Secretary and the Accountant, were the only people who knew anything about the money and nobody had a budget...but they robbed Peter to pay Paul and at the end of the day they balanced the books and nobody knew how.

Burton appears to have achieved legendary status at Camblewick, serving as a role model for the present UGM. Burton's 'success' is seen by Peterson as stemming from his relationship with the medical group at Camblewick...the implication here is that Burton was wary not to restrict medics' activities through imposing financial controls.

This alliance between administrators and medics has long been a feature of organisational life at Camblewick. Significantly, Professor Bolton boasted to me that the hospital was one of the first in the country to invite nursing and administrative members onto the MEC. As a result of this union, he argued that:

> The administrators are trusted because they are taken into the discussion. They have done very well in obtaining the resources required as a result because they have been able to take the medical staff with them to explain the reasons why the resources are required.

The administrator's role has been traditionally one of facilitating clinical practice by providing resources. Administrators have played the part of 'supporting cast' to the clinical practitioners. This was widely accepted in Camblewick as the relationship that medics still 'favour'. As Dukes said:

> If doctors are allowed to get on and do what they want and the people actually facilitate that, then that's what they are happiest with.

In medical circles, Dr Blount, Renal Physician, was particularly keen for 'treasurers' to 'let them have the cash' so that they can 'get on with it'. Throughout our conversation, Blount mentioned that:

> If the treasurer is happy, then as far as I'm concerned that is all right.

Dr Blount uses the 'old' terminology of the 'treasurer' rather than the 'accountant' suggesting he is still committed to a situation where the accountant worries about the money and his project in life is to worry about the patient. This is in direct contrast to movements in the environmental context towards resource management (see chapter 4).

5.1.5 Alliances at Camblewick: Doctors and nurses.

Another notable relationships at Camblewick Hospital has been the alliance between doctors and nurses which make up the clinical

practitioner coalition. Tony Raymond suggested to me that nurses use doctors:

> I tell [the consultant] what to write, they'll write and it will go out in their name and things happen very quickly when consultants write.

and doctors use nurses at Camblewick;

> Consultants are the ones that tend to come here with queries and it's usually about staffing and equipment because they will try to use me to get equipment that they can't get through their fund...and if you can do it you do because at the end of the day we are talking about the interests of the patient.

Whilst this relationship has largely been described by actors as harmonious, the alliance has not been an equal one in that nurses have been very careful not to 'question the clinical judgement of a doctor'. A recently appointed Sister, Sister Jenkins, was particularly surprised that nurses were reluctant to assert themselves as independent clinical practitioners:

> What I have found here is if the doctor says you can do A, B and C the nurses would never question why and the fact that it might not be quite right for the patient never occurs to them, but the doctor says do it, so they do it.

In keeping with traditional images of nursing, nurses at Camblewick have been termed the doctor's 'handmaids'. Those

nurses joining Camblewick from other institutions have been annoyed that nursing 'professionals' act so deferentially towards doctors. A recent addition to the ranks of Divisional Nurse, Pat Mooney, described Camblewick nurses as content to 'go softly, make suggestions and pussyfoot around.' Thus, nurses as well as managers characterised their parts in terms of 'supporting' the medical community.

5.1.6 Alliances at Camblewick: Nurses and managers.

Nurses were often described as being very 'cooperative' by managers at Camblewick. Apart from their apparently compliant attitude towards doctors, managers at the site have found nurses very willing to accomodate their wishes. For example, Edward Sharp, the Laundry Manager noted that:

> The nurses are very good on this site, they are always prepared to try something for you or work along with you and that's a great help.

Equally, management style at Camblewick has also been cooperative. Since the introduction of general management at the site in Septemeber 1985, administrators at the site were renamed 'managers' but did not suddenly change their style. In keeping with the facilitating and supportive character of previous administrations, management at Camblewick has largely been infiltrated by the 'caring' ethos of the clinical practitioner. This point is captured in one 'nursing' image, used by managers...that of 'handholding':

> We hold people's hands in unfamiliar situations quite a lot because for most managers the disciplinary or grievance situation is absolutely new and they find it quite frightening (Harriet Elms).

and;

> We are moving to ward budgets and that takes time to set up and even the pilot wards need quite a lot of handholding for quite some considerable time (Kathy Silver).

The part nurses and managers play at Camblewick is further discussed in chapter six when ward budgeting is proposed by Paul Hart, the Unit Accountant.

5.1.7 Camblewick as a medically led unit.

Camblewick shows many features of the professional bureaucratic configuration described in chapter four. Actors at Camblewick enact and reenact a 'reality' which supports professional action, particularly that undertaken by doctors. This position is largely an outcome of the tradition of the 'caring' clinical practitioner which had long been associated with Camblewick's development into a municipal hospital. Within the stock of knowledge enacted and reenacted by organisational members is the concept of the Camblewick Hospital as a 'medically led' unit. In simplistic terms, doctors have considerable influence over the ongoing script. This belief pervades much of the social activity within the setting. Jill Dukes eloquently makes this case by comparing

Camblewick with the Grand:

> Some hospitals may be strongly administratively led and the administration are seen as the heads of the hospital. I don't think that has ever been true in this organisation. It's always been the doctors that have been the important people and the administrators have enabled the doctors to do their job. If you had to put bets on which unit would have a doctor as a UGM it was always going to be this one whereas the Grand would always have an administrator.

Medical staff have enjoyed considerable power because they have enjoyed a large supporting cast; namely their alliances with management and nursing groups. This support has enabled medics to practice their craft and pursue the cherished project of clinical autonomy. Bolton summarised the situation as follows:

> Camblewick has always been a hospital where people talk to each other and where there are no significant factions...where [doctors] trust their elected medical committee members [ie on the MEC] and where doctors get a good deal of power and have the right to challenge these decisions [in the medical committee]...so that the atmosphere has always been very positive and friendly.

The idea that there are 'no significant factions' is a reference to traditional relationships between groups of staff at Camblewick where medics' wishes have been honoured in management and nursing circles. At Camblewick, the 'power' Bolton is referring to has

manifested itself in allowing medical staff control over key policy decisions. For example, medics have had considerable influence over service developments at Camblewick. Katie Wilcocks, assistant to the UGM, recalled a recent event:

> There is a new drug for anaesthetic and I think we are using that now. Tony Hart has 'robbed Peter to pay Paul' somewhere in the budget - you are talking of tens of thousands of pounds every year - and I'm not even sure if this was formally approved by the General Manager. It was probably the consultant in Anaesthetics.

Another event shows how medics dictate the level of service provision whilst management's task is one of reacting to these 'creeping developments'. Sally Martin said:

> Since I have been here I've actually heard that a consultant is coming two days before the event and absolutely no arrangements have been made...no out-patients mechanism for him, no secretary and no funding. I didn't know what he was going to do about his beds!

Both of the events described above suggest that professional action has not been restricted by general management. It is to Camblewick Hospital's implementation of Government projects such as general management that attention is now turned.

5.2 Implementing the Government's Management-based Projects at Camblewick.

In this section of the chapter, consideration is given to three phases of development at Camblewick throughout the 1980's. These developments were all intertwined with initiatives initiated by the Government of the day; that is to say, projects emergent from the environmental context (see chapter four). However, section 5.2 is concerned with how actors at Camblewick have reinterpreted these Government projects to 'fit' with the historical and cultural context of the setting described the first half of the chapter.

The first developmental phase to be discussed in part 5.2.1 is that associated with the implementation of general management in 1985. In section 5.2.2, the focus changes to a movements throughout Camblewick's campus towards computer-based information systems in clinical departments. The implementation of the 'Korner' initiative is then considered. Finally, in subsection 5.2.3, a particular development by the finance department towards specialty costing is outlined.

5.2.1 Phase One: General management at Camblewick.

In September 1985, the first general manager was appointed at Camblewick Hospital, this being David Dixon, a general physician at Camblewick and the Chairman of the MEC at that time. This appointment in itself suggests that the informal network of medical representatives on the MEC influenced the recruitment

process to put 'their man' into the management position. Given the organisational context of Camblewick, appointing a medic as UGM was a natural choice. Medics at the hospital were recognised by the majority of staff as the powerful grouping and this position was now being formalised in the management structure. Past relationships between groupings of staff were being maintained through this 'political' decision.

David Dixon had been a key protagonist on the Unit Team and often led this group, being described by others in the team as a 'powerful personality'. Dixon's transition from MEC chairman to UGM was not a major step. Rather than disband the Unit Team, Dixon maintained this 'team' approach for he regarded the present arrangements for the hospital to be working well. The only other structural change of particular significance was that Dixon scooped up all the managerial talent throughout Camblewick and formed the Unit Advisory Board (see appendix 15). This was a middle management tier made up of departmental managers.

Just as Dixon was getting his management structure together, Peter Monty, the newly appointed District General Manager (DGM) resigned with twenty months of his contract to run. Not wanting to appoint another outsider to Northtown District, Health Authority members lobbied for Dixon to fill the vacant post. Dixon filled the position as acting DGM in August 1986. It is the DGM's decision to resign that needs closer attention.

Katie Wilcocks recalled the events surrounding the rather quick exit of Northtown's first DGM as follows:

> Peter Monty was brought in from outside. He obviously had a commercial background of some sorts and the opinion of staff throughout the District was that he was a complete disaster because he could not appreciate the complexity of the organisation. He started blueprinting all the solutions and they just weren't working.

Peter Monty had actually been in the army and more recently worked for British Telecom before taking the post as DGM. His working methods in the NHS were based on strong management techniques borrowed from the private sector. For example, he 'decreed' that all correspondence throughout Northtown District should to be written on one side of A4 paper to facilitate quick decision making. In adopting such methods, Dixon attempted to strengthen managerial action throughout the health authority but this was found to be an intolerable policy by some members of the DHA. One member of the DHA (a senior medic at Camblewick) was particularly keen for medical staff not to be 'contaminated' by management. In less emotive terms, Colin Peterson (Dixon's replacement as MEC chairman) portrayed Peter Monty as a definite misfit:

> It was not long before the District Manager left because he was told that his contract would not be renewed about half way through the contract period...so he took the hint and left...he was bad news...he just didn't fit.

Given the events at district level, staff at Camblewick were reluctant to take on any 'outsiders' into the vacant UGM position left by Dixon. According to Silver, the feeling around the campus

was that the unit would 'welcome a time of stability'. Peterson, interpreted this feeling for stability in terms of a 'no change' policy at the site. Players were reluctant to influence the evolving script at this time:

> Camblewick were quite happy to have David Dixon and quite happy to have me but it wasn't a conscious decision to have a doctor; it was more that they didn't want an outsider coming in on a three year contract showing what a clever whizz kid he was by kicking people round here and licking the place into shape.

Whilst discussions about the appointment of a new UGM took place, Matron occupied the post of acting general manager. This appointment is of interest in itself. This temporary appointment emphasises Camblewick's commitment to professional action and the union between doctors and nurses in the clinical practitioner coalition.

Colin Peterson was a pathologist and chairman of the MEC at the time of the change of DGM. Whilst Matron acted as a stop-gap for the vacant UGM position at Camblewick, an informal lobbying process took place within the hospital, reaching a focal point through discussions in Peterson's medical department...the Pathology department. Professor Bolton, previous Chairman of the MEC and Pathology coordinator, admitted to some 'armtwisting' to get Peterson to take up the UGM post at Camblewick in April 1987. This 'armtwisting' was described by Colin Peterson in the following dramatic terms:

> I always say that I was handed the loaded pistol and directed toward the conservatory.

Like Dixon before him, Peterson yielded to this political pressure and accepted the part of UGM at Camblewick, albeit somewhat unwillingly. The dynamics behind the changes in personnel served to temporarily secure a stable position for staff at Camblewick. During discussions with Peterson in September 1988, he admitted to being a 'figure head' and this image appears to be in accordance with the cultural context of the 'organisation'. The unit's commitment to medical, professional action (as opposed managerial action) had been reaffirmed.

Given that Peterson initially regarded himself as a 'figure head', appointed to maintain stability and preserve the status quo at Camblewick, no changes in Camblewick's formal management structure took place during the first year and a half. In Peterson's words:

> The main problem was to give the place stability because there had been a lot of instability with the reorganisations, particularly surrounding the events which sent David Dixon off just as he was getting his structure together, so people wanted stability and I saw that was what was needed and that is why I haven't made any changes yet to the management structure.

The Unit Team continued to function as a consensus alliance in keeping with the time before general management rather than those envisaged by Roy Griffiths. According to Peterson, the middle

line of managers in the UAB had little influence in decision making for the unit:

> I must say in the beginning the UAB did not have a lot of direction and we didn't know what it was there for and it was a bit of a 'talk shop' and all the decision making was taken by the Unit Team.

This powerlessness of the UAB as a decision making body was a feature of my discussions with middle managers. Many of these people showed signs of discontentment which was in direct contrast to the happy, family 'public' face of Camblewick. For example, Harriet Elms seemed very alienated:

> They think that they are very open-minded, reasonable and good communicators. I don't think they are and neither does anybody else on the outside. There is a feeling that they go into a huddle up there on Thursday afternoons and you may find out that they have made a decision that affects you.

This Unit Team 'huddle' was seen by other middle managers in terms of an 'inner sanctum where there are in jokes and where things happen' (Jill Dukes). This treatment of UAB members serves as an indication of how general management might have been accepted in terms of name changes, but structural change was purely 'cosmetic' and the processes of management at Camblewick remained unaltered. As Kathy Silver was not afraid to admit in September 1988:

> The UGM doesn't manage the consultants. He doesn't appoint them, we do not hold the contracts and they sit outside the management structure.

With the arrival of general management, Camblewick members' continued to enact and reenact the Camblewick tradition of being a medically led unit. Despite the appointment of staff to 'management' positions, directive management 'of' medical professionals by 'managers' had no part in the script at this particular setting.

5.2.2 Phase two: Information Technology developments at Camblewick.

Alongside the 'cosmetic' changes in management described in the above section, key actors at Camblewick were developing computer-based systems to help run clinical departments. In 1979, Simon Toms, head of the Medical Physics department, became involved in helping physicians in the Renal department install a computer which would instantly give the doctor access to case histories of kidney patients. The development of this clinical system gave Toms a reputation for computer development throughout Camblewick and he helped founder a Computer Development Working Party (CDWP) in 1980. This group aimed to look into the way in which the hospital could use computers at a time when there were a lot of requests for computer equipment coming in from clinical departments (eg. Radiology and Pathology). The CDWP's project was to ensure the best use of future investments in computer technology.

Meanwhile, at the Grand, administrators were developing a Patient Administrative System (PAS) on new computing facilities. This development was to form the regional PAS and batches of patient identification records were sent over to the Grand from Camblewick. However, Camblewick staff did not have access to a computer at the Grand and could only access 'data' using a micro-fische. Furthermore, regional plans to create a Regional Maternity System (RMS) were to be piloted at Camblewick and there were no plans to link the PAS with the RMS.

In a report to Camblewick's Unit Management Team, the CDWP argued that this situation was unacceptable because of the duplication of resources; operators at the Grand and Camblewick would be putting the same patient information into adjacent terminals. CDWP recommended that computer resources allocated to both hospitals be combined for Northtown District, the equipment being housed at the Grand. From this proposal, a Computer Development Committee (CDC) was formed at Camblewick as a subcommittee of the MEC. Such an arrangement is indicative of the clinical practitioner's interest in computer system development which might help the daily operation of clinical departments. The CDC, like the CDWP before it, had a similar project, this being to 'bring about the most effective and efficient use of computer resources'. The CDC pressed the DHA for a 'district' distribution of resources. Toms remembered the problems this caused:

> ...when you are a hospital of this size, there's a reluctance to have your resources managed somewhere else and the thought of the Grand managing our resources!...however, when one sat

down and thought about it and divorced this inter-rivalry that exists, you realise that if you are going to have an effective computer system then it had to be one and you couldn't have a distributed system on different sites running one large [patient] index.

Significantly, the political differences between Camblewick and the Grand were overcome in this instance to pursue a more efficient use of resources. Whilst the 'district' solution to computer development appeared to be in line with Government projects of the early 1980's (see chapter four), members of Northtown Health Authority did not find this suggestion acceptable. In Toms' words:

Upto three or four years ago [1985], meetings on computer policy had really been a battle ground and we were asking for things, pointing out fallacies in the way we were going ahead and District, to us anyway, was burying its head in the sand and not saying anything...they were not listening.

With the change of management structure and the DHSS's promotion of information through the Korner reports (Korner, 1982-1984), Camblewick's project for integrating computer resources into 'one big pot' was suddenly more attractive. Korner required information to be collected via district-based categories. Patients were to be given a number within the DHA and their movements for any particular treatment period traced throughout the hospitals within the District. In the new general management era, monies for computer equipment were released from Northtown

District to enable Korner data systems to be up and running by the DHSS deadline of April, 1987.

Implementing the Korner proposals through the Medical Records Department at Camblewick was by no means straightforward. Sally Martin, Medical Records Manager, described her department when she was appointed in 1983:

> ...this is the first 1200 bedded cottage hospital that I have ever worked at because this is how I felt about it...things weren't particularly well organised or should we say coherently organised and when I came here nobody really had a perception of what a Medical Records Manager should be doing in this day and age and so I really had to say look, this is me, I do this.

By 1986, 'information' at Camblewick had become a significant topic of concern for actors and this was recognised through Dixon appointing Toms as 'Information Manager'. Toms emerged as the main protagonist, charged with the responsibility of guiding the Korner project through the unit. Martin undertook the interpretation of the Korner reports and training Medical Records staff to cope with the changes in 'data' collection. At this time, both Toms and Martin attended groups set up at district level to promote developments relating to computers and information throughout Norththown Health Authority. It was at this time that the District Computer Group established a policy document called the 'District Information and Computer Strategy'. This report aimed to translate the requirements of Korner into a

localised network of computer system developments.

Martin recalled that communication between levels of the health service was not particularly good for the Korner implementation, largely because actors at the different tiers of the service had different projects to pursue:

> At Region, they obviously worry globally about getting all the information from District and passing it up and District obviously worry about it being collected from hospitals and the hospitals, how am I going to get this bit of activity recorded and tell 150 staff of the changes...people in the higher tiers have the luxury of spending rather a lot of time talking about things and, by the time it gets down to unit, they want it yesterday and the greater problems there are for the unit because that is where the work is done.

Given the severe time pressures associated with implementing systems and training staff to collect Korner 'data', the groups set up at district level pulled together like the 'blitz spirit'. This 'spirit' at the District was supplemented by support for the technological developments from clinical departments within Camblewick Hospital. Toms summarised the situation as follows:

> Lots of departments suddenly saw that they were being given the equipment that they had been longing for and so cooperated very well with what we had to do.

'Cooperation' between staff at Camblewick is alleged once again. This cooperation may seem strange given that clinical professionals were helping to provide the Department of Health with 'data' which might well be used by civil servants to monitor their activities in the future. At Camblewick, medical and nursing staff did not interpret these developments in terms of providing managers with the 'information' tools for stronger management action. To 'fit' with the organisational context of Camblewick, the development of 'Korner' systems was interpreted by Toms (the Project Manager) in terms of facilitating the acts of clinical professionals rather than the acts of managers. Proud of his achievements, Toms stated that:

> We've probably achieved more than any other district that I am aware of...there's been an enormous turn around of getting this technology in and getting the systems in and getting people lined up and I think we've done it because we've taken the view that just putting Korner in isn't what we are here to do...Korner is the bare bones of the information and what we have said to departments is, 'You tell us what information you need to run the department and so long as it produces the Korner stats and so long as it doesn't put a massive overload on the system, you'll have it'.

Thus, the support for Korner development seemed to be largely down to the fact that all the systems were seen by members of Camblewick in terms of helping the running of clinical departments. As Martin argued in relation to the PAS, 'our PAS is an operative system and not a number cruncher'. Using information

in relation to the management of resources was still a long way away.

5.2.3 Phase three: Specialty costing.

The third phase of developments at Camblewick operated through the finance department. With the arrival of the Grand, there developed a belief throughout Camblewick in the early 1980's that the hospital was underfunded. Tony White, Sector Administrator of Camblewick in 1982, was reported to have said that 'we have pared down most of the fat'. This quotation is to be found in a 1982 article published by the Financial Times. The fact that the article was written on Camblewick Hospital is interesting in itself. The hospital's apparent lack of funding in relation to the Grand had found a wider audience:

> The provision of prestige hospitals such as the Grand without extra funding can drain resources from other hospitals to pay for the scheme.

(specific source not revealed for reasons of confidentiality).

The thrust of the Financial Times article was that Camblewick, whilst a 'reputable but not particularly famous teaching hospital', was a 'microcosm of the problems which Britain's NHS faces' being 'constantly hampered by a shortage of funds'.

Camblewick's Accountant throughout the first half of the 1980's was Jim Slate. He believed that Camblewick was underfunded for

the workload that was being handled. Measures of performance in use at the time such as cost-per-patient and cost-per-patient-day were showing Camblewick to be one of the more expensive hospitals in the Region (and more specifically, in relation to the Grand). Slate believed that the development of specialty costing could be a useful mechanism to argue for more resources (see chapter four). Camblewick housed expensive specialties such as Renal dialysis and Slate thought that despite high overall unit costs, costs by specialty would not be out of step with other hospitals throughout the country.

Having gained the support of Dixon to pursue specialty costing, Slate began an exercise to develop this technique in January 1984. This development fitted with those in the environmental context given that the sixth Korner report (Korner, 1984:15) had argued for the widespread introduction of specialty costing throughout the health service to aid 'planning, monitoring and performance evaluation at all levels'. Largely because of manpower shortages, Slate could not produce a 1984/5 Specialty Cost Report until 1986. According to two academic consultants called in by Slate during 1986 (see chapter two), this document was...

> ...a limited report covering only the inpatient costs and using a number of apportionment methods which were recognised to be no more than the best available given the scant amount of time that could be devoted to the exercise (Munson, Murphy and Taylor, 1988:8).

The two academic consultants (Taylor and Murphy) were appointed by Slate to review the progress of the specialty costing project and to provide assistance in developing the systems further in light of the DHSS information requirments and management budgeting. It was whilst the contract was being arranged between the hospital and the consultants that Slate had to reapply for his job in light of the changes in management following the Griffiths' Management Inquiry (Griffiths, 1983). Slate failed to secure his job and was replaced by the Deputy Treasurer of Northtown District, Paul Hart, in August 1986. This decision reflected the backstage movement towards budgetary devolution at the unit level and Monty's campaign to have the financial expertise available within the District's hospitals.

With this casting change, Slate took his projects with him and Hart brought new ones to Camblewick. As shall become clear in the next chapter, Hart was more interested in developing information systems for managers at the unit level than making 'better' cases for funding from the District. Thus, the arrival of Hart marked a significant attempt by the DGM to move the Government projects for stronger management action throughout the service from the backstage to the frontstage.

This third phase at Camblewick towards more sophisticated costing analysis has been shown to be a 'reactive' one. Slate took an 'external' orientation in trying to 'solve' the apparent shortfall of resources at the hospital by exposing unfair treatment in the annual negotiations with District over Camblewick's budgetary allocation. Therefore, the emphasis for specialty costing was not

interpreted by Camblewick staff in terms of the 'planning, monitoring and performance evaluation' envisaged by Korner at the unit level. Rather than trying to guide clinical professionals into working their resources harder, obtaining more money for medics and nurses to pursue their clinical duties remained the order of the day.

5.3 Conclusion.

This chapter has stressed the importance of organisational context and outlined the distinctive culture of Camblewick Hospital. Camblewick was portrayed as a medically led 'family', where relations between staff and patients were largely friendly and informal. The guiding ethos amongst Camblewick staff appeared to be one of supporting the medical community. Managers and nurses played the part of supporting cast to the needs and wants of the medical community. The Camblewick culture was contrasted with that pervading another setting; that of the Grand Hospital.

In the second half of chapter five (section 5.2), the implementation of three phases of innovation were given some attention. These were backstage projects supported by the Government and included the development of general management, Korner and specialty costing. Whilst these three projects were intended to facilitate managerial action in units, at Camblewick, the schemes were not interpreted in this manner. In all three cases, the projects were developed to protect and support the activities of doctors rather than managers. Thus, professional action remained primary and managerial action secondary. The

actors played out a familiar scenario in keeping with tradition at the site.

Having 'set the scene' for the analysis of episodes within the setting, the next four chapters portray and analyse successive 'dramas' using the 'soap opera' metaphor. The ongoing action focusses on specific initiatives promoted by senior management at the hospital aimed at developing information systems throughout the campus.

Chapter six: The Rise and Fall of Ward Budgeting.

Episode one: Hands off the handmaids.

Period: 12th January 1988 to the 22nd May 1988.

Setting: Camblewick Hospital.

6.0 Introduction.

In this chapter, the concept of scenario is used to introduce the first dramatic episode. For clarity, the scenario is divided between 'backstage' and 'frontstage' activity. The 'backstage' refers to the environmental context for action which occurs 'frontstage' at Camblewick. Throughout the episode, the other dramatic concepts outlined in the 'soap opera' model are used to portray and analyse sequences of action. 'Conceptual breaks' are introduced at the end of every part so that the narrator can reflect on the preceding action. Following on from chapters four and five, this first episode has as its central theme the tension between managerial action and professional action. This tension is revealed when the Unit Accountant threatens to disturb the alliance between managers and clinical practitioners at Camblewick by introducing ward budgeting for nursing staff.

Running Time:1 Minutes

Scenario.

Backstage:

During this period, the health service was reported to be suffering from a shortage of manpower and financial resources. Beds were being closed in hospitals and doctors and nurses in the NHS picketed Parliament to help 'save the NHS' (see chapter four). Amidst all these protests, the Prime Minister announced a review of the health service on January 25th. In February, nurses across the country continued to campaign against under-funding of the NHS and the shortage of nursing staff caused by low pay. A day of demonstrations was planned for the 3rd of February. In Northtown, nurses at the Grand organised a march through the City centre. At Camblewick Hospital, work continued as normal. There were no demonstrations. However, Paul Hart, the Unit Accountant and protagonist in this episode, was one senior manager who was well aware of the financial pressures upon the hospital...

Frontstage:

Paul Hart faced a dilemma. On the one hand, the last financial year had seen the hospital treat more patients than ever before. On the other hand, the hospital was heading for an overspent budget which was unacceptable to members of the DHA. Hart proposed a number of measures to members of the Unit Team and MEC (see appendix 16) which were intended to reduce workload in line with the hospital's budget. One of these measures was the introduction of ward budgeting which was in keeping with Hart's

information strategy for the unit. It was thought by Hart that ward budgeting would curb spending in the area of medical and surgical supplies. Therefore, the introduction of ward budgeting was targeted for April 1st, 1988. But what of the nurses? What part would they play in this movement towards managerial action at the clinical level?...

6.1 Narrative.

For the sake of convenience, this episode is divided into five parts.

6.1.1 Part one: Hart's package of proposals.

The narrator met Hart several times during the first quarter of 1988. Hart often expressed concern about the contradictory position the hospital found itself in. Put simply, the problem was that the hospital's budget was cash limited and yet the period from April to December 1987 had seen a nine percent increase in the amount of work undertaken compared with the previous year (according to Hart's figures, deaths and discharges were up nearly three thousand from 27,000 to 30,000). Despite doing more work, the costs of undertaking it were up with no additional sources of income. Hart considered this situation to be unfair and commented that:

> If we were in private business, we would be declaring a dividend and doing great, but instead we are getting threatened with the sack for overspending. So somehow or

other, we have got to try to reconcile those two different things and try to get the workload and resources back into balance.

The previous accountant, Slate, had assumed that the mounting financial pressures on Camblewick could be solved by securing extra money from the DHA. Having worked in the backstage areas of the DHA, Hart had an alternative view. He thought that DHA members considered pleas by Camblewick staff for more funding to be a case of 'crying wolf'. As Hart said in one meeting in February:

...they just don't believe that we are overspent.

Slate's 'external' solution to Camblewick's financial problems had been pursued for so long that it had lost its impact. Over the past twelve months, Hart had decided on a different strategy, this being to opt for 'internal' solutions to easing the financial problems of the unit through a policy of stricter budgetary control.

This process towards internal budgetary control first took effect at Camblewick in the area of general services. By March 1988, control of budgets in areas such as Catering, Laundry and Domestics had largely been achieved as a result of the Government policy of competitive tendering. These three general services had prepared detailed tendering documents and won the contracts but this now 'kept them to the pound'. Similarly, budget holders in clinical services such as Pathology, Radiology and Para-Medical

services had been subjected to increasing pressure from the UGM and Hart to work within cash limited budgets. Hart explained the situation as follows:

> Traditionally, the Unit Team would always make sure that patient areas were the last places to take action against but in the last twelve months we have overspent on drugs, theatres and surgical sundries so that control of all those other areas which are exercised more closely has got harder and harder so the real effect is that we push pressure on those areas we can control closely. And that also means that we must also try and to exercise more control over those remaining areas that we have been less able to control in the past, hence the move towards budgeting.

Silver (General Services Manager) was able to confirm this situation:

> Service side managers have been told quite specifically to work within the defined budget to be agreed with the General Manager and Unit Accountant...Budgets like drugs and medical and surgical sundries are running away but most others are O.K. In fact, it is because that they are running within their budgets that we are able to demonstrate that we are not overspending as we might be.

By squeezing budgets in the clinical services and the general services, the Unit Team had hoped to avoid taking action against budgets linked to the clinical practices of doctors and nurses.

However, by March, Hart felt that he could no longer 'wave a bloody magic wand anymore'. The increased cost of undertaking extra work through the hospital was being reflected in overspends on drugs, theatres and medical and surgical supplies. This position had been exacerbated because of the short-funding of pay awards passed on by DHA which amounted to £150000 in the financial year 1987/1988. These things were clear to Hart. The Accountant made sure that this interpretation of the hospital's financial situation was presented to other key actors. Hart prepared a paper for members of the Unit Team and the MEC to consult on the 7th March, 1988 (see appendix 17).

Hart's document argued that the short-funding of pay awards and the growth in caseload in the hospital meant that the hospital was heading for a £600,000 overspend by 31st March if no action was taken. As a result of the financial pressures on the hospital, Hart proposed a number of measures to ease the situation. One of Hart's suggestions was to close a medical ward so as to curtail workload but the Accountant had admitted to the narrator earlier in February that this was 'the last thing the Unit Team want to do'. However, Hart's report offered another solution to ease the financial situation on the hospital, this being to take a 'tougher approach' to budgeting in clinical areas in the new financial year. In Hart's words, the immediate measures were to:

(1) Agree a theatres budget that we can afford (ie less than we are spending at the moment) and apply strict budgetary control in 1988/1989.

(2) Reduce the budget for medical and surgical supplies, allocate down to *ward* areas and apply strict budgetary control in 1988/1989.

Source: Hart's report to the Unit Team and the MEC; 7th March, 1988:1.

Members of the Unit Team and MEC accepted the seriousness of the financial situation and found the suggestion to introduce ward budgeting a favourable one. However, members decided to think over the other proposals, reluctant to restrict the activities of the medical community.

CONCEPTUAL BREAK.

The protagonist's immediate project is to balance service plans with financial constraints. With no more funding available from the District, the squeeze on finances is the trigger for looking 'inwards' and tightening control over budgets throughout the hospital. This movement towards stronger managerial action has already begun in areas such as the general services and more recently, the clinical services. The dramatic tension increases as Hart intends to challenge the Camblewick culture by extending budgetary control to the activities of clinical practitioners. On this occasion, it is to be the ward sisters who are the targets of a budgeting innovation. However, there is a suggestion that the doctors will be next to suffer an intrusion into their 'professional' activities.

Hart attempts to gain support for his ideas from senior management and doctors at the unit by creating a formal document outlining mechanisms for 'solving' the short term financial problems. The Accountant's language is stark advocating 'strict' budgetary control in theatres and medical and surgical supplies. Whilst members of the Unit Team and MEC accept Hart's definition of the situation, they are only prepared to attempt ward budgeting for nurses. This solution appears more acceptable to the managers and medics than tackling the domain of theatres which would necessarily trespass on what has traditionally been thought of as doctors' territory.

6.1.2 Part two: Hart characterises his part according to a backstage script.

It was not purely the financial pressures on the hospital which had led Hart to 'do the unthinkable' and tackle budgetary control in clinical areas. Hart's emphasis on budgeting was one project that stemmed from his overall information strategy for the Camblewick site. A few days prior to writing the report for the Unit Team and the MEC, Hart revealed his three-tier information strategy to the narrator in the following manner:

> 'Mark I' is to sharpen up the budgetary reporting system ...we've changed all that and sharpened that up. 'Mark II' is to incorporate to the Unit Team members all the financial and non-financial information such as how many theatres are overrunning, how many theatre sessions have been cancelled and how many patients are going through the

hospital...'Mark III' is then to get the users on the ground supplied with the same sort of information.

The origins of Hart's three-tier project lay backstage with actors in the Government, DHSS and NHS Management Board. Health Notice 86(34) characterised the doctor and nurse as a 'resource manager' and Hart had been influenced by this idea:

> We [the Unit Team] have had one or two ideas starting to formulate in our minds how 'Mark III' might be achieved. This is what the pilot districts, the resource manager is doing at the moment. Official advice is that we shouldn't do anything about reorganising our structure or giving people information lower down. Ian Mills [Financial Director of the NHS Management Board] wants everybody to go slow on that and the official advice is that while we are waiting for advice, we should make sure that all of our systems are credible and clear.

Hart's statement about 'official advice' was borne out in an appeal for caution by Mills (1988:9) at that time:

> Clearly, until the current initiative has been evaluated it would be premature for large numbers of units to try to introduce full resource management systems.

Since his appointment, Hart had been content to follow Mills' advice and pursue 'Mark I' of his strategy. Hart summarised 'Mark I' in terms of 'cleaning up his own patch':

> The major objective is to make a more credible budget reporting system. Most people didn't believe in it. When I looked over the reports I was unimpressed as well and spent a long time straightening them out.

Hart used the expertise of the two backstage consultants appointed by Slate to help him improve the financial information systems on site (see chapter two, four). In particular, the consultants helped Hart to set up a specialty costing system which could meet the requirements of the sixth Korner report (Korner, 1984). However, apart from wanting to establish a financial system that could meet the data requirements of the DHSS, Hart wanted to go further than this and utilise the data at the local level. 'Mark II' and 'III' of his information strategy aimed to provide managers ('Mark II') and clinical practitioners ('Mark III') with packs of information which could be used to manage resources more effectively. Ward budgeting for nurses was seen by Hart as a stepping stone towards 'Mark III' and the involvement of doctors in resource management.

CONCEPTUAL BREAK.

Part two puts the ward budgeting initiative into context by locating the project within a porfolio of plans that the protagonist has for the unit. Hart's projects for Camblewick enact an environment (Weick, 1979) which is in accordance with the projects of backstage actors in the central tier of the NHS. Hart uses Ian Mills' script to structure his own projects at Camblewick Hospital. In making this interpretive effort, the

Accountant moves backstage scripts onto the frontstage.

By March 1988, Mills' script was a well-known one to Hart who kept an eye on the NHS and financial management journals and had been to three one-day seminars on resource management. The similarities between Mills' and Hart's position are clearly shown in a paper by Mills in the Health Service Journal in November 1986. Mills (1986:1545) argues that:

> *If I were unit accountant in the NHS my main preoccupation would be to establish as quickly as possible the basic financial planning and reporting systems necessary to ensure all routine management decisions were financially well informed.*

Mills' script is also reiterated in other commentaries on resource management during 1987. In the Health Service Journal report on the six resource management sites (Davies, 1987), the Freeman Hospital is reported to have been 'concentrating on clarifying the basic information on which the success of resource management will depend' and Arrowe Park's first task as being to 'clean up' the information collected and modernise the clinical information system. Thus, the emphasis at this stage is on technical innovation in isolation from cultural and political processes.

6.1.3 Part three: Hart departs from the backstage script by pressing on with ward budgeting.

By the time of the meeting with senior Camblewick staff on 7th March 1988, Hart considered 'Mark I' of his project to be complete; the budgetary reporting system had been 'sharpened up'. This paved the way towards devolving financial information to the nurses and ultimately, the doctors. At this time, Hart believed the nurses to be 'keen on being budget holders'. Hart was well aware that ward budgeting might present a threat to the clinical practitioner alliance at Camblewick. However, the Accountant was relying on the cooperative nature of the Camblewick nurses to see the project through (see chapter five):

> ...the emphasis has never been on budgeting, there has never been strong budgetary control. It is going to be a different regime from what's gone before but I don't think that will worry anybody. In any case, I think it will be introduced in the same sort of way that they are used to. Everyone is on good terms with everyone else here and I don't think that it will be that much of a culture shock.

The speed at which Hart wanted to introduce ward budgeting was something of a surprise. Hart felt eager to get on with 'Mark II' and 'III' of his information strategy and set his sights on introducing ward budgeting on the 1st April. This date was only a matter of three weeks away! Hart had obviously had enough of following Mills' 'go slow' script. This was not the only reason for Hart's haste to introduce ward budgeting. The DGM was keen to

get the budgeting project underway and Hart was under pressure from Dixon to implement the scheme:

> I promised them at District that we'll do it from April so we'll have to do it warts and all.

This desire to get on with the initiative had also been fueled by a recent visit to a local resource management pilot site. Hart considered the trip to be 'disappointing' and that the budgeting systems at the pilot site were not particularly impressive. Hart felt that an equal, if not better system could be developed from the specialty costing work that had already been carried out at Camblewick Hospital.

CONCEPTUAL BREAK.

Hart's building confidence leads him towards making a more positive attempt to influence the storyline. The tension continues to mount as Hart departs from the cautionary script of Mills and intends to implement ward budgeting from the 1st April, 1988. The Accountant's new found confidence is based on an assumption that the technical information is now available and that the nurses are enthusiastic about recharacterising their parts in terms of managerial responsibilities. Curiously, Hart suggests that ward budgeting may easily be accomodated by a culture which is used to facilitating professional rather than managerial action. The Accountant admits to ward budgeting leading to a 'different regime' but then suggests that it will not be a 'culture shock'. It is as if Hart is attempting to rewrite

the script and hoping that none of the actors will mind too much!

Hart's sudden urgency frontstage also needs to be understood in relation to the backstage. The Accountant is under pressure from key actors (the DGM) to implement the ward budgeting as soon as possible. The DGM plays the part of a 'ghostly' audience that is not physically present at the setting but influences the action nevertheless. Alongside this pushing force, Hart recognises that other backstage hospitals have only achieved a modest amount of progress in relation to the development of budgeting systems for clinical practitioners. Hart feels that he can match that.

6.1.4 Part four: Reactions to ward budgeting from Matron, Divisional Managers and Ward Sisters.

During the second week of March, Mrs Minter (Matron) filtered the news down through the nursing chain that Hart wanted to introduce ward budgeting on the 1st April. Following the meeting on the 7th March, Matron had been receptive to the idea of devolving budgets from the Divisional Managers to the ward sisters. In an attempt to sell the idea of ward budgeting to nursing staff, Matron used the concept of 'housekeeping' to explain the initiative:

> Ward sisters order, so they should be responsible for the budget...they are worried about it but it isn't any more than good housekeeping. It's simple and easy to do budgeting...whether you buy steak or mince beef depends on how much money you've got.

Running Time:14 Minutes

The Divisional Managers had been given responsibility to do the 'housekeeping' for the past twelve months. However, several Divisional Managers were not finding the 'housekeeping' as simple as Matron had envisaged. Part of the problem was that Divisional Managers still considered the financial statements to contain inaccuracies despite Hart's efforts to improve them. These errors were undermining the Divisional Managers confidence in the budgeting process. Consequently, the prospect of devolving budgets to ward level was thought by some nurse managers to be 'putting the cart before the horse'.

At the time of Hart's ward budgeting proposal in March, Mooney (Divisional Manager, Health Care of the Elderly, (HCE)) had been at Camblewick eighteen months. During this period, she had devoted half of her time to tackling the budgeting for her nursing division. Budgeting had presented her with problems:

> I think the area I am most dissatisfied with at the moment is the financial prints...there have been a lot of hiccups with it. I tend to feel that we haven't got this side right and we are going on to the next stage.

and;

> Because of the inaccuracies, the nurses don't take the budget statements seriously. I am concerned that because of the inaccuracies that show up and the time it takes to get information that people will adopt a blase attitude to budgeting in the early days.

The accuracy of the financial statements was not the only thing to concern Mooney. She also questioned the whole philosophy behind characterising the ward sisters' part in terms of budgetary responsibilities rather than clinical care:

> What are we asking ward sisters to be? People say that they should not be responsible for the financial side of the ward because they are not trained accountants. Are we making them a jack of all trades? If so, then then where does their clinical commitment lie?

Hooper (a long standing Divisional Manager of the Mental Illness Unit) wondered whether nurses would want to do the budgeting:

> I understand the budget is going to ward level. It really worries me...there has to be training and I have heard nurses say that enough is enough, we came to nurse and we don't want the paperwork.

Hooper had built up some confidence in her ability to do the budgeting and did not want to bother the ward nurses with this duty. Apart from feeling that the budgeting was her responsibility, she doubted whether sisters were up to the job of 'housekeeping':

> It doesn't matter how many times you go down and say, you must go to the cupboard, you must know what you use in seven days, you must do your housekeeping job properly, then the next week, the Charge Nurse might give it to the SEN to do, or Staff Nurse

to do. It worries me.

and;

...you could have somebody who is a sister who can't even run their own housekeeping at home. How can they manage money at ward level?

The Divisional Manager is here taking the task of checking and ordering ward supplies to be a good indication of nurses commitment to the 'housekeeping' duty. Hooper feels that the nurses still lack a sense of ownership over this task and is anxious about the proposed devolution of budgets.

Whilst Mooney and Hooper considered budgeting a part they should perform, there were other Divisional Managers with long experience of nursing at Camblewick who had yet to involve themselves in this task. Barton had been a nurse for sixteen years at Camblewick before being made Divisional Manager for theatres in 1986. She admitted that she enjoyed the 'clinical involvement' that went with her part but had yet to feel comfortable with management ideas such as budgeting:

Once a month you have a formal meeting with other Divisional Managers and on some occasions you come away thinking that everyone else is much more switched on and on a different planet to you talking about all these management ideas. You come away feeling very inefficient and wonder what the hell you are meant to be doing.

Part of Barton's anxiety about budgeting was due to a lack of training:

> I don't think that we have had sufficient training to be able to cope with the budget properly and I don't think that it is sufficiently broken down for us.

Despite feeling isolated, there were other Divisional Managers of a similar frame of mind. Raymond had been a night nurse for seventeen years before moving into the area of nurse management. Raymond still regarded himself as playing the part of a nurse rather than a manager or an accountant:

> I hope I'm not thick about budgets but its never been my forte. I'm not an accountant. Could Hart come and do my job? Could he look after a patient on a ward? He couldn't, so he shouldn't expect me to be an accountant.

In agreement with Barton, Raymond felt annoyed that he and the ward based nurses had been given no training:

> We are nurses. I know we have to be educated as to how to spend money but no-one is making any attempt to educate us. We are now not far off April 1st and there has been no training given so far. Nurses are getting worried.

At the ward level, nurses were worrying about the prospect of doing the budgeting. Sister Thomas, one of the senior nurses within Raymond's division (general medicine), foresaw that doing

the 'housekeeping' would mean a change in the part she had hitherto played at the hospital:

> It's the Divisional Manager that gets a total of how much the wards are overspent this month. At the moment, it doesn't mean much to you because what have you overspent on? I can imagine that when I have to do the housekeeping it will be different.

Having been protected by Raymond from analysing the budget statement so far, Thomas thinks that the introduction of ward budgeting will bring new responsibilities in relation to the ordering of medical and surgical supplies. According to new recruit, Sister Jenkins (HCE), the reigning attitude amongst Camblewick nurses was that of 'if you ran out you ordered'. Jenkins went so far as to say that she could 'open Tesco with the present amount of stock on the ward'. This appeared to be one of the main reason the UGM had recently appointed a Supplies and Equipment Adviser to reclaim unused goods at the ward level. Sisters believed this actor playing this part would seek out cheaper products to keep in stock for the future without reducing the quality of the patient care provided.

However, despite advice being available from the Supplies and Equipment Adviser, nurses remained uncertain about how the ward budgeting initiative was to be introduced. For example, Thomas said:

> What we hope is not going to happen is that from the first of April you do your own budgeting with no training.

In other areas of the hospital, the feeling was similar amongst the sisters. For example, Sister Jenkins expected to have some sort of training before taking on the responsibility of the budget:

> Budget forms are difficult to interpret, you have got to have someone explain it to you.

Sister Bell (HCE) seemed to be relying on her more senior sister, Sister Noakes, to help her with the budgeting:

> Accountability for the budget is to be with the Senior Sister and so she will help us. I feel apprehensive about new things but there have been so many lately that it's just something else.

Noakes, meanwhile, was hardly prepared for the task herself:

> I was in a meeting in the middle of March with Mrs Mooney who talked of ward budgeting being introduced in two and a half weeks time. I was about to go on holiday for two weeks and certainly not going to come back to that.

Amidst the confusion about what was going on there was some genuine concern on the part of sisters that budgeting would take them away from 'hands on' care. Thomas echoed the comments made by Mooney and Hooper in arguing that:

...budgeting is going to be an extra responsibility and take you away from patient care which is basically what we are here for.

CONCEPTUAL BREAK.

As a nursing leader and senior manager, Matron has the task of promoting the ward budgeting initiative. In conceptualising the budgeting technique in terms of 'doing the housekeeping', Matron uses language as a political instrument to reshape the meaning of the scheme. Rather than ward budgeting being a 'strict' mechanism of managerial 'control' (Hart's terminology), the technique is couched in softer and less threatening terms. In budgeting becoming 'housekeeping', the suggestion is that nurse anxiety at the prospect of ward budgeting can be countered by a simple, domestic image - that of watching the pennies when doing the shopping. Doing the 'housekeeping' at home is an image that Matron assumes nurses will be able to relate to. Thus, the language of the Accountant and his budgetary system is being demystified into a more accessible, everyday image.

The Divisional Manager's reaction to the prospect of giving the Ward Sister 'housekeeping' duties reveals the tension between managerial and professional action. Both Mooney and Hooper are protective over the budget but for different reasons. Mooney lacks confidence in the financial statements and questions the rationale for devolving budgets before she and the nurses in her division have more faith in the system. Meanwhile, Hooper finds budgeting easy and enjoys the control she has achieved by working

with the budget. Both Mooney and Hooper do not fully believe in the ward budgeting proposal and are not convinced that ward sisters should become a 'jack of all trades and master of none'. A direct contrast is established between nursing as a 'clinical' activity and the 'paperwork' of the accountant. Whilst both parts are skilled activities, the Divisional Managers feel they have only been trained for one; that of nursing.

Barton and Raymond represent 'stock' characters. Both have been working at the hospital for a considerable amount of time and can be thought of as 'traditionalists' who are resistant to change. Their experience as a nurse runs deep and they are daunted and intimidated by 'management ideas'. Barton and Raymond complain that they need training for the budgeting part as much as anyone else and are ill-prepared to supervise ward budgeting. Once again, the Divisional Managers make contrasts between the parts of nurse and accountant. In the rhetorical question, 'Could an accountant do my job?', Raymond constructs a dichotomy between the 'stock' parts of nursing and management (seen as accounting in this context). In Raymond's mind, there appears to be little possibility of combining parts. Dramatic tension is heightened in Raymond's final comment when he suggests that the 'nurses are getting worried'.

Last but by no means least, there are the reactions of the ward nurses to the ward budgeting proposal. Nurses such as Thomas and Jenkins seem anxious about the scheme. They feel they are being expected to perform a part they have had no time to prepare for. Nobody has provided the direction that they require. Other nurses

reactions ranged from complacency ('it's just something else') to anger ('I'm not coming back to that'). Thus, the dramatic tension reaches a peak as the ward nurses attitudes conflict with the project of the protagonist, Hart. Right on cue, Thomas emphasises the potential discord by performing according to type. The Senior Sister introduces a 'stock' characterisation when she suggests that nursing is basically about 'hands on' patient care. Professional action remains primary in the minds of Camblewick practitioners and budgeting is regarded as something 'extra'.

6.1.5 Part five: Ward budgeting is taken out of the script.

Towards the end of March, tension on the wards had reached fever pitch. Divisional Managers responded to nurse anxiety about ward budgeting by rallying to protect their staff from this extra responsibility. The Divisional Managers made their feelings clear at their weekly meeting with Matron. Their first point was that they had had insufficient time to get used to budgeting themselves without having the responsibility of overseeing ward budgeting foisted upon them. The nurse managers still regarded budgeting to be their part and not the sisters; nurses at ward level had enough to do. Equally, the Divisional Managers complained that the financial information was still not accurate enough to enable budgeting to run smoothly. To make matters worse, the nurses had had no training to deal with the 'housekeeping' task. Matron reacted to these complaints by supporting her Divisional Managers and pressing Hart and the Unit Team to go more cautiously with the ward budgeting initiative. Matron's attitude became one of 'not taking the big stick' to nurses ordering practices on the wards

and 'giving them a year to get used to working with the budget and getting to know it'.

By the 22nd March, Hart's attitude towards ward budgeting had changed considerably. He indicated this by saying that he understood the sisters were 'not very enthusiastic' towards the budgeting initiative. The softening of Hart's position was clearly seen when he admitted that:

> ...although I have not said that the first year may be a demo run it may turn out to be that way.

Hart also understood that all the nurses needed training before formally asking them to be budget holders. This included the Divisional Managers as much as any of the others:

> I've got to give all the nurses a talk on what budget statements mean and how they work and what will happen if they overspend and the first one of these was to be with the Divisional Managers on Thursday but they've just cancelled it.

April 1st came and went and the tension associated with the ward budgeting initiative subsided. In May, the narrator asked Hart whether he intended to hold any training sessions for the nurses and he replied that he 'probably wouldn't get round to it'. He went on to justify this statement by arguing that he had:

> ...agreed budgets with the Divisional Managers rather than the Sisters so that the formal authority remains with the

Divisional Managers. The Unit Team felt that it was necessary to secure their position.

Another factor also conspired to make sure that Hart had little opportunity to pursue his ward budgeting project at Camblewick for time being. Hart learned in May that the DGM of Northtown Health Authority wanted him to temporarily fill the vacant post of District Treasurer until a replacement could be found. It was purely coincidence that the previous Treasurer had decided to leave for another appointment at this time. Dixon expected Hart, as Deputy Treasurer for the District, to bridge the gap for a few months whilst another actor could be found to play the part.

Meanwhile, at Camblewick, there were no plans by the Unit Team to fill Hart's place whilst he was away from the site. For the timebeing, the ward budgeting initiative had been sidelined.

CONCEPTUAL BREAK.

In the final part of the episode, the ward budgeting initiative is written out of the ongoing script. Matron emerges as the main antagonist, being subject to pressure from the Divisional Managers who wish to object to the movement towards 'housekeeping' at the ward level. Matron shows that she can readily change parts to suit the occasion. Having at first supported Hart as a member of the Unit Team, she now acts as a leader and spokesperson of the nursing profession and gives her allegiance to the Divisional Managers. When put to the test, Matron puts the nurses before senior managers and negotiates with Hart to postpone the

introduction of ward budgeting for one year. In the grand tradition of Camblewick Hospital, professional action is once more maintained, largely protected from the pressures for stronger managerial action at the clinical core.

Equally, this fifth part of the episode reveals that Hart is willing to 'back down' rather than risk a confrontation with Matron and the nursing profession. In accordance with the Camblewick culture (see chapter five), the protagonist avoids conflict in order to preserve harmony. Tough decisions are postponed out of regard for the feelings of nursing staff. Of course whilst consensus is important to Hart, another interpretation of the situation could be that there are other 'battles' ahead and that he does not want to jeopardise his long term projects by pushing ahead with the ward budgeting scheme.

Hart's move to District headquarters may seem to the reader (and audience) like a coup de theatre where the protagonist is promtly rescued from an awkward situation by a sensational act not of his own making. In the Accountant's case, it may be that the DGM's intervention was a timely one for Hart could avoid having to try to resurrect the ward budgeting initiative at Camblewick. Indeed, as the next episode shall illustrate, Hart's recasting as acting District Treasurer allowed him to switch his attention to other projects of interest. Despite being physically removed from the Camblewick setting, Hart was to be very much involved in the escalation of events towards resource management at Camblewick Hospital ('Mark III' of Hart's original information strategy).

Running Time:26 Minutes

6.2 Conclusion.

This first dramatic episode has portrayed the dynamics leading to the rise and fall of a ward budgeting initiative. A number of issues emerge from this drama. Firstly, management have to tackle problems which are a result of the combination of backstage and frontstage pressures. Backstage, the Government were exercising strict financial controls through the RHA and the DHA and this meant that Camblewick too was under pressure to stay within its budget. Frontstage, management had to contend with an increase in workload by clinical practitioners which the hospital could not afford. Given this scenario, the main protagonist (Hart) argued for a stronger managerial action at the clinical level and ward budgeting was proposed.

A second theme to emerge was that whilst it was intended that extending financial information to ward nurses would lead to a stricter management of resources (ie 'better' management), this proved to be far from the case. In this episode, ward budgeting was blocked by the nursing community before any budgeting system could be established. The problems were not only of a technical nature (ie. poor quality financial data) but mainly a lack a consideration for the context in which the scheme was meant to operate. For example, budgeting had yet to 'bed down' within the nursing community at the level of divisional management; the scheme did not have the support of the Divisional Managers; there was little time to prepare ward sisters for the part and nurses had not received any formal training in budgeting. In short, the project was mismanaged.

Running Time:27 Minutes

A third essential idea was that the ward budgeting initiative threatened to disturb the balance between managerial and professional action at the unit. Hart attempted to influence the ongoing script by introducing management techniques at the clinical level. However, this development was a challenge to the Camblewick culture and resisted by those actors playing 'stock' parts. For example, the 'traditionalists' were eager to preserve the distinction between management and clinical parts. In keeping with the implementation of previous 'management' based projects at Camblewick (see chapter five), professional action at the clinical level was largely protected from unwelcome intrusions.

Following on from the last theme, the use of language played a significant part in mediating the meaning associated with Hart's original definition of the project (ie. 'stricter budgetary control' at ward level). By using the 'housekeeping' image, the stark and autocratic terms of the Accountant were transformed into something 'softer' and more superfluous. The 'cutting edge' of the project had been 'blunted' making the budgeting initiative less threatening and easier to cast aside. This is indeed what happened. Camblewick's culture of harmony and stability was maintained by management deciding not to confront the nurses and choosing to postpone problems for another day.

Chapter seven: The Origins of the Clinical Information Project.

Episode two: Birthday surprises.

Period: 23rd May to the 8th December, 1988.

Setting: Camblewick Hospital.

7.0 Introduction.

In the last episode, nursing staff rebuffed moves by the Accountant at Camblewick to characterise the Sister's part in terms of budgeting responsibilities. This second episode reveals how Hart's three-tier information strategy was to reemerge to shape the Unit Team's plans for the future of the hospital. Particular attention is paid to the processes leading to the creation of the Clinical Information Project. In keeping with chapter six, the 'soap opera' model is once again used to analyse the ongoing action. Much of the narrator's interpretation of events is to be found in the 'conceptual breaks' after each part of the episode.

Scenario.

Backstage:

The NHS became forty years old on the 5th July 1988. On this day, two different scripts were being rehearsed in backstage arenas. One came from the Health Secretary, Mr Moore, who can be

considered an important spokesman for the political coalition (see chapter four). The other script emerged from members of the BMA representing the clinical practitioner coalition.

Mr Moore, the Secretary of State for Health and Social Security, addressed members of the Centre for Policy Studies and said that he wanted to 'unleash the entrepreneurial energies of managers...by removing some of the cumbersome centralised restrictions going back to the days when the NHS was administered rather than managed.' Moore hinted at what projects might be written into the Government's script for reforming the NHS by proposing the creation of an 'internal market' in health care delivery. This reform would allow money to follow a patient if they moved across health authority boundaries (The Independent, 5/7/1988).

Meanwhile, members of the British Medical Association (clinical practitioner coalition) were holding their annual conference on the 5th July. The doctors made no proposals which included the possibility of creating 'markets' in health care. In direct contrast to Moore, BMA members backed a script consonant with historical trends, this being to support the NHS as a tax funded service, free at the point of use and available equally to all. Rose, a G.P. from Buckinghamshire, reminded the public that there were doctors reluctant to compare management of the health service with that in private sector organisations. In a statement widely reported by the media, Rose argued that 'hospitals are not supermarkets and in particular, patients are not baked beans being pushed along a conveyor belt' (The Independent, 5/7/1988). The

origins of this 'supermarket' comparison can clearly be linked back to the NHS Management Inquiry (Griffiths, 1983) led by the Managing Director of Sainsbury's; Roy Griffiths (see 4.3.2).

At the end of July, the Prime Minister acted in the last week of Parliament to split the DHSS into two seperate departments; the Department of Health and the Department for Social Security. A casting change was also made by the Prime Minister. Mr Clarke was appointed as the new Secretary of State for Health with the responsibility of presenting the Government's future plans for the NHS to Parliament.

In Northtown, there were no birthday celebrations. Four weeks before the NHS's fortieth birthday, a Northtown M.P. leaked a confidential report to a local newspaper. This document had been written by Northtown's clinicians and claimed that the Health Authority was facing a funding gap. As a result of the financial situation, the consultants alleged that nursing levels were being kept low, a quarter of medical equipment was not being replaced and operating lists had to be cancelled. Dixon, the DGM, countered this argument by stating in a local newspaper that there was 'no crisis' as far as he knew. Despite, Dixon's reassurances, the financial pressures on Camblewick Hospital continued to increase.

Frontstage:

At the end of May, Camblewick's accountant (Hart) decided to hold one last 'strategy' meeting before departing to District headquarters. This meeting was with Sally Martin, the Medical Records Manager. The meeting was held to consider how to educate Camblewick staff into using sets of data extracted for the Regional Patient Information System. In June, Hart took up his new post as acting District Treasurer and 'Mark II' and 'Mark III' of his three-tier information project looked as if they might fade from the scene. More pressing matters were at hand.

During June, Peterson (Camblewick's UGM) closed an operating theatre and followed this action by cutting the hospital's non-urgent operations by ten per cent in July in order to keep within a strict budget. Further theatre closures were made during August. These restrictions on professional action were thought by some Camblewick consultants to be unacceptable and an indication of management's incompetence. At the end of August, there was a medical committee meeting and Cooper, a leading consultant, challenged the UGM to account for his actions. It was the outcome of this confrontation which pushed members of the Unit Team towards a reappraisal of Camblewick's situation. On the 28th September, members of the Unit Team attended conference rooms at Harrogate for a three day 'time-out'. It was during this period that these key players were to review Camblewick's management structure and reconsider the part doctors should play in the management of resources...

7.1 Narrative.

This second episode is a drama composed of four parts.

7.1.1 Part one: Hart's 'strategy' meeting with Martin.

On the 23rd May, Hart arranged to see Martin in the Medical Record's department. Martin had been a key player in interpreting the Korner reports and getting the Patient Administration System (PAS) established (see chapter five). Hart wanted to discuss with Martin the possibility of gathering data from the Regional Patient Information System (PIS) and sending it out to doctors at Camblewick ('Mark III' of Hart's three-tier project).

This was not the first time these two players had met. Earlier, in March, Hart met Martin to discuss 'Mark II' of his project; that of sending the Unit Team members a package of data. In that meeting, Martin had given Hart advice about what she considered to be the categories of data that members of the Unit Team might need to help them to ask and answer questions. Following the March meeting, Martin instructed Abbot (General Administrator in the Medical Records Department) to access the data from the Regional PIS by using the terminal at district headquarters. Abbot was the only person at Camblewick who knew how to do this.

The Unit Team's 'information pack' was ready by the end of March and consisted of a twenty page document split between financial and non-financial data. The financial data consisted of pay and non-pay items for each department at Camblewick and whether the

department was underspent or overspent for the proportion of its budget (financial year to 31st January 1988). The non-financial data as at the 1st February included in-patient activity by ward and consultant (eg. available beds, occupied beds, deaths and discharges, percentage occupied beds, length of stay, day cases, ward attenders) and out-patient activity by ward and consultant (eg. attendences referred by G.P. or consultant). Hart had sent out this pack to Unit Team members at the end of March and, according to him, they had received it in the following way:

> My first question to the Unit Team was 'Is this the kind of information that you need?' They said 'Yes, smashing, super'...So I said, 'I've got more information on the same sort of basis, can I bring this to you as well?' They said, 'Not just at the moment. Give us a couple of months time when we've got used to this.' The main thing is that I want them to be aware that the information is there.

Eight weeks on, Hart was keen to implement the next phase of his 'strategy'. The May meeting with Martin was arranged so that discussions could begin about sending out data to individual consultants. As the meeting got underway, Martin suggested to Hart that he was taking a 'big step'. Having been the architect of the PAS at Camblewick, the Medical Records Manager still felt protective about the Korner data and wanted to make sure that other actors did not 'misinterpret' it. Given this concern, Martin questioned the whole philosophy behind Hart's project. She hoped that the objective of the exercise was to 'educate' consultants rather than expect them to 'do anything with the

data'. The Medical Records Manager made it clear to the Accountant that she undertstood 'Mark III' of his project in terms of 'sending the medics something to capture their interest'.

In response to Martin's comments, Hart agreed that the approach must be cautious. He had originally sketched out a briefing letter for the doctors using terms like 'information for managerial control' but now considered these words to be 'too strong'. It was as if Hart's experiences with ward budgeting had taught him a lesson, this being that a redefinition of clinical practitioners' parts would take quite some time. The Accountant was now prepared to wait for nurses and doctors to change their characterisations.

Martin then suggested eight categories of data that she thought would be of interest to doctors. These categories were the consultant episode, deaths and discharges, average length of stay, percentage of emergency admissions, waiting list, day case, ward attenders and primary diagnosis. Hart thought that this data would 'frighten them to death' because doctors had 'never had this before'. Martin retorted that 'they could do with a shake up'.

As the meeting drew to a close, Martin said that she would ask Abbot to gather the data from the PIS. She said that the hospital 'could do with having their own terminal'. This would save Abbot going to district headquarters. Hart said that he would pressure officers at regional level for funding for such a terminal. In the meantime, Hart said he would 'get the green light from the Unit Team' with regard to 'moving onto the next phase'. Hart

seemed excited that he had found an understudy to pursue his projects for him whilst he was away from Camblewick Hospital. He left the meeting in a bouyant mood.

Hart left the campus for the DHA headquarters in the first week of June. Despite the Accountant's efforts, 'Mark II' and 'Mark III' of the information strategy seemed to come to a standstill over the summer period. Whilst the Unit Team had apparently been 'enthusiastic' over the data Hart had given them, a closer inspection of the responses of Unit Team members to 'Mark II' indicated that this belief was somewhat illfounded. For example, in June, Matron made the following complaints:

> ...it's a thick document which is off-putting. The problem is that it comes over as a month's statement and what you really need is to be able to compare last month or last year with now to see where you are going to and what it's costing you and what's the difference. So there is a lot of information there and because it is new data, you can't use it to compare with last year so I am waiting for a bit.

and:

> It's difficult to wade through it all. Frankly, its not as useful as it might be.

Kathy Silver (GSM) had similar comments to make about the 'new' data pack:

> I am not very good at handling lots of numbers. I prefer something visual, bar charts or something rather than loads of loads of data that's just numbers.

Peterson, the UGM, summarised the position as follows:

> We [the Unit Team] decided that we were being presented with loads of bumph and lots of figures and that it was a bit of a turn off and we asked, and this hasn't happened properly because Hart has gone off to District and so on, that we ought to get this summarised in some way so that we could understand what the figures meant. It's a commentary that we want.

Whilst 'Mark II' of Hart's plan had reached a 'dead halt', 'Mark III' was to fare no better. Abbot was particularly busy during July and August and had little chance to go to District headquarters. When he did, Abbot's endeavours had ended in frustration because the PIS kept 'going down'. Martin explained that it only needed six people to be trying to access the PIS around the region for the computer system to 'crash'. Martin's hopes were resting on Camblewick getting its own terminal. In July, members of the District Computer Group told the Medical Records Manager that the hospital could have a terminal. Since then, actors at Northtown DHA had been 'stalling' and by September, Martin had still not received the terminal. She admitted that she could get actors at District to undertake the data gathering task for her but felt reluctant to do so. Martin said it was wise 'not to let District know too much about units.' Rather than trust backstage actors, Martin wanted to 'keep things

local'. Consequently, little had been achieved by the end of September with regard to 'Mark III' of Hart's information strategy. However, the initiative was to be revived through a different series of events.

CONCEPTUAL BREAK.

It is revealed in this second episode that Hart has not been deterred by the events leading to the failure of the ward budgeting initiative. As a key protagonist, Hart seeks support for his vision, this being to make information 'work' at all levels of management throughout the hospital. At a strategic level, the Accountant has already implemented 'Mark II' of his plan by distributing an 'information pack' to members of the Unit Team. To complement 'Mark II', Hart collaborates with Martin as to the next stage of his three-tier strategy; providing doctors at the clinical level with computer-based data.

Throughout this first part, Hart emphasises information 'provision' rather than 'use' in order to make his 'management' projects palatable to actors supportive of professional rather than managerial action. The accountant admits that 'Mark II' is a way of letting senior managers know 'what information is available'. Similarly, in discussing 'Mark III', Hart moves away from the language of 'control' and agrees with Martin that the scheme is an 'educational' exercise. Following on from themes introduced in the last episode, the use of language is significant in mediating the meaning of information-based projects less threatening to allies and members of medical and nursing groups.

It would not seem a correct interpretation of the action to assume that Hart's projects have been completely emasculated through language. Both Hart and Martin are aware of the possibilities of an evolutionary shift towards managerial action resulting from 'information' provision. This understanding is played out in the following interaction. In discussing the available data on clinician's workload, Hart suggests that this will 'frighten [the doctors] to death'. Martin responds that 'they could do with a shake up'. One plausible analysis of these remarks is that Hart and Martin both realise that information is a potential power resource (Pettigrew, 1972). In making computer-based data available, actors have the opportunity to use it to pursue particular projects. With the Government advocating the pursuit of economic utility as a primary project (see chapter four), doctors are faced with the choice of getting involved and monitoring their own use of resources or having someone else take on this management responsibility for them which could well lead to restrictions in professional activity (eg. ward or theatre closures).

Hart had long been aware of this dilemma and thought that doctors would want to start playing the manager's part:

> *...once the information starts to get disseminated and the doctors realise that all this information is available not just for me or the UGM but they can have the information and they can make the decisions, well they won't be satisfied with letting the General Manager close down a theatre. Once the information is available, they will want to argue their own*

corner.

Whilst the above analysis notes the possibility of information systems creating a new kind of organisational script, the excitement of Hart at the end of his meeting with Martin is contrasted with subsequent events. Having distributed 'information' to the Unit Team, the members initial reaction is that there is too much data and not enough information. Matron, Silver and Peterson all agree that Hart's pack is difficult to interpret. Given this situation, the accountant's initiative seemed to have been temporarily cut out of the storyline.

Alongside the problems associated with 'Mark II', a shortage of resources hampers the progress of 'Mark III'. Only Abbot has the expertise to access the PIS and he is busy with other projects. This difficulty has been exacerbated by technical problems with the regional computer system and the fact that the Unit still has to receive its own terminal. With Hart playing a part in the backstage, all these factors lead to a collapse of the Accountant's plans for the time being.

7.1.2 Part two: Battling over theatre closures.

Alongside the events in part one, other stories were developing which were to have a bearing on information system development at Camblewick. On May 27th 1988, it was alleged in the Northtown Post that the District was eight million pounds underfunded. Following this announcement, an M.P. published segments of a report from doctors and consultants on Northtown's Medical Staff

Committee (Northtown Post, 9/6/1988) to support this claim. The doctor's report argued that:

> We are being faced with an increase in an uncontrollable workload at the same time as having imposed on us savings targets.

and that:

> Existing clinical services will almost certainly have to be reduced in order to demonstrate the savings, as there must come a time when no further savings can be made in non-patient services.

This statement was to prove prophetic as far as Camblewick was concerned. The backstage discussion turned into managerial action at the local level when the UGM closed an operating theatre used by Orthopaedic surgeons throughout June and July. Peterson justified this action by declaring that the Government were to blame for the situation:

> It's not a case of cutting back, rather that we are trying to keep a strict budget while the number of patients has increased. It is something of a 'Catch 22' situation where the Government is asking us to put more patients through the system and cut waiting lists - and we are supposed to fund that with efficiency cuts.

This decision to close one theatre meant that only seven out the eight were open. However, despite this decision, Beeston (acting Unit Accountant for Hart) produced figures for the UGM at the end of July which demonstrated that there had been no drop in work by consultants as a result of the theatre closure. Slack from six of the theatres had been taken up by consultants in Obstetrics and Gynaecology. On the 20th July, the UGM acted on this information by cutting the theatre budget for non-urgent operations by ten percent. It was this latter decision to cut the budget which demonstrated that the UGM was now prepared to play the part of a manager (rather than be a doctor in a manager's costume) and use information to help 'make' or 'justify' what he termed as some 'painful' decisions against the medical community.

> It is easy to say that we don't use information much but when you think about it you realise almost unconsciously you are using information either to justify decisions or help you make them. Theatres is a good example. We [the Unit Team] realised at the beginning of the financial year that we hadn't got enough money to break even and we took various steps to try and curb it. We have used performance indicators to show an increase in activity over the past few years which has not come with any funding and we set the budget on the basis of reducing the budget by ten per cent because we had a twelve per cent increase in activity in the last two years and we felt that because that wasn't funded we had to peg activity back to break even. That hasn't happened because we closed one theatre hoping this would solve the problem and all the consultants have done is put the same number of cases through fewer

theatres.

Alongside the UGM's decision to cut back theatre budgets, further theatres were closed during August. This decision had been made in association with members of the MEC who agreed to do emergency surgery only through August because that was the time when a lot of doctors were away on holiday. The number of theatres remaining open during August fell from seven to three. These theatres were reopened in September. Whilst the UGM may have had the support of the eight MEC members, it was not clear how Peterson stood with the other eighty-one consultants at Camblewick. It was not long before Peterson found out. In late August, the UGM was challenged by Cooper (Consultant in Obstretics) to account for his actions over theatre closures. The confrontation was to take place at the next Medical Committee meeting.

Since the narrator was not present at the meeting, the drama which took place at the medical committee meeting remains obscure. The significance of the meeting may not have been what actually happened but the fact that Unit Team members came out of the meeting feeling more confident that they could rely on doctors support in the future. Hart recalled the event in the following manner:

> The medical staff here are not a militant lot. It is only when they feel under threat that they organise themselves to do something about it. It is the aggressive ones at Camblewick who are the ones out of step. Take the theatre closures over the summer. That decision was a threat to the doctors but the

majority of them took that calmly until one surgeon [Cooper] wrote an aggressive letter to his colleagues saying that Colin Peterson and I were incompetent. He raised questions for the UGM at the Medical Committee having distributed these questions to all consultants. These questions were the ones that no one could answer, you know, questions like 'what is the cost of an idle consultant?'. There was a big turn out for the meeting as a result of management being under fire. About sixty had come to see the fireworks with the expectation that the UGM would get crucified by this consultant. In fact, Colin Peterson crucified the Obs and Gyne consultant and it all turned out to the UGM's advantage. He asked the doctors 'are you with us or against us in getting to grips with the spending problem?' and they gave him their support.

For Williams (Chairman of the MEC), the message from the meeting was clear:

Some of my colleagues see the decisions made because of the financial problems as management decisions which they can object to and want no part of. They believe that economics do not come into medical decisions and this is the perpetual difficulty. But doctors have to take responsibility and ensure that services are related to the financial situation. It is not Colin Peterson's fault that we have had to close three of four theatres in the summer to keep the budget in balance. Medics should get annoyed at District, Region or the Department of Health and not local management. Some priority decisions have to be made.

Running Time:44 Minutes

In September, the UGM was to use his success at the medical committee meeting as a springboard for a new vision; one which would attempt to bring more of Camblewick's doctors into the management process rather than allowing them to act like a 'Greek chorus' by judging the actions of managers from afar.

CONCEPTUAL BREAK.

Throughout this second part, the main project guiding the acts of the UGM is that of 'balancing the budget'. In order to do this, clinical activity has to be restricted. In making this decision, the UGM moves away from the Camblewick tradition of facilitating professional action within the setting (see 5.1.4). In the place of this ethos, another is forged according to economic principles. Peterson's project shifts towards that of restricting clinical activity according to cash limits. Thus, the closing of the first operating theatre is an important event at Camblewick because it symbolises a change in the characterisation of the UGM's part and a movement towards purposeful managerial action at the clinical level.

Given the importance of the closure of the operating theatre (and subsequent closures throughout August), it is not surprising that an antagonist (Cooper) emerges to challenge the acts of the new protagonist (Peterson). The main drama is played out in the Medical Committee meeting. Hart's recollection of the event is significant in that it illustrates how different players can contest the meaning of the ongoing script. Once again, a major theme of the drama is that of the tension between managerial and

professional action. In order to appease backstage actors by balancing the budget, Peterson has to justify restricting the clinical acts of medical staff. This movement towards managerial action is justified by referring to extraneous events (ie the spending problem) that the UGM claims he cannot be expected to control. In contrast, Cooper attempts to alter the ongoing script by mobilising medical support for his project of clinical autonomy; in simple terms, management should provide resources, clinicians should practice their craft. On this occasion, the UGM's contribution to the script appears to have been foremost in shaping the action.

Equally important is Williams' version of the event. The Chairman of the MEC indicates that medical opinion is divided between the two competing contributions to the script. Some doctors refuse to have their parts tampered with by managers and challenge the competence of management. Other medics feel that their part can include management responsibilities and have sympathy for managers. As a member of the Unit Team, it is not surprising that Williams supports Peterson and has recharacterised his part to include managerial tasks. Williams does not regard Peterson as the 'villain' of the piece for he has found some other culprits, these being actors allied to and influenced by the Government of the day. In keeping with the traditions of the hospital, Williams is able to support the medical and management alliance because he regards the problems of the unit as stemming from events in the backstage rather than the frontstage.

Running Time:46 Minutes

7.1.3 Part three: The White Hart Plan.

On 22nd September, the UGM made it clear to the narrator that he was concerned with two main priorities. The first was that of promoting the characterisation of doctors' parts as including an element of management:

> One priority has been to try and persuade medical staff to become more interested in management, not general management but management in their own areas because with limited resources you cannot go on expanding. I don't know whether I have been successful in that there's a lot of resistance to that idea but I think its beginning to get through.

The second priority was that of reforming the management structure of the unit in order to make the UAB more effective:

> When I was the Chairman of the medical staff, I was part of the Unit Team and David Dixon simply grafted on the management structure to the existing Unit Team. I came to realise that perhaps that wasn't the right thing to do. You have to have a strong Unit Team but you have to involve the UAB managers in the decision making.

Since becoming UGM in 1987, Peterson had seen his part in terms of maintaining stability and continuity with the Dixon era (see 5.2.1). Peterson was now confident enough to challenge Dixon's approach to management at Camblewick. The UGM appeared to have accepted that he does have a significant part to play in shaping

the future management style of the hospital.

On the 28th September, members of the Unit Team (Peterson, Silver, Minter, Hart and Williams) 'took time-out' by going backstage to the NHS training centre in Harrogate. This was the first of three days to be spent with a management consultant with the aim of considering the hospital's current problems and formulating a strategic plan for Camblewick. The outcome of these discussions yielded a report which was written up by Silver a few days after returning to the hospital. This report was named 'The White Hart Plan' (see appendix 18) after the name of the conference centre in Harrogate.

The White Hart Plan was a very brief statement of the Unit Team's intentions for the hospital. Silver divided the plan into three sections. The first section described the 'current problems' of the unit and addressed the 'Unit's financial position'. Clinical activity had risen, the hospital's budget had not and it was only through the savings generated by 'those services affected by the competitive tendering process' that the hospital had been able to expand its caseload. The challenge for the Unit Team was then to tackle the overspends on drugs expenditure and medical and surgical supplies by getting doctors involved in management (Peterson's first priority for the hospital). This statement of the unit's position should now be familiar to the audience (ie. the reader).

The second part of the White Hart Plan was entitled 'The Vision - Resource Management'. According to Hart, resource management had

become the Unit Team's 'solution' to the spending 'problem' and the following ideas were proposed:

> It is proposed that a Consultant and Operations Manager should be appointed for each specialty. They would then be jointly responsible for the compilation of the annual budget, based on an agreed level of activity, and would then control the daily operations of this budget. It is envisaged that this will involve 'buying in' of all the necessary services, both clinical and non-clinical, that are required for the efficient running of their specialty. However, this system could only be implemented following a re-organisation of budgetary management and the way the necessary information would be made available to the various specialties.

The third and final section of the White Hart Plan included a list of tasks to be undertaken including the implementation of pilot schemes for resource management in selected areas, the integration of computer networks, disbanding the Unit Team to make better use of the UAB (Peterson's second priority) and the appointment of a Project Manager. These tasks were to start immediately. On the 2nd April, the Unit Team members appointed Simon Toms (Head of Medical Physics at Camblewick) as Project Manager of the 'resource management' scheme. The Unit Team was then disbanded four days later. Ironically, 'winding-up' the Unit Team appeared to be a commitment to including UAB members in the unit's decision making and yet, by the 6th October, a considerable amount had already been decided without including the middle managers.

The two year appointment of Toms as Project Manager for the resource management scheme was not too surprising. Toms had a long history of developing computer systems in clinical departments (see 5.2.2) and been involved in the successful implementation of systems to meet the Korner requirements in 1987. In addition to this record of project management, Unit Team members also thought Toms to be well respected amongst the medical community at Camblewick. Toms' alliance with the medics was considered very important by Unit Team members. Hart, for example, envisaged Toms main task to be that of 'building up doctor's involvement in management now that doctors are on our side'.

Having made this casting change, the responsibility for implementing resource management transferred away from members of the old Unit Team to Toms alone. In particular, Hart was enouraged by the UGM to distance himself from the scheme. Indeed, Hart attempted to create an important part for himself in the new project by asking the UGM if he could work along side Toms upon his return to Camblewick in February. Hart thought that resource management was really 'clinical budgeting' and so felt entitled to expect a leading part. The UGM did not offer Hart this leading part for he considered Hart to have more important duties to perform in his capacity as Unit Accountant. On the 2nd November, Hart admitted that he was 'out of the driving seat and Toms was in.'

It was not long before Toms was to shape the direction of the new resource management scheme by introducing his own interpretations

and understandings of the new 'vision'.

CONCEPTUAL BREAK.

With Peterson apparently having the support of his medical colleagues following the drama with Cooper, the UGM considers this the right time to reappraise management within the unit. Rather than treat the previous UGM's management structures as sacred, Peterson is willing to challenge the 'old' ideas. The Unit Team 'time-out' provides the perfect opportunity to discuss how the Camblewick script should be influenced over the coming months.

A closer look at the White Hart Plan indicates that the developing 'vision' is a reinterpretation of 'Mark III' of Hart's three-tier project. The reader will recall that 'Mark III' of Hart's scheme for Camblewick anticipated a change in the management of resources resulting from devolving financial and non-financial data to clinicians. However, the Unit Team's 'vision' is a more formal commitment to this future through the use of structural change as well as the development of more sophisticated information systems. As a way of symbolising a new era, the Unit Team is disbanded to leave the UGM playing a solo part at the apex of the organisation, propped up by a large supporting cast of middle managers.

In the shaping of the White Hart Plan, the term 'resource management' is introduced by Camblewick actors. By adopting this slogan, members of the Unit Team enact an environment which is sympathetic to innovations being developed in the backstage (see

4.3.3). For the Unit Team, resource management is about treating clinical specialties as resource centres where the leaders of each centre are budget holders and 'buy in' services to perform agreed levels of work. This contribution to the ongoing script has moved beyond Hart's original projects and now seems to be guided by a backstage script being rehearsed by politicians eager to develop an 'internal market' in health care services (see scenario).

Without any further discussion with middle management (ie. members of the UAB), senior management start to act in accordance with their new project. As soon as the players return from Harrogate, the search for a suitable actor to perfom the part of 'Project Manager' is undertaken within the setting. Given his successes with major initiatives such as Korner (see 5.2.2), Toms is selected by the UGM for the part. Toms emerges as the new protagonist seeking to influence the ongoing action at the unit. Hart is left to look on from his backstage part as acting District Treasurer. For the time being, the Accountant is confined to the supporting cast.

7.1.4 Part four: Toms' reinterprets the White Hart Plan.

During November 1988, Toms started to reconsider the White Hart Plan. His understanding of the Plan was that 'the Unit Team saw the need to involve clinicians more in management since any costs incurred in the hospital are a direct result of doctors treating patients'. Toms was aware that the Medical Committee members had been 'critical' of the way in which the Unit Team had been managing the hospital during the summer and that it was through

greater 'medical involvement' in management that they could all 'arrive at a more efficient service'.

One of the first tasks Toms performed was to discuss the resource management scheme with members of the MEC. Toms intended to 'fight all the battles before the project gets started' and met the MEC members on 8th November. According to Toms, the doctors were concerned about whether the infrastructure was there for the clinical information to be produced and more detailed points such as how resource management centres would cope with patients under the care of more than one specialty. Despite these reservations, Toms considered that there was a 'general acceptance of the way we are going'.

One outcome of the meeting on the 8th November was a renaming of the title of the document. Rather than keep the Unit Team's title 'The White Hart Plan', Toms had become concerned by the 'sarcastic comments' of medics on the MEC who allegedly regarded the scheme as resulting from the 'Unit Team boozing it up in Harrogate'. Not wanting these associations to stick with the project and jeopardise the chances of doctors taking the scheme seriously, Toms renamed the plan the Clinical Information Project (CIP). With this new title, Toms had begun to personalise the initiative and make his contribution to the ongoing script.

The title of the CIP was preferred to that of 'resource management' for at least two reasons. Firstly, Toms wanted to make the CIP distinctive and not necessarily linked to initiatives being sponsored by the Department of Health in other hospitals.

Indeed, the Department of Health were discouraging the use of the title 'resource management' at this time. Units were being asked by members of the NHS Management Board to await the results of the six original pilot sites before embarking on their own initiatives (see chapter six). The second reason for renaming the scheme was that Toms believed resource management to have 'an image of allocating resources and working within them'. This emphasis was 'unacceptable' to Toms who wanted to present a 'positive image' of the CIP to doctors. The Project Manager considered himself to be the 'good news spokesman' and rejected any associations that might lead back to the initiative imposing financial constraints on doctors. Thus, already Toms was beginning to distance the CIP from the original intentions of the White Hart Plan.

Toms understanding of the CIP was that of 'providing clinicians with information so that they might consider what effect their activities are having on the hospital as a whole.' By using the title 'Clinical Information Project', Toms hoped to direct medics away from the idea it was a 'management exercise'. The CIP tag reflected the 'right concern', this being to provide medics with information that would be of some value to them. By the 15th November, Toms rejected any 'political' questions concerning the management 'of' doctors as 'getting caught up in something nothing to do with us'. He thought that it would only be in the 'long run' that the implementation of the CIP would lead to changes in the management of clinical practice.

During the last two weeks of November, Toms set about shaping the structure of the CIP. He produced a report which would go to the MEC members on the 5th December and the UAB on the 8th December (see appendix 19). Toms' ideas were based on a previous assignment in which he had been managing the installation of telephone systems for the District Health Authority. In the telephone project, Toms had created a 'technical group' which developed a problem solving part and evolved by 'throwing ideas around'. For the CIP, Toms proposed a Support Group which would perform the same part as the technical group. In Toms' words:

> The Support Group will provide services to the Task Groups and Steering Group such as secretarial, computing and financial advice. In time, the group will be responsible for the purchase, installation and commissioning of equipment and services.

Toms regarded this group as 'the ones who will have to do all the work', the main task being that of 'extracting sources of information'. Apart from the Support Group, the CIP would be managed at two other tiers. The Task Groups would be established for each of the specialty areas to be studied and consist of three actors - a consultant from the specialty, a manager from the specialty and a Support Group adviser. The Steering Group was to have a cast based on the existing alliance between senior managers and doctors at the hospital. The list included the UGM, the Project Manager, MEC members and UAB managers. According to Toms, this group would be the 'political' committee and have a common set of 'objectives', these being to 'define policy',

'monitor progress' and 'review the outcomes of Task Groups'.

The final section of Toms' report outlined eight specialties for the initial pilot studies which had been decided in consultation with the UGM. These were:

1. Renal Services.
2. Maternity Services.
3. Mental Illness Unit.
4. Orthopaedics.
5. Cardiology.
6. Respiratory Medicine.
7. Endoscopy.
8. Radiology.

In his report, Toms argued that these specialties were selected because they were 'well defined specialties which either have established information systems or will be able to identify deficiencies in the information available.'

On the 5th December, Toms met the MEC medics once again to show them his report. According to Williams, the doctors on the committee interpreted the CIP as an 'experiment' whereby small groups would be allocated budgets and be able to 'run their own show'. The doctors appeared to want to 'test' the CIP in terms of the degree of financial autonomy it provided for practitioners. During the MEC meeting, the medical representatives also influenced Toms' selection of the pilot sites for the CIP. In particular, the medics rejected the area of Endoscopy as a

potential Task Group specialty. Toms' told the narrator the next day that the MEC members considered this a 'difficult' area. Toms had wanted 'a difficult consultant' in the pilot areas because it was 'useful to have a doubter amongst the enthusiasts'. However, he had accepted the committee's decision and struck Endoscopy off the list. Toms admitted that the remaining seven specialty areas did not 'tackle the massive ones' in general medicine and general surgery but that would come when a 'feeling' for the project had developed. For the time being, Toms seemed reluctant to disturb any areas which senior doctors at Camblewick considered contentious.

The final event within the episode occured in Camblewick's boardroom on the 8th December. Toms and the narrator both presented papers to the members of the UAB (see chapter two). The narrator's own paper (see appendix 5) had been circulated by Toms a week before the meeting and this report was the first item on the agenda. The major theme to emerge from the narrator's presentation and subsequent discussion was that practitioners in clinical areas suffered from an 'underdeveloped internal orientation' when it came to monitoring the costs of their own practices. Peterson took the narrator's report to be useful because 'the direction of the paper had come to the same conclusions about the need to conduct a resource management initiative'. The narrator had held up a mirror and reflected the action at Camblewick and, to this extent, added to the momentum towards resource management on the site.

Running Time:57 Minutes

After the narrator's paper, Toms showed a video on resource management at Guy's hospital. Several members of the UAB found this video amusing. There was a common trigger for their laughter, this being when the actors on the video displayed something of the 'creative tensions' between doctors and managers. For example, there was much amusement when one doctor on the video claimed that 'they are trying to stop me from operating...do management think that I do more work for fun!' At the end of the show, Toms joined in this lightheartedness by claiming the video to be 'soft soap'. Behind this statement seemed to be an assumption that his own project (the CIP) was much more serious.

In the following session, Toms presented his own report on the CIP to members of the UAB. The Steering Group, Task Group and Support Group were explained in turn. The technical features of the project were emphasised in Toms' treatment of the Support Group. The Project Manager conceptualised this body as being a 'think tank' concerned with the 'technical aspect of getting the right information to the right place at the right time'. These descriptions were received without any intervention from the other members. However, upon proposing specialty areas for the Task Groups, a number of UAB members burst out into laughter when Toms suggested that Endoscopy now had to be be struck from the list as a result of MEC members' 'objections'. Once again, the laughter surfaced because of 'creative tensions' between doctors and managers. However, on this occasion, the members of the UAB recognised the problem as a frontstage issue for Camblewick rather than belonging to the backstage of Guy's Hospital.

Running Time:58 Minutes

This interpretation of the UAB's reaction to the CIP proposals was later confirmed through conversations with three women members of the group. Silver, Dukes and Elms all agreed that the major obstacle facing the implementation of the CIP was whether doctors were committed to the initiative. Elms understood Toms to be a technocrat who 'expects others to see the logic of what he is doing'. The Personnel Manager thought that Toms' emphasis on implementing systems did not address the fundamental problem of 'attitudinal change'. Likewise, Silver saw the Support Group members as 'computer boffs' who would provide 'small opportunity to talk about people problems'. The most lucid statement on this subject came from Dukes:

> Part of the problem for the women [ie. Silver, Dukes, Elms and Minter] was that the project had suddenly changed from resource management to clinical information. The project was now being treated as a costing and computer project with the emphasis being on the scientific and technical rather than the people problems... a change in evolution had taken place.

For Dukes, Silver and Elms, it was clear that resource management as described in the White Hart Plan had been reinterpreted by Toms and these ideas put forward in presentations to the MEC and UAB. Rather than recharacterising the doctors' part in terms of management responsibilities, the CIP aimed to provide information to practitioners with limited expectations about how it should be used. Toms was making no attempt to challenge medics understanding of their own parts and, as a consequence, the repertoire remained unchanged.

CONCEPTUAL BREAK.

The political use of language is particularly noticeable in this fourth and final part of the episode. In renaming the scheme the CIP rather than the White Hart Plan or resource management, Toms is influenced by a desire to support rather than confront the medical community. In adopting the name the 'Clinical Information Project', Toms introduces a 'weaker' strand to the innovation in that information 'provision' is the main objective rather than 'use'. This is very similar to Hart's reappraisal of his projects discussed in part one of the episode.

Equally, the rejection of the title 'resource management' is intended to make the scheme more attractive to clinical practitioners. Toms makes it clear that the project is not an attempt to impose cash limits on doctors. In renaming the scheme the CIP, the project becomes disassociated with meanings the 'strong' images of budgetary control and responsible management outlined in the White Hart Plan. The 'management' initiative is reinterpreted to make the proposals more palatable to members of the medical community at Camblewick. The new title of the project emphasises 'technical' innovation, the main concern being to develop computer-based systems and 'provide' information rather than tackle management problems.

In attempting to make the CIP largely apolitical, Toms development of the project is clouded by his interpretation of the setting. All Toms explanations of the scheme are couched in terms of the impact that operating within a 'medically led' organisation has on

him. Rather than adopt a stance which challenged the most powerful group (ie. the clinical practitioners), Toms' project is framed in such a way as to maintain the doctors in a fashion to which they have become accustomed. In particular, Toms is reluctant to face one possible future scenario of his actions; that developing information systems might lead to restrictions on professional action.

Having selected the pilot areas for the CIP, the meanings associated with the project become further emasculated through Toms discussions with members of the MEC. The doctors treat the CIP as if it were a medical experiment, designed to 'test' for financial (and clinical) autonomy. It is possible to speculate that if the testing 'fails' then the medical community will not make any changes in the way they manage their clinical practice. Whilst the doctors appear to sit in judgement of the scheme, they also lobby Toms to redesign the structure of the project. Endoscopy is dropped from Toms' original pilot sites for the CIP because the leading consultant is not in favour of the innovation. Thus, the structure of the project is transformed to that which accomodates the interests of the medical community. The alliance between doctors and managers is preserved because of this compromise by Toms.

The final event of the episode is the UAB meeting. What is particularly distinctive about the session is the informality between members and more specifically, the sense of comedy which characterises the action. The comedy theme first emerges when actors watch the 'soft soap' video (ie. resource management at

Guy's) and a doctor takes a 'stock' part in wishing to practice his craft without managers' restricting his activities. This search for 'clinical freedom' is a medical project that the UAB managers are familiar and it represents a major way in which doctors avoid taking any managerial responsibility for their actions. Thus, the tension between professional and managerial action is illustrated in this clip of film and the members of the UAB ease the tension by laughing at this stock representation of a doctor's attitude to managers and management.

The comedy theme also appears when Toms informs the UAB that Endoscopy has been 'struck off' the agenda. Once again, this event prompts laughter for the incident portrays a stock portrayal of medics in terms of their lack of cooperation with management initiatives. What seems to bind the UAB together is that the members (including doctor-managers) understand medics to be 'difficult' and 'awkward'. Humour acts to sustain the group against the feeling that the CIP is another 'management' initiative which will fail to draw doctors into the management process. The dormant scepticism in members of the UAB is somewhat confirmed by the three female actors - Silver, Dukes and Elms. These three managers are well aware that the CIP has been transformed into a 'technical' exercise which fails to tackle the 'real' challenge; that of changing the minds of clinical practitioners so that they contribute to a rewriting of the Camblewick script.

Running Time:62 Minutes

7.2 Conclusion.

This dramatic episode has explored the processes leading to the creation of the Clinical Information Project. A number of themes were established. Firstly, the movement towards developing more sophisticated information systems in the search for 'better' management was not a natural evolution but one that emerged as an outcome of a specific events. The factors leading to the development of information systems included the need for a 'champion' of the idea to pave the way for subsequent innovation. Hart performed this part. Equally important was the way in which senior managers came to decide the time was right to reappraise management at the site. The 'battle' between Peterson and Cooper amounted to a vote of confidence in the UGM from his medical colleagues and provided members of the Unit Team with a platform on which to launch a new management strategy. It was only then that Peterson enlisted the support of other senior managers and a new 'vision' was created in the form of the White Hart Plan. This set out the Unit Team's intention to develop information systems and extend management of resources to the clinical level.

Another theme to be introduced was that the meaning of a particular innovation is likely to be reinterpreted within the confines of the frontstage setting as actors intervene in the process. In the case of the White Hart Plan, resource management was reconceptualised by a new protagonist (Toms, the Project Manager) in terms of the Clinical Information Project. This title reflected the traditional culture of Camblewick in that it

stressed the technical task of developing networks of information rather than the management of resources by clinical practitioners. Thus, the political use of language played down 'strong' managerial action throughout the hospital in favour of a 'weaker' form in which the medical community would not be expected to rewrite their parts.

The power of the medical community to influence the ongoing script at Camblewick was also evident in the way that one of the original pilot sites for resource management was cast aside because of the objections of the doctors. This example illustrates clearly that the project was being developed according to the wishes of the medics rather than those of senior management.

A new theme was introduced towards the end of the drama. This was the emergence of comedy within the UAB meeting. Comedy served as a way of binding the group of actors together and relieving tension between professional action on the one hand and managerial action on the other. It was suggested that there could be a common trigger for this comic release, this being the arrival of any evidence to support the stock characterisation of a doctor as being an 'awkward' and 'difficult' character.

In sum, the episode played out a similar repertiore to that portrayed in the previous episode. In keeping with the outcome of the ward budgeting drama (ie episode one), the CIP was reinterpreted by Toms so that the meanings associated with the project remained consistent with the traditional Camblewick

culture. In Toms understanding the CIP in terms of supporting rather than challenging the professional acts of clinical practitioners, alternative modes of action seemed to be concealed. The original connection between information system development and stronger managerial action at the clinical level appeared to have been severed.

Running Time:65 Minutes

Chapter eight: The Clinical Information Project.

Episode three: Moving into the spotlight.

Period: 9th December 1988 to 20th June 1989.

Setting: Camblewick Hospital.

8.0 Introduction.

In this episode, the narrative is separated into two main stories which are both part of a larger drama; that of the development of the Clinical Information Project (CIP). The first story (Story one) plots the progress of the Support Group and reveals how these middle managers are implicated in the ongoing action. Influences from the backstage are also considered for they provide a backcloth against which to interpret the scene. The second story (Story two) of the episode portrays the development of the Task Groups at Camblewick, concentrating on the contribution made by doctors to the development of the CIP. In accordance with the 'soap opera' model, both of these stories are interwoven throughout the narrative.

An important theme running through the chapter is that the CIP evolves through a combination of interventions from actors in the backstage and the frontstage. Initially, the meanings associated with the project emerge through the interpretive acts of the main protagonist (Toms). These meanings are then transformed and elaborated upon as managers, doctors, nurses and politicians

interpret and contribute to the CIP. Whilst the action is always moving forwards, the actors at Camblewick do not have a clear script to follow. In seeking a script, the players add to the ongoing action but are never sure how the drama will work out.

Scenario.

Backstage:

In December 1988, sources at the RHA announced that there was money available for a 'roll out' of resource management. Five schemes were to be funded in Northtown's region. This announcement was followed by a leak of the findings of the Government review of the NHS. According to a report in The Independent (5/1/1989:1), the forthcoming White Paper would propose that hospitals 'opt out' of health authority control; that GPs have their own budgets with which to buy hospital care; and that health authorities would be encouraged to purchase services from each other, the 'self-governing' NHS hospitals and the private sector.

On the 31st January, the Secretary of State for Health presented the White Paper 'Working for Patients' (Department of Health, 1989a) to Parliament (see appendix 20). The Government claimed that these reforms would improve the standard and range of health care available to the population and make the NHS more responsive to patients. At the heart of the programme of 'reform' was the separation of buyers and the providers of health care. The Government hoped that health authorities and G.P. budget-holders

would become discriminating purchasing agencies seeking 'value for money' (1989a:7) for the residential population by buying services from hospitals in the NHS, self-governing hospitals, private sector hospitals and voluntary groups. It was intended that such a framework would permit more choice and , therefore, stimulate competition throughout the service. Operating decisions would be devolved to local health care managers and their professional colleagues so that these players could balance service demands against economic utility.

This event marked the end of a period of rehearsal and the setting out of three phases of reform to be implemented by 1991 (see appendix 20). The publication of the White Paper meant that the Government's script was finally exposed to eager critics. Members of the political coalition went about its customary debate about the contents of the document. According to press reports (eg. The Independent, 1/2/1989:2), 'there was a cautious welcome from many Tory MPs'. Robin Cook, Labour's health spokesman, was widely reported as saying it was a 'prescription for a health service run by accountants for civil servants, written by people who would always put a healthy balance sheet before a healthy patient'. Similarly, the clinical practitioner coalition had serious reservations about the proposals. For example, members of the BMA were concerned that the Government intended to 'go ahead with its proposals without conducting experiments first' (The Financial Times, 1/2/1989:1).

Of particular significance to this study was the fact that the White Paper emphasised the importance of improving the

accessibility of computer-based information and involving medical staff more directly in management decisions. Given these aims, the White Paper announced that the Resource Management Initiative (RMI) would be 'extended' to as many as 260 hospitals by the end of 1991-1992 (Department of Health, 1989a:16). This news was in accordance with the 'roll-out' of resource management expected in Northtown's region.

In February, there were widespread reports that 'the Government would announce spending of three million pounds on a pilot scheme at three general hospitals', one of which would be in Northtown (The Independent, 13/2/1989:5). If successful, the experiments could be introduced in 320 hospitals. The Northtown Post (13/2/1989:1) published an article which claimed that the Grand was the 'most likely candidate' to pilot a network of new health care computers.

It was not long before doctors mounted a campaign against the NHS reform plans. On the 2nd March, a unanimous attack from the eighty strong BMA council warned that the reforms would 'produce a fragmented service, would limit patient choice and ignored the central issue of inadequate funding' (The Independent, 2/3/1989:5). Further concern from members of the clinical practitioner coalition surfaced in the first week of April. Consultants involved in five of the original resource management sites wrote to the Secretary of State to distance their hospitals from being linked to self-governing status arguing that it would be 'premature' to 'opt out' (The Times, 11/4/1989).

On April 13th, it was announced in the Health Service Journal that the BMA and the RCN were planning an 'SOS for the NHS' campaign aimed at informing patients of the clinical practitioners opposition to the White Paper proposals. A special conference of the BMA on the 17th May found doctors voting 'overwhelmingly' not to cooperate with the Government's proposals for change in the NHS (The Daily Telegraph, 18/5/1989:1). However, there were resolutions supporting the improvement in information services, financial management and clinical audit.

Despite these protests by clinical practitioners, the Secretary of State for Health refused to accept the need for pilot studies to 'test out' the NHS reforms or slow down the pace at which the proposals would be implemented. This was particularly apparent when Clarke acted in accordance with the Government's script by announcing the members of the new NHS Policy Board (formerly the NHS Supervisory Board) on the 22nd May 1989. A number of leading industrialists were recruited to the Board which would be responsible for determining strategy and policy objectives of the NHS. This new body complemented the formation of another, this being the NHS Management Executive (to replace the NHS Management Board).

Indications that the Government's script was starting to influence the actions of players throughout the health service was apparent in June. On the 8th June, managers in 178 hospitals around the country 'expressed an interest' in 'opting out' of health authority control. Whilst the Grand was in this list, actors at Camblewick Hospital had made no such commitment.

Running Time:70 Minutes

Frontstage:

At Camblewick, Toms spent the latter part of December writing a proposal which was to be submitted to the RHA in support of Camblewick's claim for funding for the CIP. In preparing this document, the Project Manager interpreted the CIP in terms of providing clinical information for clinicians. This view was proposed to the Support Group at its first meeting on the 19th December.

In January, some of the Task Groups met for the first time. A number of participating medics reinterpreted the CIP in order to suit their own particular projects. Alongside this development, members of the Steering Group and the Support Group were starting to feel uneasy about the way the CIP was unfolding. Matters were made more confused in February with the publication of the White Paper and the news that Camblewick was selected as a site to pilot Hospital and Information Support Systems (HISS). With it becoming more certain that the hospital would receive funding for resource management and HISS, Toms reinterpreted the CIP to involve both of these elements. Members of the Task Groups were asked to consider how the specialty should be managed instead of concentrating on their information requirements.

In March and April, members of the Support Group shifted their attention away from the Task Groups to meeting the demands of the backstage actors supervising the HISS scheme. In May, Toms was particularly concerned about intervention from players in the backstage who were attempting to reinterpret his understanding of

the CIP. Different conceptualisations of the HISS initiative were then played out in the backstage. It seemed that actors at Camblewick had lost their opportunity to influence the ongoing script. Toms was left to consult the reports of the Task Groups and prepare a document for the Steering Group recommending how resource management should be implemented at the site...

8.1 Narrative.

For the sake of clarity, this episode is divided into two stories (story one and story two). Story one is loosely focussed on the conduct of the Support Group whilst story two follows the activities of the Task Groups. Whilst the stories are very much interlinked, each section of the chapter considers only one of these stories.

8.1.1. Story one, part one: Toms makes a bid for the script.

During the second week of December 1988, Toms learned from sources at the Regional Health Authority (RHA) that money had become available for units wishing to pursue resource management projects. This was a case of serendipity. Before the creation of the CIP, the Department of Health and the NHS Management Board were advocating that resource management remain the exclusive concern of the original pilot sites. Now the Department of Health had come 'full circle' and were claiming that the pilot sites were a 'success'. No formal evaluation of the original resource management sites had taken place but Regions around the country were instructed by the Department of Health to 'roll-out' resource

management schemes across the country. The Department of Health would provide RHA's with the necessary funding for the venture. In Northtown's RHA, there were five funded places for resource management. Toms was determined to make a bid for resources.

On the 13th December, 1988, Toms wrote a document aimed at securing £140,000 for the CIP from members of the RHA. This bid was to rise to £900,000 over the coming weeks as Toms learned that his original bid was somewhat 'undercooked'. Hart had been informed by Region that they had three million pounds available to spend on the five resource management pilots. The Accountant had suggested to Toms that the bid should be increased.

Toms' case for funding relied heavily on the fact that Camblewick was a large site and already had computing facilities which the Project Manager thought to be 'better than other hospitals'. The District already had a District Information and Computing Strategy which Toms had helped to create (see chapter five). The hospital had also developed a number of operational systems which supported the daily activities of departments at Camblewick. These factors were complemented by the attitudes of health care professionals according to Toms. The bid document stressed the 'clear and unequivocal support' from the UGM, the UAB, the Project Manager and the medical staff.

The bid document for the RHA proved to be a significant attempt by Toms to establish a script for the CIP. On page one of the report, Toms argued that:

> At the Camblewick Hospital, we have chosen to call this project the Clinical Information Project because in our view, it more accurately describes our ultimate objective. In addition to enabling management of resources, we see our future developments as being aimed at providing clinicians with information about their clinical practice, with the emphasis on clinical information, including that about individual patients. The by-product of an effective clinical information system is very detailed data about the use of resources which would form the basis of resource management.

The report made it clear that Toms understood the development of the CIP in terms of utilising the network of operational systems already in place at Camblewick. In Toms' paper, these systems were termed the 'feeder' systems for the District Patient Information System (see appendix 21). Toms stressed the significance of this infrastructure by stating that the 'feeder' systems were 'generally capable of providing far more information'. The CIP's task would be to 'access the District Information System and...provide all managers, wards and consultants with a desk top service'.

On the 19th December, the Support Group assembled for the first time (see appendix 7). The setting for the first meeting (and the next thirteen) was a seminar room in the Post Graduate Medical Education Centre (PGMEC). Actors involved in the CIP were still scattered around a number of departments and had not been relocated to any new premises. The PGMEC therefore provided the main forum for the exchange of news. On this occasion, Toms made

it clear to the players present that the aim of the project was to 'provide clinicians with information about their services and resources'. Consequently, the Clinical Information Project (and not resource management) was the 'right image to present'.

This emphasis on information provision was further reiterated in discussions about the structure of the CIP and in particular, with regard to the Task Groups. Toms argued that the first step was for members of the Task Groups to 'define the boundaries of the area being tackled' and 'consider the quality of information available and what information they require'. In the context of other backstage projects, Toms' proposal could be described as a 'technology' approach rather than a structural approach to resource management.

CONCEPTUAL BREAK.

The first part of this narrative concentrates on Toms' attempts to define the CIP. The meaning of the CIP has yet to be firmly establish in the minds of actors and, to some extent, is negotiable. It is the possibility of funding from the RHA which prompts Toms into outlining his understanding of the CIP. Whilst the CIP is still a 'twinkle in the eye' (Toms' words), the cash nexus takes the initiative out of the fronstage and sets it within the context of the backstage. This is an early indication that the CIP may have to serve the projects of backstage actors as well as those of frontstage players.

The bid document for Region provides Toms with an opportunity to 'steal' the script before members of the Support Group (or other actors involved in the CIP) can intervene in the interpretive process. The opening paragraph of the report is an attempt to formalise the ideas already presented to UAB members on the 8th December (see episode two). It is clear from this official statement that Toms is concerned about developing information systems for clinical practitioners. Resource management is seen as the 'by-product' of this. Thus, Toms has reinterpreted resource management in light of his own personal experience; that of developing computer systems to track the operations of clinical departments (see 5.2.2).

Meanwhile, frontstage, Toms leads the opening Support Group meeting and makes sure that actors are familiar with the emphasis on 'information provision'. The Support Group members are not very active in the first meeting and act as a 'sounding board' for the protagonist's ideas. In short, the Support Group performs the part of supporting cast.

8.1.2 Story one, part two: Pilots that fail to take off.

Casting arrangements for the seven Task Groups were made in the second Support Group meeting. Each Task Group was allocated a consultant, a manager, a Support Group adviser and an external adviser (see appendix 9 for a list of the actors in each of the groups). It was also decided by Toms that the Support Group would meet weekly. The Task Groups were scheduled to report at the end of March 1989. The Project Manager then informed Support Group

members that he would collate the results of the pilot studies and present a document to the Steering Group in April.

On the 3rd January, Toms' received a letter from Don Duncan, the chairman of the Radiology Consultants' Group (RCG). This group had given thought to the idea of creating a Task Group and preferred not to set up another body for fear of causing 'unnecessary bureaucracy'. Toms interpretation of the letter was that all the consultants wanted to be on the Task Group rather than select one to represent the specialty. The consultants did not want 'one of them to be seen to be above the others'. Duncan's letter suggested that the Project Manager sit in on the meetings of the RCG every Monday. Upon informing the Support Group of the contents of the letter on the same day, Toms' account brought forth a laugh from the members of the Support Group. Sally Martin joked that this was 'a good start to the project!'

During the next two weeks, the expected flurry of Task Group meetings did not take place. During a Support Group meeting on the 16th January, Toms admitted that the main problems facing the CIP were ones of 'inactivity'. Apparently, it was the doctors who were emerging as the main antagonists. Toms said they were being 'elusive'. This was demonstrated by the fact that four of the seven Task Groups still had to arrange meetings. Only the Radiology group had met by the middle of January.

CONCEPTUAL BREAK.

Of particular significance in this brief sequence of action is the letter from Duncan. One reading of this incident is that the members of one 'task' group are attempting to redefine the structure of the project so that it can be accomodated by existing structural arrangements within the department. The CIP becomes an extra item for consideration within the Radiology Consultants' Group. It is also important that no doctor is singled out as a representative of the others in the department. The medics unite and set their own terms for participating in the project.

Martin's reaction to Duncan's letter reintroduces the comedy theme into the proceedings. The Medical Records Manager's recourse to humour surfaces at a time when it is clear that the protagonist's projects are being challenged and weakened by the medical community. At this early stage, there is a strong possibility of conflict between Toms and the medical group unless the manager backs down. Martin's joke eases the tension in the situation but also highlights that this may well be the first of many problems to inhibit the development of the project. Martin's pessimism is somewhat borne out in the lack of activity generated by the Task Groups. This is blamed on the 'elusiveness' of the medics and the audience is left wondering whether the doctor's are really committed to making the CIP work.

8.1.3 Story two, part one: Doctors contribute to the ongoing script.

The first Task Group to meet was that of Radiology. Radiology was the odd-ball department of the seven Task Groups since it was a clinical service set up to 'support' rather than 'deliver' health care. The other six task groups were on the 'delivery' side, this category being based upon those specialties that admitted patients to a hospital bed and, therefore, created the need for supporting services. The reason that the Radiology department had been included as a task group seemed to be due to the enthusiasm of Phil Smith, a consultant radiologist and manager of the support service. The CIP was a progressive project that Smith wanted to be associated with.

Smith's interest in management appeared to be in direct contrast to his medical colleagues. On the 16th January, the Consultant Radiologists made it clear to Smith that 'they did not like doctors being involved in management'; the two parts should be kept distinct. Toms had been present at the meeting so that he could introduce the initiative (he did this with all the Task Groups). After the meeting, the Project Manager told the narrator that Duncan's attitude was one of 'doctors tell the managers what to do and the managers get on with it'. Smith confirmed this observation at the next Support Group meeting by saying that Duncan seemed to want a return of the 'administrator'. In accordance with the tradition of medic-manager alliances at Camblewick (see 5.1.4), Duncan was alleged to have said that the hospital needed characters like Ray Burton (former Hospital

Secretary) rather than 'new models of management'.

The next Task Group to meet was Cardiology on the 20th January. With Martin and Dukes in attendance, Toms introduced the CIP to Dr Marshall in terms of 'providing information to clinicians so that they might have more input into the management of resources'. Ultimately, doctors would be able to 'influence the amount of resources that they received and become more involved in management'. Marshall did not seem to accept this interpretation and claimed that the CIP was a 'management exercise' and that what Toms called resource management was a form of 'clinical audit'. The Consultant said that he could 'put a case on paper that said he was super efficient and in need of more money'. However, it became apparent that Marshall was not at all attracted to the idea of putting the Task Group's case on paper. In the middle of the meeting, Toms suggested that the consultant undertake this exercise so that he might have some 'ownership' over the contents of the report. Marshall rejected this idea and wanted another member of the group to do it.

For the later part of the meeting, Marshall was particularly interested in the implications of charging other resource centres for undertaking cardiac work on 'their' patients. The consultant seemed keen to gain control of the budget (particularly the largest budget; that of physiological measurement). Apparently, he had been asking for a budget since his arrival at Camblewick and had not been given one 'unlike the other end of town' (ie the Grand). The Cardiologist ended the meeting by claiming that Camblewick was 'practising medicine in

the dark ages'.

There were also developments in other groups at this time. Members of the Mental Illness Unit (MIU) Task Group wanted to improve the service by controlling the budget for cleaning and domestic staff. The group saw the benefit of financing its own nurses so that it could charge other specialties for using MIU staff. It was not clear whether the MIU would be able to recruit the nurses to their specialty given that it was a 'cinderella' service. The meeting had not only produced positive suggestions. Hooper (Divisional Nurse Manager of the MIU) objected to the idea of 'allowing doctors to run the unit' for she thought this would result in 'a right shambles'. By the end of the meeting, Hooper had convinced herself that 'her job was being taken off her'. The day after the meeting (23rd January) , Toms heard from Matron that Hooper was considering resigning. The Project Manager had to calm the Divisional Manager by explaining that no decisions had been made about the most appropriate model of management for her department (or the hospital). No one was trying to shift managerial responsibility away from her towards the resident consultant at the MIU.

On the 26th January, Toms was involved in another introductory session with members of the Orthopaedics Task Group. There were two Orthopaedic surgeons present (Ball and Monkton) and they listened patiently whilst Toms 'sold' the project to the doctors in terms they could relate to. For example, Toms suggested that the doctors consider whether 'efficiency would be increased by undertaking two hip replacements on one list in an extended

session'. Toms stressed the need for 'flexible thinking'. He was interested in 'finding out what information they needed to run the specialty'. Both Ball and Monkton seemed to understand that the Government's review would extend resource management and that better information systems were required before changes in management could be made. Ball argued that it was 'better to get cracking' before the Government 'compelled' the hospital to undertake resource management. Thus, the Government script was starting to influence clinical practitioners even before the announcement of the proposals in the White Paper.

More news of the Task Groups' progress came on the 31st January. The Renal group met for the first time on that day. Dr. Blount (Renal Physician) had been putting off a Task Group meeting because of a backstage project initiated by members of the RHA. A group of accountants had been commissioned by the Region to look at the costs of end stage renal failure. Blount thought that the CIP would involve a similar exercise and that he 'didn't have to do anything'. Toms had convinced Blount that the CIP was a different project and that questions would be asked about what constitutes the work of the department and how should it be 'managed'. As a result of Toms' intervention, Blount agreed to a meeting.

According to Toms, Blount dominated the first Task Group meeting and made it clear that he wanted to be a 'clinical director' so that he could 'solve all his problems'. These problems were apparently to do with a shortage of nurses in the specialty and the fact that capital expenditure on buildings had been

'frozen'. For Blount, involvement in the CIP provided a possible route towards controlling the 'purse-strings' and greater freedom of action.

CONCEPTUAL BREAK.

This is the first opportunity to scrutinise the contributions made by medical staff to the development of the CIP. Starting with Radiology, there are clear differences of opinion between Smith (the Radiology Manager) and his medical colleagues. The first meeting of the group yields competing interpretations of the doctor's part. For the Consultant Radiologists, the doctor is purely a clinical practitioner. It is up to 'Ray Burton' types to undertake the management of the hospital. These 'stock' characterisations are rooted in Camblewick's historical context when 'administrators' balanced the budget and facilitated professional action (see chapter five). In contrast, Smith is one of a new breed of doctor-managers who understands the need to integrate management with clinical practice rather than keep the parts separate. There seems to be little possibility to renegotiate actors' parts at this early stage of the proceedings.

One reading of the Cardiology Task Group meeting is that Marshall is more interested in his own projects than worrying about those of 'management'. This is aptly illustrated through the consultant's reluctance to take on a job from Toms' agenda (ie writing the report for the CIP). What is of primary importance to Marshall is that he considers his department to be 'super efficient' and therefore, a prime candidate for more resources.

The Cardiologist appears to be bent on 'empire building', wanting to gain control on one of the larger budgets (Physiological measurement) and 'charge' other medics for any cardiac work undertaken on 'their' patients. Unlike the radiologists, Marshall interprets the CIP as an opportunity rather than a threat. By taking an active part, the Consultant hopes that he can secure a powerful position at the hospital rather than being regarded as a misfit versed in the ways of the Grand (see chapter five).

The MIU Task Group also interpret the CIP as an opportunity for fairer treatment. The charging out of MIU nursing staff is one way of receiving some benefit for an informal working practice of using the MIU as a 'back-up' supply of nurses when other specialties have insufficient staff. Whilst this may seem an optimistic start to the CIP, Hooper's reaction illustrates that the CIP can be considered a threat to managers as well as medical practitioners. The Nurse Manager thinks that her managerial competence is being questioned by the innovation and that she will have to play the part of supporting cast to a clinical director rather than Matron.

Perhaps the most positive response to the CIP, as far as the Project Manager is concerned, is that of the Orthopaedics group. Ball and Monkton seem to be interested in making a more efficient use of resources (eg in relation to hip operations). They also demonstrate a more cooperative attitude towards Toms and seem to be aware of innovations in the backstage (ie. resource management) that make the CIP a necessary part of the Camblewick script.

Finally, the Renal Task Group reintroduces the 'stock' trait of the doctor'; that of being 'awkward' and uncooperative. Blount is the medic who chooses to adopt this pose in relation to the development of the CIP. Being concerned about backstage interference into his affairs, Blount is anxious that the CIP might represent another intrusion. The physicians initial tactic is that of obfuscation. When Blount is convinced of the merit of the project, he makes it clear that he wants to remain in control of the department. Taking a similar stance to Marshall, Blount understands the CIP in terms of helping him secure financial autonomy so that he can solve projects which are on his agenda.

8.1.4 Story one, part three: An explosion of doubt.

Apart from participating in and commentating on the activities of the Task Groups, Support Group members also used their weekly meetings to share their knowledge about the information that was available in the hospital. Throughout the first three months of the CIP, different players made presentations on the data that could be collected as a 'spin-off' from operational systems supporting the daily routines of departments at Camblewick. Sessions were held on patient-based information systems and systems in Renal, Pharmacy and Radiology. The reason for adopting this 'technical' emphasis was that Support Group members could call upon each others' expertise when 'chasing' information required by Task Group members. However, these discussions about 'technical' systems were to serve as a masquerade for an ongoing sub-plot. The latter was constituted by members' doubts concerning the development of the CIP.

One issue that was a constant source of worry throughout the early Support Group meetings was the lack of formal objectives for the Task Groups. Leighton (Pharmacy Manager) was the main exponent of this view. He was concerned that the original emphasis on 'information provision' was not very helpful. Leighton's understanding was that 'clinicians would chase the budget' and would not use the information potentially available to them. The Pharmacy Manager wanted to guard against 'reflecting the political interests of one consultant' and was 'reluctant' to go to clinicians 'without some kind of direction'. In Leighton's view, the Support Group members should set the Task Groups objectives covering matters such as 'quality of care' and 'the numbers of deaths and discharges'. This approach was suggestive of stronger managerial action.

Whilst Support Group members such as Martin, Abbot and Smith admitted to the narrator in private that they were sympathetic to Leighton's views, it was left to the latter to voice the worries of the group to the Project Manager. On the 31st January, the Pharmacy Manager attempted to recharacterise the part played by Support Group members in the Task Groups. Rather than acting as the supporting cast in Task Group meetings, Leighton wanted Support Group members to lead the Task Groups. He stressed the need to set objectives or goals that were meaningful to participants taking part in the CIP. Leighton considered this as a way of channelling the thinking of practitioners away from any negative associations to do with resource constraint and 'staying within budget'.

In response to Leighton's ideas, Toms stated that there would be no objectives for the pilot groups and that the climate was one of 'freethought' at the moment. The Project Manager considered it the task of the Steering Group to consider the progress of the CIP in May (the timetable had slipped from April to May by this time). This 'formal' evaluation would be the time to yield core objectives for each specialty area. For the time being, Toms' response succeeded in supressing the Support Group members' anxieties.

The Support Group members were not the only people to have doubts about the project. A wave of anxiety followed the first meeting of the Steering Group in February. This body was composed of UAB and MEC members. However, medical representation at the meeting turned out to be very poor. In reporting the event to Support Group members, Toms said that there had 'not been much discussion' because only 'one or two members of the MEC turned up'. Tandy had also been at the meeting and described it as a 'hollow' event. Toms put this down to the CIP being in 'limbo' awaiting the reports from the Task Groups.

The narrator received another interpretation of the Steering Group meeting upon talking to Elms about the event. The Personnel Manager argued that the meeting had been a 'shambles'. It had 'turned out to be a sherry party for the clinicians'. The reason for these remarks soon became clear. According to Elms, 'the UAB members had arrived on time but the MEC members had drifted in at ten minute intervals'. Elms thought this very 'rude' of the medics and that this reflected their 'lack of enthusiasm' for the

project.

This was not the understanding of Williams (Chairman of the MEC) who saw the doctors' poor attendance as being due to the medic culture. Firstly, Williams argued that doctors believed that 'no-one' would 'make decisions without asking them first'. Secondly, the MEC chairman indicated that 'doctors stay away when everything is fine' and that there was 'nothing very contentious happening at the moment'. Williams thought that when Toms made some proposals then the doctors would 'want to voice their opinions and get changes if necessary'.

However, there were more supporters for Elms' view of the way the CIP was developing than for Williams' understanding. Gilbert (Out-Patients Manager) commented that his 'main worry' was that 'consultants are not committed and that there are just a handful of volunteers'. Equal apprehension was expressed by Christine Docks (Pathology Coordinator) who made a similar case to Gilbert:

> The CIP has picked out people that are interested but the rest of the consultants remain uncommitted.

Within two months of the start of the CIP, there was some real concern amongst players as to whether the project would 'succeed'.

CONCEPTUAL BREAK.

The Support Group members play out Toms' understanding of the CIP by embarking on a number of 'technical' presentations. However,

under the surface, there are a whole host of 'political' questions which keep intruding. 'Political' issues are introduced in two important areas. The first relates to the possibility of consultants using the Task Groups as a mechanism for to pursuing their own projects. Thus, the CIP does not enhance managerial action at the clinical level but strengthens the autonomy of clinical practitioners. Such a future scenario is particularly pertinent given the comments of Marshall and Blount in their respective Task Group meetings. The second 'political' issue relates to the attempt by Leighton to challenge the part being played by the Project Manager. Toms' 'laissez-faire' approach towards the management of the Task Groups is questioned and Leighton calls for stronger managerial action from the Project leader. Toms pride is ruffled and he quashes this uprising, relegating Leighton (and any future pretenders) to the ranks of the supporting cast.

The dramatic tension mounts as there are further examples of discontent at the way the CIP is developing. At the first Steering Group meeting, few members of the MEC play a part and this leaves members of the UAB doubting the commitment of the medical community to the project. Whilst Williams attempts to put the lack of medical representation into context, there is an ironic twist to his comment that 'nothing very contentious is happening at the moment'. This seems to confirm that Toms has successfully constructed the CIP so that it is not threatening to the medical community. However, the audience is left to wonder whether the project may turn out to be a 'lame duck', the doctors never allowing any 'contentious' alterations to the Camblewick

script.

8.1.5 Story one, part four: Backstage directions.

The publication of the Department of Health 'Working for Patients' (Department of Health, 1989a...see appendix 20) on the 31st January was not overlooked by staff at Camblewick and made a valuable contribution to the ongoing script. In his usual address to Support Group members on the 7th February, the Project Manager argued that the White Paper put the CIP 'into context'. Toms said that 'we can't do what is in the White Paper unless we do this project'. Whilst Toms did not mention the possibility of Camblewick opting for self-governing status, there seemed to be a hidden assumption that the hospital might go that way. The Project Manager continued by saying that 'we need an operational resource management system or at least to convince others that we have one'. This was a stronger hint about self-governing status. Having read the White Paper, Toms was well aware that achieving self-government depended on hospitals' demonstrating 'adequate information systems' and involving consultants in the 'management of the hospital' (Department of Health, 1989a:27).

Toms seemed to have drawn some confidence from the Government publication. The White Paper had provided the manager with a strategic framework within which to operate. Whilst Toms early interpretations of the CIP had stressed the provision of 'clinical information', the Governent's agenda provided him with a reason to push for more revolutionary changes. The effective management of resources was now a key issue to be faced by all

health care staff (especially medical staff) and Toms seemed less inhibited about pursuing changes in management. For example, in response to the inactivity of two of the Task Groups (Maternity and Respiratory Medicine), Toms stated to Support Group members that:

> ...those groups who do not get started will lose the freedom to consider what arrangements are suitable for managing their department and have an arrangement imposed on the department from what is found elsewhere.

The mood had changed and there was more urgency about the project than ever before.

During the middle of February, there was speculation backstage that a hospital in Northtown was to receive funding for a computer system developments (see scenario). However, it was not until the 21st February that the Project Manager confirmed to Support Group members that he had heard informally from sources at the RHA that Camblewick had been selected as the site for Hospital Information Support Systems (HISS). Reports in Northtown press about the Grand's involvement in the initiative proved to be incorrect. This seemed to please the Project Manager and member of the Support Group.

Initially, HISS involved a limited investment of three million pounds for computer developments at three pilot sites. HISS was a parallel but seperate initiative to the 'roll out' of resource management, also being supervised by members of the NHS Management

Board. Whilst resource management was being monitored by the Director of Finance (Ian Mills), HISS would be reviewed through a 'central team' of Management Board members which included Mike Fairey, the Director of Information Services (see appendix 22 for the management structure of HISS and resource management).

According to the CIP Project Manager, the reason that Camblewick was involved in HISS was due the hospital's 'timely' bid to Region for the funding of resource management. This document had apparently 'impressed' actors at Region as had Northtown's District and Information Strategy (see chapter five). Toms claimed that Northtown had a 'good reputation' for getting things done in the area of Information Technology following the success of the implementation of systems to meet the Korner proposals (Korner, 1982-4). Furthermore, the 'good relations between medics and management had been a point in the hospital's favour'. All these factors had led to members of Region proposing Camblewick as a possible HISS site.

With Camblewick likely to be involved in both the 'roll out' of resource management and the creation of HISS, Toms felt the need to reappraise the CIP. Toms noted that HISS would be 'district' led with the appointment of a Project Manager and a Management Board. At Camblewick, a Project Coordinating Team (PCT) would be established (see appendix 22). Toms stressed that this did not detract from conceptualising the CIP in terms of both HISS and resource management. The CIP Project Manager made it clear that resource management would continue to be managed at Camblewick because the 'staff and structure at the hospital were right'.

This was an important issue for there had already been some difference of opinion between frontstage and backstage actors. A regional spokesperson for the HISS initiative was claiming that Camblewick develop HISS first and resource management eighteen months later. Toms had an alternative understanding. He considered it 'nonsense' that HISS and resource management had been made into separate projects by the management board. Toms continued by stating that 'resource management should not be delayed for HISS to be implemented'. It was thought by Toms that the hospital could continue with its resource management programme using the information it had knowing that 'everything else would be coming on board when the HISS money arrives'.

In a newsletter to staff at Camblewick dated the 23rd February (see appendix 23), Toms confirmed that Camblewick had been 'selected to be one of twenty hospitals to receive special funding to introduce Resource Management, and that the hospital was 'one of only three hospitals in the country to pilot Hospital Information Systems'. Toms wrote that 'both of these projects combined are, in effect, our Clinical Information Project'. The CIP was no longer purely to provide clinicians with accurately and timely information through HISS, it was also about 'clinicians understanding the resources they are using and proposing modifications to their practice which will continue to improve patient care and provide an indication of cost'.

It became clear how members of the Support Group were reacting to events at a meeting on the 27th February. Toms was absent which meant that the discussion was more open than usual. Much of the

meeting was devoted to a discussion of the development of the Task Groups and resource management. All of the Task Groups were now underway except Respiratory Medicine. However, there was concern amongst members of the Support Group that they had let Toms dominate the forum and that there had been very little 'mutual support' and exchange of problems. This was an opportunity to change all that.

Martin seemed to speak for most members when she claimed that there was some confusion about what the Task Groups were meant to be discussing. Should it be the information requirements of doctors, nurses and managers?, the management structures of specialties?, or ways in which to manage resources? Martin argued that the Support Group was in need of a more 'standardised' approach to the pilot sites. These words echoed Leighton's earlier concerns about the need for Task Group 'objectives'. It was generally felt that the Task Groups needed to be 'knitted together' rather than members taking an 'adhoc' approach. Given this consensus of opinion, Martin suggested that the group compile a list of objectives for the Task Groups and present this to the Project Manager at the next meeting. This never actually happened and seemed to be suggestive of a reactive rather than proactive stance to Toms amongst group members.

It was Mrs Vale (Nursing representative on the Support Group) who raised the issue of how the HISS initiative was being handled at Camblewick. She complained that there was 'no clear view of the vision' that members of management at Camblewick were working towards. Vale was 'sick of people getting into huddles' and

suggested that there was great confusion within her profession as to what was happening. Martin agreed with Vale and talked of a 'hole in the corner approach' where communication about the initiatives was only partially 'leaked' through gossip from members of the UAB. Like Vale, Martin was 'tired of picking up bits of information which were supposed to be confidential but were never kept that way'. The only comfort for Martin was that the UGM intended to hold an 'open' meeting about the HISS initiative when Camblewick's involvement in the scheme was 'official'.

CONCEPTUAL BREAK.

The publication of the White Paper is not an event which is left 'off set' but one that is used by Toms to clarify and justify his understanding of the CIP. The project now has new meaning, for the CIP appears to satisfy one of the requirements for achieving self-governing status. The local innovation is 'put into context' by the White Paper and the Project Manager accepts the Government's ideas as an important contribution to the script at Camblewick. It is as if Toms position at the hospital has been vindicated as a result of this backstage development.

Toms' reinterprets the CIP according to the requirements of the White Paper. Rather than keep to a 'laissez-faire' approach to the Task Groups which does not challenge the traditional Camblewick culture, the emphasis switches to the need for stronger forms of managerial action at the clinical level. This is most noticeable in Toms' comments on the deviant Task Groups.

Management of the department has now become the immediate objective of the CIP rather than information provision. In arguing that solutions will be 'imposed' on uncooperative groups, Toms is starting to take a 'tougher' stance towards meeting the new goals of the project. Once again, the use of language is a political device for engineering certain preferred outcomes rather than others.

The emergence of HISS and its movement from the backstage to the frontstage is of primary importance to the ongoing action. Initially, there is the usual rivalry played out between Camblewick and the Grand (see chapter five) over which setting is to be chosen for this major adaptation. The Grand is singled out as the likely pilot site for the innovation by commentators in the Northtown Post. This makes the unofficial announcement that Camblewick is to be the HISS site that more sweeter for actors in the setting.

Toms' confidence is further boosted by the arrival of HISS. He not only considers his bid document to have helped in the selection process but also his previous achievements in integrating 'Korner' systems into the Camblewick script. The Project Manager also claims that the relationship between managers and medics was a critical factor. Whilst the traditional alliance between these groups has been largely harmonious, the problems being experienced in the Task Groups (story two) provide a foil for the action which is being portrayed (story one).

It is not long before Toms is engaged in contesting the meaning of the CIP with actors in the backstage. Whilst the regional spokesperson argues for information systems to be developed before resource management is attempted, the protagonist is eager for HISS and resource management to work in tandem. Whilst HISS is being managed backstage, this is an attempt by Toms to protect the local initiative already underway at Camblewick. It is now clear that Toms interprets the CIP in terms of both the national initiatives. His newsletter article confirms that the link between information system development and changes in the management of clinical work is an expected outcome from the CIP.

But what of the Support Group? Alongside all these developments linked to the backstage, there is a build up of confusion and anxiety amongst Support Group members. These worries are 'leaked' at the meeting on the 27th February for Toms is not there to dictate the terms of the debate. It appears nobody is at all clear about what the Task Groups should now be trying to achieve. The middle managers' are in need of some direction and a more coordinated approach. With senior management engaged in negotiating with actors from the backstage, frontstage actors have had to rely on gossip and rumour to get a sense of what is going on.

8.1.6 Story one, part five: Going for gold.

Much of March and April was taken up with the HISS initiative and this deflected attention away from the Task Groups. A 'tight' timetable had been set by the Central Team for HISS. Members of

the HISS Management Board had secured the services of a group of management consultants (Tony Black Ltd) to produce an operational requirement (OR) or technical specification for HISS. Three management consultants were to meet members of the Support Group and attempt to define HISS both conceptually and technically. The OR had to be produced by the 30th April, 1989. The OR would then have to be agreed with the Central Team, tenders for equipment invited and received, contacts received and the hardware delivered by the 31st March 1990.

On the 21st March, Toms had had sufficient time to consider how to conceptualise HISS so that it would complement the existing computer resources within the District. Toms appeared very comfortable talking to Support Group members about the technical aspects to HISS. Northtown DHA was just about to purchase another mainframe computer. Toms thought this machine could be used to link up the existing operational systems at Camblewick and collect 'spin-off' data from these 'feeder' systems. Users of the information system would then 'interrogate' the new database at District headquarters rather than the operational systems.

By the 4th April, a lot of time had been wasted on trying to establish a management structure for HISS that was in keeping with the requirements of the Central Team. Mary Budd had just been appointed Project Manager of HISS and Toms thought that her job was one of 'making sure people stick to the timetable' and 'liase between the HISS Management Board and Camblewick's Project Coordination Team'. Martin regarded members of the PCT as 'the workers'. It had become clear that most of the work for the OR

was to be undertaken by Camblewick personnel rather than the management consultants. For example, Martin and Leighton had been scheduled to look into the functions of the PAS and Pharmacy systems respectively. The Central Team were also intervening at the unit level by specifying the exact format of the OR and asking for sections of the document to be sent to them as they were finished.

On the 10th April discussions about the future of the CIP went 'backstage'. On this day, Toms attended a meeting about resource management for HISS sites. Tim Scott, a member of the NHS Management Board, put Camblewick's development of the CIP into perspective. By 1991, there would be funding for one hundred resource management sites and sixty HISS sites. An associated programme, Doctors in Management (DIM), would also be funded in two hundred and sixty hospitals to encourage doctors to become involved in the management process. Rather than being in control of a 'local' initiative, Camblewick had become intertwined with supervisory bodies concerned with a 'national' perspective.

The next day, Toms attended another meeting of members from the three HISS sites. Toms informed members of the Support Group as to what transpired a week later. The other two HISS sites at Northport and Southlands were 'doing well' according to members of the Central Team and had put in bids for £470,000 for the first year. This only pointed out the fact that Camblewick was 'running behind schedule'.

Apparently, the Central Team had been eager to 'protect' their investment in Camblewick. Given that there could be as much as £1.5 million for Camblewick over the next three years for HISS and resource management, the Central Team were proposing to maintain a 'central record' of costs for the HISS programme. According to Toms, the Central Team wanted all claims for money to be sent up the hierarchy to be considered for approval. Toms had resisted this move but the 'unwritten rules' were that 'if you did not toe the line' then you would be 'slapped back into line by the Central Team'.

The discussion of the HISS initiative dominated the discussion at the Support Group on the 18th April. There were worries from Toms, Martin and Leighton that the OR would not be produced by the end of the month. Toms was particularly aggrieved that the Central Team were 'sending a man down' to assist in the creation of the OR by conducting a study concerned with modelling data flows within the hospital. Toms did not want 'outsiders' interfering in the project for he thought that Camblewick staff had the necessary skills to implement both HISS and resource management.

Support Group members were managing the growing tension between central demands and the practical 'realities' of undertaking the work through the use of humour. Martin had been used to being 'dropped on from a great height' in previous national initiatives (eg Korner) and summed up the group process for HISS and the CIP more generally in terms of the following pattern:

(1) Enthusiasm.

(2) Disillusionment.

(3) Panic.

(4) Look for the guilty.

This brought some humour to the proceedings and dispersed the tension. Leighton saw the CIP as drifting between stages two and three.

CONCEPTUAL BREAK.

The pattern being established during this part of the episode is that the HISS initiative is leading towards an increase in backstage interference in the Camblewick script. These intrusions include the arrival of management consultants and an expert in data modelling to the setting, the establishment of a formal structure of accountability from the Central Team through the DHA to the unit, tight technical specifications (OR) and the centralised monitoring of project expenditure. Of these developments, the need to produce an OR is becoming a matter of increasing importance to Toms and other members of the Support Group. Rather than being solely a local initiative, the CIP is now a matter of national interest; the Central Team intend to extend HISS and resource management to many more settings by 1991.

This tension between central demands and local needs is bonded together through the 'cash nexus'. Money has a seductive appeal and by accepting funding, Toms and other actors at the site tie their projects to those of backstage players. Whilst the CIP was

created by actors responding to local circumstances, the scheme is now subject to the glare of backstage scrutiny. It is this switch in focus from the frontstage to the backstage which reorientates the initiative towards the wishes of the guardians of public money (in this case, the Central Team and ultimately, the Government).

Once again, comedy surfaces as the dramatic tension increases. On this occasion, the tension is not between managers and doctors but frontstage managers and backstage managers. Martin has had experience of implementing other national initiatives and the CIP seems to be turning into another. Early enthusiasm has been undermined by doubts and confusions and now the Support Group have to 'panic' and produce an OR for the Central Team. This parody of the ongoing script allows the middle managers to ease the tense situation; they laugh in the face of adversity.

8.1.7 Story one, part six: Contesting the ongoing script.

On the 25th of April, there was a change of setting from the PGMEC to a block of offices at the other end of the campus. After four months of asking for premises, Toms had managed to secure some. These offices became known as the 'bunker'. This conjured up images of a place of retreat to hide from missiles being thrown onto the heads of the Support Group members by other interested parties.

The Central Team deadline of the 30th April was approaching rapidly and Toms, Martin and Leighton had been working furiously to complete the OR. It was now clear that the document would not

be finished on time. Martin found some comfort in criticising the OR from the Northport pilot site saying that it had some 'holes' in it. One example was that the Northport specification for the Pharmacy computer produced data by ward and not by patient. This seemed at odds with developments in the backstage towards costing patient treatments according to diagnosis. Another criticism was that Northport expected users to wait seven seconds in response to any requests they made from the hospital information system. This was considered too long by Toms who argued users would be 'reaching for the filing cabinet'. Thus, there was a growing confidence amongst Camblewick staff that despite 'trailing' the other HISS sites, they had 'got it right'.

The CIP went 'international' on the 11th May when three members of the Support Group (Toms, Martin and Leighton) went to the USA to a conference held by IBM. This was part of a nine day expedition researching the latest developments in information technology and exploring different hospital information systems in use in different States. Whilst these actors were away, there were some 'political problems' developing in the backstage. It was only on the return of Toms that the full extent of the difficulties became known.

On the 23rd May, Toms reported to the Support Group that there had been 'major panics over HISS'. The problem seemed to be that members of the HISS Management Board at district level rallied to support Toms' definition of HISS in negotiations with the Central Team. Thus, actors in Northtown were working on a description of a system that could satisfy the needs of users (eg doctors, nurses

and managers). This understanding contrasted with that held by members of the Central Team who were expecting members of Camblewick to produce a specification of the feeder systems already in place. Toms argued that Camblewick did not want to make technical descriptions of systems already operational. The prefered emphasis was to consider how to meet the 'gap in information' stemming from a lack of distilled patient-based data for doctors, nurses and managers. Toms thought that the OR should 'describe the problem', this being to provide an information service. It should be up to the suppliers of equipment to work out how the problem might be 'solved'. In short, the 'political problems' were a result of Camblewick 'not providing the information that the Central Team have been seeking'.

Toms experiences in the USA had 'reassured' him. The CIP Project Manager had been to Miami and seen a hospital information system 'at work'. People were using the central information systems to access the equivalent of patient notes, laboratory results etc. The data was available for patients and departments. The Miami Hospital' system had been in stark contrast with Boston hospital's system. The Boston system had relied on the user accessing the appropriate feeder system direct and because of the diversity of departmental systems, there was little evidence of the system working in the hospital.

Negotiations concerning the contents of the half completed OR were now taking place at various levels. According to Toms, the management consultants involved with the HISS initiative considered Camblewick's OR to be 'unacceptable'. Alan Badger,

Northtown's Director of Information Services and chairman of the HISS Management Board intervened and entered into discussions with Mike Fairey of the Central Team.

At a meeting between Fairey and the HISS Management Board, Badger argued the case for an information service at the centre of the specification but Fairey did not think that the specification was 'right enough' and there was 'talk of throwing Camblewick out' of the HISS initiative. According to Toms, Fairey wanted to know why Camblewick was so keen to protect their existing computer developments rather than buying in new systems. Apparently, Fairey had asked the question; 'Have you got a lot of computer power in Northtown, then? Badger had informed Fairey of the £1.5 million pounds spent on computer developments each year. Fairey then understood why Northtown wanted to keep it and a change in attitude had prevailed. From this position, Badger was able to 'rescue' the situation by arguing that a 'roll out' of HISS to sixty hospitals in 1991 was not possible using the Northport and Southlands' specifications. The Chairman of the HISS Management Board had convinced Fairey that it was the Camblewick OR that provided the Central Team with a model which could easily be 'lifted' across to other sites.

Fairey was to meet members of the HISS Management Board again on the 24th May. Toms was pleased to report that Fairey now considered Camblewick and Northtown HA to be 'doing a good job'. Camblewick had been given a three month extension to produce a full OR for HISS.

CONCEPTUAL BREAK.

Of critical importance here is the tension between frontstage and backstage actors' definitions of the HISS project and in particular, what the OR should represent. Toms' personal interpretation of the OR is that it should describe the campus-wide information system required by users. This stance is developed by looking at the activities of other pilot sites in the UK and the Miami Hospital in the USA. In contrast, members of the Central Team require specification of the different 'feeder' systems which are the basic components of the hospital information system. Thus, the design of the HISS project is not purely a 'technical' matter but one that is intertwined with 'political' and 'cultural' concerns.

The main event which concludes story one takes place in the backstage between Badger and Fairey. With Toms taking a diffent stance on the OR to other pilot sites, Badger intervenes on behalf of the Project Manager to defend the performance of the unit. The battle for control of the ongoing script is clearly illustrated as Badger attempts to expose Fairey's ignorance of the setting. The chairman of the HISS Management Board also claims that modelling the OR 'the Camblewick way' can increase its portability to other large hospital sites. Both of these arguments make Camblewick's approach an efficient use of resources and it is this concern for economic utility that enables Badger to secure an extension to the HISS programme.

8.1.8 Story two, part two: The neglected community.

Alongside all the backstage dramas involving one half of the CIP (ie HISS), the other half (resource management) had been somewhat neglected by the Project Manager and members of the Support Group. Whilst the Task Groups met spasmodically during March, April had been the report writing stage. Toms had required the Task Group consultants to submit their reports to him by the end of April. By that deadline, he had received five of the seven reports but because of developments with HISS and the USA trip, was unable to consider the reports until the last week in May. Consequently, the Steering Group meeting scheduled to discuss the outcome of the pilot study had to be delayed until July.

Analysing the Task Group reports was not a solitary activity for the Project Manager. Toms decided to invite Tim Broad, a surgeon at Camblewick, to consult the reports with him and help him formulate ideas for the Steering Group report. Toms told the narrator that he 'needed a doctor associated with the CIP' so that this representative could explain 'how HISS can help doctors be more involved in the management of resources'. This was very necessary for the CIP was suffering from a bad image amongst the medical community. Toms said that one consultant had been to see him and accused him of trying to exclude doctors from the decision making process and attempting to 'sabbotage the power of the MEC'.

On the 25th May, Toms received another Task Group report from Dr Marshall (Cardiology) which just left the Orthopaedics Task Group report outstanding. The reasons for the delay in the Orthopaedic

Surgeon's report are worth investigating. At the final meeting of the group on the 20th April, the early enthusiasm of the surgeons to get involved in resource management had definitely cooled. The reason for this loss of interest seemed to be related to events backstage. The publication of the White Paper 'Working for Patients (Department of Health, 1989a) had added to the 'uncertainty' surrounding the project. Mr Ball argued that splitting off groups into 'empires' and having to pay for any services received was 'against his upbringing' and he was 'worried' what the new project might mean for the service. Mr Monkton's 'gut feeling' was to agree with Mr Ball. Monkton had a 'dislike for guess work' and was only 'happy to consider the CIP as an academic exercise'. Towards the end of the meeting, Monkton admitted that the Task Group report would be a 'smokescreen' that was 'sufficiently nebulous' to be disregarded. In light of this lack of enthusiasm, the report was not submitted until the middle of July.

The problems experienced in the Orthopaedics Task Group were not unique. Whilst the other groups submitted a report, two Task Groups (Radiology and the MIU) delivered two reports. Whilst this could have been suggestive of added enthusiasm for the CIP, a closer inspection of the groups revealed that there were two reports because there had been two divergent sets of opinions. In Radiology, Smith made it clear in a earlier Support Group meeting that 'his views should be treated separately' to his colleagues views. Similarly, the MIU group submitted two reports because May Hooper (Divisional Nurse Manager) seemed to be threatened by the thought of a clinical director controlling the MIU. As a

result of this belief, Hooper submitted a report to Matron. Meanwhile, Dr. Owen (Consultant in MIU) produced a document for Toms which neatly side-stepped the issue of appointing a clinical director.

Having received all the Task Group reports, Toms verdict on the contents of the documents was that they were largely 'disappointing' and that there was 'not much in them' (an analysis of the reports is given in appendix 24). Despite this rather negative evaluation, the Project Manager was to use the reports to suggest a series of recommendations for introducing resource management at Camblewick (these recommendations are to be found in appendix 25). It is the evaluation of these proposals by members of the Steering Group which forms the main focus of attention in the next and last dramatic episode.

CONCEPTUAL BREAK.

Whilst tensions in the backstage may have been eased by Badger, this concluding part of the episode suggests that there are still significant problems frontstage. Toms is trying to rescue the 'image' of the CIP by asking Broad to represent the 'eyes and ears of the medical profession'. However, it appears that this gesture is too late for some of the doctors that have taken part in the Task Groups. In Orthopaedics, Ball and Monkton had been one of the most enthusiastic groups but now it is revealed that they are the last to submit a report. The reasons for the delay seem to be linked to the publication of the Government White Paper. Indeed, the surgeons adopt similar language to that used by BMA

spokespersons in response to the NHS 'reforms' (see scenario). In suggesting that the Task Groups are turning into an 'academic exercise' based on 'guess-work', Monkton reenacts the BMA claim that 'experiments' are needed to 'test out' the Government's proposed changes. The backstage innovations of the Government are used by the surgeons as an excuse for erecting 'smokescreens'.

Other kinds of problems have been experienced in the Task Groups. The Task Group reports do not provide Toms with the information that he had hoped for. Equally, the CIP has brought to the surface the tensions between management and medical groups. Indeed, there is so much discord between the two parties in Radiology and the MIU that they cannot cooperate sufficiently to write a joint report. This does not bode well for the Project Manager who is intent on bringing doctors more into the management process (see chapter nine).

8.2 Conclusion.

This chapter traced the development of the CIP through the intertwining of two stories. The first followed the experiences of the Project Manager and the Support Group whilst the second was more concerned with events in the Task Groups.

A major theme of story one was the growing confidence of Toms (Project Manager of the CIP) and how this was linked to his interpretation of the CIP. Having originally understood the project in terms of information provision, the publication of the White Paper provided Toms with an excuse to recouple information

provision with the management of resources at the clinical level. Consequently, Toms defined the CIP in terms of the backstage projects of resource management and HISS. In making this interpretive effort, Toms replaced the 'weak' programme consistent with professional action with a 'stronger' programme emphasising managerial action at the clinical level. Once again, the development of information systems led to management challenging the traditional Camblewick culture.

Toms redefinition of the CIP was an early indication that the project was becoming inextricably intertwined with backstage concerns. The interdependence of frontstage and backstage seemed critical in relation to the cash nexus. Having secured central financing, Toms ensured that the CIP would be subject to increasing backstage interference from the guardians of the money. Toms and the Support Group spent an increasing amount of time attempting to balance the central demands of backstage managers with their own local needs. This tension was particularly noticeable in relation to the definition of the HISS project. Toms and Badger (on behalf of Toms) contested their understanding of HISS with the standard approach of the Central Team. Thus, the meaning of HISS was not purely a 'technical' matter but also 'political' in nature.

A third theme considered the ineffectiveness of the Support Group. Throughout the development of the CIP, the Support Group process was inhibited by the management style of Toms. The latter did not want to entertain 'negative' evaluations of the project from middle managers and supressed the few challanges made against his

approach. In Tom's absence, a whole host of doubts and anxieties surfaced but were never fully resolved. This was because the group had developed a tendency to 'put off' problems to another day and await further instructions from Toms, the group leader. In short, Support Group members remained confused and dissatisfied with the way the CIP was unfolding and were only able to ease some of the tension by resorting to comedy.

Story two focussed on the doctors' contributions to the CIP. This narrative provided a contrast to story one in emphasising the variety of intepretations of the CIP within the setting rather than between the frontstage and backstage. One striking theme was that doctors involvement in the Task Groups amounted to political manoeuvering. Consultants in Cardiology and Renal attempted to establish central control of their respective departments by 'chasing the budget'. The MIU consultant hoped for a fairer treatment in respect of resource allocation. The Orthopaedic surgeons were more adventurous in looking to increase the efficiency of their operating theatre time. In short, all of these doctors aimed to bypass constraints put upon them by the 'organisation'.

The experiences of the Radiology Task Group introduces another theme; that of the politics of structural design. The Radiology Consultants' Group lobbied Toms to redefine the Task Group structure so that existing arrangements in the department could be continued. Whilst this suggestion was contrary to the Project Manager's original intentions, Toms succumbed and somewhat emasculated the whole exercise.

Running Time:112 Minutes

The final theme of the episode focussed on the doctors lack of enthusiasm towards the CIP. This was noticeable not only in relation to the attendance of MEC members at the Steering Group meeting but also in terms of the development of the Task Groups. Whilst the Task Group reports were scant, two of the groups (MIU and Radiology) sent in two reports because of the difference of opinion between doctors and managers. However, it was the Orthopaedic surgeons who became more and more suspicious of the CIP. Having been early 'enthusiasts', Monkton and Ball appeared to distrust the Government's White Paper and adopted a policy of obfuscation.

Running Time:113 Minutes

Chapter nine: The Steering Group Meeting.

Episode four: A meeting of minds.

Period: 21st June to 1st November, 1989.

Setting: Camblewick Hospital.

9.0 Introduction.

A 'soap opera' model has been used throughout the previous three episodes to portray and analyse sequences of action. As a way of extending the dramatic metaphor, the final episode is written in the form of a dialogue. Each part of the episode is once again analysed using conceptual breaks. There are a number of reasons for making this change in style. First, the material used in this episode is drawn from one meeting in which particular definitions of the social world are proposed and contested by the actors present. Using dialogue to depict this contest in meaning is one way of capturing something of the richness and fluidity of such an event. Secondly, it is hoped that the reader will find the exchanges entertaining and that the dramatic tension increases as the action unfolds. Finally, attempting to reproduce the meeting verbatim allows the reader to make their own interpretation of the action and see how this complements or contradicts the narrator's reading.

Running Time:114 Minutes

Scenario.

Backstage:

On the 29th June, 1989, it became 'public' knowledge that the HISS pilot study had been delayed at Camblewick. The Health Service Journal reported that managers at Camblewick had 'obtained a last minute postponement in inviting contracts for the information system'. Staff at the unit had until the 30th November 1989 to complete the operational requirement (OR) for the Central Team. It was envisaged that contractors would then be invited to bid for the tender and the equipment delivered in December 1990. In the Health Service Journal article, Mary Budd was quoted as saying that there was a need for a 'deeper' analysis of the hospital's requirements. Camblewick was the 'jewel in the crown' of the HISS pilot sites and the delay in meeting the Central Team's deadline would ensure that the eventual system would meet all the hospital's needs and act as a 'template for the rest of the NHS'.

Frontstage:

At Camblewick, the extension in the timetable for HISS had given the Project Manager a chance to develop the other side of the CIP; that of resource management. Toms had been analysing the Task Group reports with Broad and prepared a report for the Steering Group which was scheduled in July (recommendations listed in appendix 25). Whilst the MEC and UAB members were to be invited to consider the progress of the CIP in general, Toms' main proposals involved the introduction of resource management at the

Camblewick site. At 5pm on the 24th July, members of the Steering Group met to consider Toms' document...

9.1 The Steering Group meeting.

For reasons of clarity, this episode has been divided into seven parts.

Cast:

Colin Peterson - UGM and Chairman of the Steering Group.

Simon Toms - CIP Project Manager.

Alan Badger - Director of Information Services.

Kathy Silver - General Services Manager.

Mrs Minter - Matron.

Phil Smith - Consultant Radiologist and Manager of the dept.

Steve Gilbert - Out-Patients Manager.

Jill Dukes - Manager of Para-Medical services.

Harriet Elms - Personnel Manager.

Tom Jones - Planning Manager.

Tracey Tandy - District Training Officer.

Mr Williams - Consultant Surgeon and Chairman of the MEC.

John Cherry - Anaesthetist and Secretary of the MEC.

Malcolm Fish - Pathologist.

Don Duncan - Chairman of the Radiologist Consultants' group.

Professor Tatum - Senior medic in Respiratory Medicine.

Philip Munson - Researcher / Narrator.

[Paul Hart was on holiday and not present at the meeting]

Running Time:116 Minutes

Time: 5.00 pm, 24th July, 1989.

Setting: The board room, Camblewick Hospital.

Different players enter the main boardroom at Camblewick and sit down at a large circular, wooden table. The atmosphere is light. There is a lot of frivolous conversation interspersed with laughter. Amidst all the noise, Mrs Minter and Tom Jones pass around tea cups. Colin Peterson looks at his watch and asks Simon Toms if he should chair the meeting. Toms' suggests that he should. Peterson then addresses the wider audience...

9.1.1 Part one: Speaking to an agenda (see appendix 26).

Peterson: It's five o'clock - can we get started please. I'll take apologies as read. Any comments on the minutes of the last meeting? (enclosure A)

Toms: Section four is incomplete because funding for resource management is still not known. I received a letter from Region this afternoon about funding but have not had time to absorb it for the purposes of this meeting.

Peterson: Probably everyone around this table will know that there has been problems with the HISS project. It looked like we would be thrown out when we were in America but can I take this opportunity to thank Alan for sorting Fairey out in his own den and convincing him that we are playing the right game. Our project offers more value

than the other two mickey-mouse sites. Ours is a big site and there are other similarly large hospitals around the country that can benefit from what we are doing here. You may know that the timetable for HISS has slipped because of the problems and sorting that out has meant that the review of the Task Groups has been neglected. That is why we are late in discussing resource management. Are there any comments on the progress report? (enclosure B)

Gilbert: Can I refer to section eight of the progress report. Have you any plans for developing clinical audit?

Toms: There are no proposals as yet. I am working with Tim Broad and we are going to meetings around the country about this and this subject will be one for future discussion.

Peterson: Region are providing financial support for the appointment of a lecturer in clinical audit as part of Community Medicine. I think the post will be one of acting as a facilitator to encourage clinicians around the Region to carry out their own projects.

[ENTER Malcolm Fish].

Peterson: Come in Malcolm. Malcolm is not a spy for the Grand hospital. He is representing Pathology in the absence of Christine Docks who is on holiday.

Toms: Can I just mention that Philip Munson from Nottingham Polytechnic has been working with us on the CIP and he is here tonight in an observing role. He is interested in the reactions of the group to the resource management proposals as part of his own research work.

Munson: Yes, I'm a spy.

Peterson: A Nottingham Polytechnic spy [laughing].

Williams: I'll just open the door. I don't think there are any spies out here.

Tatum: Can we talk about Diagnostically Related Groups? What is happening? I am unhappy with the coding of operative procedures.

Cherry: So am I.

Toms: There is a paper going to the MEC. We are using the 1988/9 figures because the coding structure was changed prior to 1988 and we want to conduct analysis on the basis of the present method of coding.

Peterson: Can we discuss this in another forum? The paper will be going to MEC and that is the appropriate place. Let us turn to the green document which was sent to Region in May. This is point five on the agenda.

Toms: This is now a historical document and maybe we should not spend too much time on it. It was sent in to Region six weeks ago for a bid for resource management funding.

Gilbert: Have we heard any reaction?

Toms: Apparently, Region was impressed by all the six plans.

Gilbert: They are easily impressed! [laughter]

Toms: Thanks Steve.

[The report promotes no discussion].

CONCEPTUAL BREAK.

In part one, Peterson and Toms emerge as the main protagonists. These players are speaking to the formal agenda of the meeting. This is most clearly illustrated in the incident involving Tatum. The late entrance of Fish distracts the protagonists from their task of working through the formal agenda and provides the players with a brief opportunity for some comedy. In Peterson linking 'spying' with the Grand Hospital, the rivalry between Camblewick and its competitor is confirmed once again (see chapter five). It is then that Tatum attempts to take control of the agenda by trying to change the debate to a matter of personal interest; in this case, DRG's. This intervention is quickly quashed by the chairman and the discussion returns to a consideration of the next point on the formal agenda - the bid document for the RHA.

Gilbert's jibe about the quality of the bid provides the audience with an early warning that members of the UAB are not necessarily going to play the part of supporting cast to the protagonists.

9.1.2 Part two: Is resource management feasible?

Peterson: Let us move on to number six on the agenda. This is a report written by Simon with regard to his proposals for introducing resource management (enclosure C).

Toms: This document does not resolve all the problems but I feel it raises the issues that need to be talked about. I would hope that the arguments we have today will enable us to see a way forward on the road to resource management.

Peterson: I think that it is tiresome to work through every page but this is an important document that tackles all the important issues. I suggest we work through all the recommendations. I have a letter here from Paul Hart (Unit Accountant) as to his reactions to the document and I will introduce these at appropriate moments. Right, what about recommendation 1.1 (see appendix 25).

Gilbert: Just a minute, Chairman. Before getting immersed in the detail, I think it is important to stand back and consider what we are trying to do. I feel this document crystallises what resource management is all about - resource management means giving doctors management

responsibility and I want to ask my medical colleagues here today, are there enough of YOU to make it work. Are doctors interested in management, like you, or are they very happy with what they are doing and don't want this sort of responsibility?

Peterson: Well, we've been through all the right channels - the Hospital Medical Committee, the MEC and the UAB - and agreed that we should go down the resource management line. If the doctors don't accept resource management now then we have wasted the last nine months.

Williams: We have picked this up at the meetings and whether the doctors grasp resource management or not, is up to them.

Gilbert: The different reactions of doctors to resource management may effect the way we structure it.

Williams: Tim Broad has picked up the project with enthusiasm and is going around groups spreading the message so it should be alright.

Silver: Will doctors be the ones who are penalised for taking part?

Dukes: What happens if they don't take part?

Tatum: In the Respiratory Group, we were unclear who would take on the job of leading resource management. We were

worried about the time involved in setting up resource management, especially at the beginning. We thought that there should be a manager along side us to do a lot of the work.

Peterson: One thing that I want to know is where are the Business Managers to come from?

Toms: I think that we have to ask ourselves 'Are we going to have Clinical Directorates?' and 'What is to be the role of these Directors?'

Dukes: If there are problems, are you going to kick the Business Manager rather than the Clinical Director?

Toms: The Clinical Director is the manager of the directorate and it is he that gets kicked when the specialty is overspent or whatever.

Dukes: So the Clinical Director is managerially responsible to the UGM?

Toms: Yes, that is how it should work.

Cherry: I would like to make some comments. Firstly, are managers really ready to manage multifaceted specialties such as the Renal unit? Secondly, the Clinical Directors are likely to be selected because they are successful as consultants rather than being good

managers and thirdly, is the information available yet to enable resource management to proceed? I think we should proceed more slowly.

Toms: I don't think we can wait for the information to be right in its ideal form. Resource management must proceed on what we have now and improved as the information comes on line.

Peterson: I see that resource management can be eased in with Directors in the initial Directorates only having full responsibility when the information becomes ready. The problem with this plan is that people could become demotivated - it could be that they say resource management is the excitement for last year, what is it for this year? However, I think that the evolution of resource management will get them interested.

Williams: Going back to Steve's point, is resource management feasible? Well, if there are not enough people of calibre to make it work then the Department of Health will find out and that is the end of the problem.

Cherry: Shouldn't we be waiting to the end of October when the six pilot sites are reviewed and look at what the reports say?

Toms: We can't do that. The other projects are not going down the same track as us.

Cherry: I think that with these new initiatives we don't bother to look at the mistakes and problems of other sites - we should do.

Toms: Yes that is typical of the Resource Management Initiative.

Cherry: I suppose we are jumping to a political timetable.

Elms: I think that we are going to follow the other sites into the same problems.

Toms: Not necessarily.

Peterson: I realise that we are dancing to the political tune of the Resource Management Initiative as they roll out resource management over the country. But we may decide that the cost of, say, having Business Managers, is too high. We need to do it to find out.

Duncan: Are you expecting Consultant Managers to be Business Managers?

Peterson: That depends whether you think managing your department efficiently is part of the consultant's job.

Duncan: It's part of it but not the whole [getting tense].

Peterson: I think it should only be part...for example, look at Pathology...the budget has been successfully managed by consultants for seven or eight years.

Gilbert: It comes down to who has the willingness and time to lead, for example, medicine.

Tatum: How much time will resource management take? It is bound to take a lot at the beginning and needs to be properly funded.

Toms: In the Guy's model, directors spend one session per week.

Williams: That's more than they do on the NHS! [laughter]

Peterson: It's not a question of whether medics will participate in resource management at this time. We have gone through all the committees and are committed to this line. The spotlight is on us. I think doctors probably will get involved because that will mean a place on the Management Board which is a place of influence. Let us look at recommendation 1.1. I am not sure about the term Clinical Directorates - it seems insensitive but I don't want to spend time on that now.

Toms: What the recommendation is asking is whether the group is committed to the idea that certain specialties be established to undertake resource management?

[silence]

Silver: I am not happy with the word Clinical Director, that's all. I prefer 'Clinical Manager'.

Elms: Manager is better because it indicates that there is a chain of accountability to the UGM.

Peterson: Let's have manager then.

Silver: It's only a suggestion.

CONCEPTUAL BREAK.

In the second part of the drama, the chairman introduces Toms' report on resource management into the arena. Whilst Peterson is content to work through the recommendations, Gilbert intervenes and questions the feasibility of introducing resource management. Gilbert asks whether there are sufficient numbers of doctors interested in taking on a managerial part to make the initiative work. This line of inquiry opens up the debate and allows different actors to play their part in the discussion.

Toms and Peterson are keen for resource management to proceed and argue that they have used formal channels such as the committee structure to develop the CIP. However, despite the protagonists' efforts to secure support for the CIP from different groups of actors at Camblewick, other members of the Steering Group doubt that this has been achieved. Two alliances emerge to challenge

the protagonists. The first alliance is that of the middle managers (Gilbert, Silver, Dukes and Elms) who question whether doctors have anything to gain by becoming 'managers'. Indeed, they believe that medics may even lose some autonomy if doctors are to become formally accountable to the UGM.

The second alliance is composed of doctors (Cherry, Duncan and Tatum) who are sceptical that medics have the skills or the resources (eg. time, information, funding) to manage complex specialties. These players play a more antagonistic part throughout the drama. Cherry adopts a similar position to BMA spokespersons in the backstage. The Secretary of the MEC argues that Camblewick should await the formal evaluation of the original six resource management pilot sites before 'jumping to a political timetable' set by the Government. Cherry believes that resource management at Camblewick should proceed more slowly. Thus, the competing scripts played out in the backstage between the political coalition and the practitioner coalition are also enacted at the local level.

The part played out by Williams is less clear. It seems he is caught between supporting the protagonists and representing the views of his medical colleagues. Given this potential dilemma, the MEC Chairman rejects both parts and adopts a rather 'fatalistic' position.

The conclusion of part two is signalled by Peterson's intervention when he argues that the debate is somewhat irrelevant given that the unit is 'committed to this line' and that the 'spotlight' is

now on the hospital. The implication here is that all the actors should support the protagonists' attempts to support resource management and help introduce more managerial action at the clinical level. Whilst the UGM may be 'committed' to the CIP, the silence which follows the proposing of recommendation 1.1 (the introduction of Clinical Directorates) does not appear to be a major indication of support. Whilst Gold and Elms squabble over the appropriate title for a 'director', this does not tackle the main substance of the proposal. Problems are avoided and the Chairman moves on to the next recommendation.

9.1.3 Part three: Creating divisions.

Peterson: How about recommendation 1.2 (see appendix 25).

Cherry: I am not happy about the distinction between Clinical Directorates and Clinical Services being based on bed usage. Can you explain it.

Toms: Clinical Directorates are those specialties where consultants have bed ownership whereas Clinical Services are those where workload is a result of requests by consultants in the Directorates for their services.

Cherry: Hmmh.

Fish: I am worried about treating Clinical Services as reactive. In Pathology, we often need to initiate our

own investigations.

Toms: I am talking about how the workload is initiated by request. Other investigations may lead on from that.

Duncan [aggressively]: Speaking on behalf of the Radiology Consultants, we do not want to be put into a second rate group of Clinical Services. We are happy with the present arrangements for our group and find the distinction made between Clinical Directorates and Clinical Services an artificial one.

Toms [defensively]: It is no more artificial than the one you have just made about first and second rate groups. The distinction was made on a functional basis only.

Williams: I think Don [Duncan] is worried about representation when his service is lumped together with other services. He does not want to be seen as a supporting service to Clinical Directorates in the equivalent manner as Laundry. Doctors are worried about this. But there is a need to establish that all the time in the health service, one group demands the services of another group. This is important for resource management to proceed.

Gilbert: I can understand the distinction being made. Consultants make the decisions that commits the

resources of other groups and this works as long as service groups can say 'I think you should do this'.

Toms: Clinical Directors essentially buy services and Clinical Services supply services. They are the sellers.

Cherry: Clinical Directorates also sell services.

Toms: Yes, there is some overlap.

Duncan: I think our overlap is with consultants in the Directorates and not with the Clinical Services. It is important that we are lumped in with our consultant colleagues. The buying and selling distinction is not valid for consultants.

Tatum: Do we need two groups at all?

Toms: Don is arguing for clinically-based groups to be treated like Clinical Directorates.

Duncan: Yes.

Cherry: Yes.

Duncan: Why not have one unit of government and not have Clinical Services with which we (as Consultant Radiologists) have nothing in common.

Cherry: I thought resource management would involve short term management posts where doctors would come and go. I apologise for jumping ahead but I am unhappy to be represented by a single doctor on the Executive Board who can't understand our problems. I must point out that the method of appointment for Clinical Directors is also different to that of Clinical Services. Clinical Directors are appointed and the supporting structure is provided under them. This is not the case for Clinical Services.

Duncan: They are second division.

Peterson: Why?

Duncan: For the reasons we (ie. Cherry and himself) have been talking about.

Peterson: I can't understand the problem. The Pathology Manager manages a wide variety of people.

Cherry: Is this really managing? The budgets are split between five people.

Peterson: They may not be in the future.

Fish: Could clinicians stop pathology tests and buy something else instead?

Peterson: No. The consultant and pathologist have to agree on a contract.

Matron: Surely, there is more of a chance of directors buying in cheaper, underqualified nurses.

Dukes: Is the problem not just one of labels? For example the 'Executive Board' has a formation much the same as the Unit Team.

Cherry: There is a problem in that recommendation 4.1 is less attractive than that of its counterpart, 3.1. In 3.1, the Clinical Director is appointed by the UGM after consultation with the specialty. In 4.1, the appointment of the Manager of a Clinical Service is made by the UGM without consultation...a person is just plucked out of the air. People in their right minds would not want the post and we might get a person in their wrong mind doing it.

Gilbert: A second division of consultants.

Peterson [provocatively]: And third and fourth divisions.

Duncan [angry at Peterson]: That was only implied in your mind. I did not say that.

Gilbert: I think these groups can be handled differently. It may be that there could be different arrangements for

Anaesthetics and Theatres...they may want to be put together. There is a need for sensitivity here.

Peterson: If we go self-governing and down the route to further independence then the Executive Board will be made of five people and only one will be a doctor. This doctor may not even be elected from the unit but appointed by the trustees.

Williams: If people don't understand the changes then there is going to be a problem. If you have an out-patient clinic you have to realise that you have got to have two groups...one that buys and one that sells. We have always had clinical consultants and service consultants and there is a need to have two groups.

Duncan: Why have the distinction?

Gilbert: Because, for example, in Pharmacy, we respond to the clinical consultant.

Duncan: We prefer our own unit structure rather than that of a Clinical Service.

Toms: O.K. but I do need the general feel on this.

Gilbert: There is a need for flexible arrangements for different groups to get round this.

Dukes: I think that we are all reacting to what we have read later in the document. We are treating the establishment of the Executive Board as if that is the arrangement and not a suggestion and reacting to these recommendations on that basis.

Peterson: I must be extremely stupid or something because I can't see the problem at all. If you take Physio, a consultant asks for Physio and the physiotherapist then says what will be done - it is not left for the consultant to say that the patient needs three poundings on the back each day. The only difference is that one is a consultant and one is not. I am quite happy being in with Kathy as a Clinical Service. That is what pathology is.

Duncan: I am not objecting to the idea that we provide a service.

Cherry: It is the whole package that describes the different roles that I object to. I shall have problems selling this idea of a Clinical Service to the doctors.

Toms: Can we at least accept the concept of a Clinical Service?

[Silence]

Peterson: What about recommendation 1.3 (see appendix 25) which says that non-clinical services be known as Support Services. Here is your chance to react to this proposal, Kathy.

Silver: I hate to disappoint you but it is well established that general services are in the third division and I humbly accept this...I'm used to it.

CONCEPTUAL BREAK.

The dramatic tension reaches a climax in part three of the drama. The main issue of contention is that Toms is proposing dividing clinically-based groups between directorates (those specialties that admit patient to beds) and support services (those that contribute directly to care but do not admit patients). Duncan plays the part of antagonist because he feels threatened by the fact that Radiology may be regarded as a Clinical Service rather than a directorate. Duncan interprets Clinical Services as being 'second rate' or in a 'second division'. It is clear that his project is to maintain the 'present arrangements' and ensure that the Radiology department is 'lumped in with our consultant colleagues'. There is a definite concern amongst members of the medical community that resource management sets up a status differential. This is highlighted by Williams who argues that doctors are worried that Clinical Services will be regarded as equivalent to general service departments (eg. Laundry) rather than being equal to a Clinical Directorate.

Cherry echoes the fears of Duncan by expanding on how Toms' document can be interpreted as treating Clinical Directorates in a different manner to Clinical Services. His main point is with regard to the appointment of a Clinical Director and that of a Clinical Service Manager. The former is appointed through consultation with doctors in the specialty whilst the latter is just selected by the UGM without consultation. This difference in treatment between the two medical groups is unacceptable to Cherry and not a package that he cares to 'sell' to the his 'colleagues'.

Throughout the doctors' attacks on the proposals for introducing resource management, the Chairman appears to be rather baffled by what is taking place. Peterson understands the differential between a Clinical Directorate and a Clinical Service in terms of a conceptual distinction. For the UGM, the issue is not a matter of status. A breakdown of communication between Peterson and Duncan nearly occurs when the former suggests that the doctors are constructing a pecking order (division one, two, three etc) of departments within the hospital. Duncan refutes this allegation but the discrepancy in views between the protagonist and the antagonist is highlighted.

It is left to members of the middle management alliance to bridge a gap between the two competing view points by calling for 'sensitivity' or a 'rewording' of Toms' document. Indeed, the accomodating attitude of the middle managers is in stark contrast to the protagonists and antagonists. Silver's concluding speech about the 'third division' of general services provides a foil for the dramatic tension played out throughout the third part.

Running Time:137 Minutes

9.1.4 Part four: Putting off the difficult areas.

Peterson: Section two. Do you want to run through this Simon?

Toms [distributing a report]: The Task Groups have now reported and the paper coming round is the Orthopaedics report which was received after the others were sent out. The area of general medicine found difficulty in defining their boundaries since some physicians were general physicians with an particular interest and not all their patients fitted into the Task Group specialty. Renal is a regional specialty and slightly different in that eighty per cent of its activity could be traced. The recommendation is for Renal to become a Clinical Directorate.

Peterson: This would put Renal with a representative on the Management Board with equal representation as General Medicine. That seems unfair.

Toms: Perhaps we can discuss the structure of the Management Board later when we come to it.

Dukes: We seem to be putting off the difficult areas.

Toms [getting tense]: It's not that I am putting it off. I did not really know what to propose. That is why I have recommended in 2.2 that the other Clinical Directorates in general medicine be discussed further with the

general physicians.

Tatum: I don't know if going to the general physicians is the answer [laugh]. I can't see them muscling down unless they have been given clear guidelines.

Toms: I thought the guidelines would come from this discussion.

Peterson: Can resource management be organised on specialty lines? Patients such as stroke victims are general patients - this presents a problem.

Gilbert: Yes, but at the moment, the Nightingale ward houses Renal, Cardiology and General Medicine patients. It could be one idea to take blocks of wards and give them over to single specialties to facilitate data capture on activity and costs.

Badger: That's a bit like buying a dish washer and only eating what a dishwasher likes. It would be wrong to restructure the hospital to fit into resource management.

Dukes: You do need a change in structure.

Toms: I think that we need to take the decision to the groups. What about going to the surgeons and talking to them about the options for setting up resource management?

(recommendation 2.3).

Williams: The surgeon group is a smaller group.

Peterson: What about the splitting of Obs. and Gyne...would each have a Clinical Director and two reps. on the Management Board?

Tatum: Surely size of specialty is important.

Toms: I think we should shelve the point and have talks with the surgeons [looking at Williams for support].

Williams: The surgeons have not talked about resource management except the Thoracic surgeons so this would be alright.

Peterson: Would having one directorate for the surgeons be acceptable?

Williams: That would be too big for one group. Having Theatres include Anaesthesia may be one way.

Dukes: Having a general group would allow for a trade off of resources within the group across the present boundaries.

Toms: It was thought that Theatres go in the group so that problems could be resolved amongst themselves.

Cherry: There is an overlap in that Aneathetists respond to surgeons but there are problems with this.

Peterson: The present across town service is also likely to change in light of the 'White Paper'. Self-governing status would send us down seperate paths.

Cherry: I can see people gravitating to one end of town or the other in time.

Gilbert: There is still a distinction between surgeons and anaesthetists. If surgeons decide not to operate then they don't need theatres and anaesthetists. The other resources are affected by the surgeons' decisions.

Cherry: This is 'Alice in Wonderland' stuff.

Williams: Resource management should make us more efficient because a group of users will be charged for a full theatre list at times when they have not used it.

Peterson: What about point 2.4...this is the MIU. I suppose St Patrick's could become part of the Mental Health Unit.

[No discussion takes place]

Peterson: What about Maternity as a proposed directorate?

Tatum: I think Maternity is similar to Respiratory Medicine. In our group we did not rule out the possibility of combining with the Thoracic surgeons...at a senior level it could work. This is the same for Maternity.

[There is little discussion].

Peterson: Now we come to Radiology. We are faced with the original problem of whether Radiology should be defined as a Clinical Service or not.

Duncan: We see the consultant's role as part-time management. Our concept of the manager is not the same as the concept put down here and not what we want.

Peterson: Phil?

Smith: I don't agree but there are six of them.

Duncan: Phil abstained when we discussed this matter and the six of us were unanimous.

Gilbert: Life is full of compromise and solutions that none of us really want. There is a way forwards here.

Dukes: The main problems come in chapter six.

Duncan: I am not arguing that Radiology is not a Clinical Service but with the relationship it would have

with other groups.

Peterson: I don't understand the problem. Is it that you want to appoint your own manager?

Duncan: We want to be treated the same as Clinical Directorates with the same supporting structure.

Toms: The wording in the report does not reflect that.

Peterson: Pathology is next and the issue here is whether the present situation of five disciplines should become one under a Pathology Manager with that person negotiating the budget for all and negotiating the split with the divisions. At the moment we have a Pathology Coordinator and not a manager - so it's a cop out.

Fish: I am concerned about where Microbiology would stand in this since it is the area that I am most familiar with. How would we cost bench work and the technicians activities?

[silence].

Toms: We should shelve this and discuss the issue with the pathologists to see what they decide.

Tatum [surprised]: Can we really let Pathology decide if they want five managers or one?

Toms: I am only floating problems and want to see how different groups see the future. Once I have talked with other groups I can feed the opinions back to the Steering Group for discussion.

Peterson: Let's go onto the management of services.

CONCEPTUAL BREAK.

The fourth part of the drama is characterised by Toms being content to pacify the members of the medical alliance and recommend that further discussion take place with regard to arrangements for resource management in the 'difficult areas' (eg. the major clinical areas of general medicine and general surgery). Whilst Toms is able to pick off some of the marginal specialties not represented at the meeting (eg. Renal, MIU and Maternity), the Project Manager makes little progress in relation to the other Task Group sites. The tension between Duncan and Peterson threatens to be revived in relation the Radiology department. However, the general theme running through this part of the drama is that the protagonists have to 'shelve' their plans. They are unwilling to 'take on' the antagonists.

9.1.5 Part five: Areas of neglect.

Toms: You have missed recommendation 2.8 (see appendix 25). I thought I would raise this as I know something about the matter. Where should Medical Physics and the medical secretaries be managed within resource management? I am

thinking especially of the new Radiotherapy unit when it is completed. Where would staff fit?

Cherry: What about the MESU (Medical Equipment Service Unit). Is this up for grabs?

Silver: It would be wrong to say it is up for grabs. The Estates Manager is looking into this issue at the moment and will advise me on a course of action.

Toms: With regard to the management of services, my argument is largely one that recommends that the supporting services should not be fragmented.

Tatum: These services seem to have been given a small amount of attention.

Gilbert: I think there needs to be minimum standards for the service so that directorates are allocated, say, two physios. That is a necessary minimum and if they want more they will have to pay for it as an extra.

Silver: I must complain that there is an assumption in the section marked 'Management of Services' that para-medical staff are the only professional staff and I find this insulting to those professionals who work in catering, estates and laundry.

Toms: It was not meant.

Running Time:145 Minutes

Silver: I think the wording should be changed.

Peterson: The next section on nursing presents us with the problem of divorcing managerial and professional lines of responsibility. Who should win out if there is a dispute between Matron and a Consultant Director over levels of nursing staff?

Elms: The UGM should win.

Dukes: It is not a simple distinction for the two lines of responsibility inevitablty merge together and overlap.

Matron: I would be quite happy seeing nurse managers in a directorate.

Toms: Would doctors be happy about managing nurse managers?

Badger: The advantage of resource management is that staff can start to plan and so management should be streamlined and nurses rostered by skill and grade so that patients get the appropriate levels of care.

Peterson: Should nurse managers be managerially accountable to Clinical Directors?

Matron: I have not thought it through yet.

Peterson: Should nurses be a service that is purchased?

Cherry: The relationship is a bit better than that. Line management should only be stressed when things are not going well.

Duncan: Isn't the relationship about planning together rather than worrying who is the deputy.

Matron: It could be that nursing standards are compromised by them bowing down to Clinical Directors.

Peterson: Nurses have their own standards and these are not necessarily what doctors want.

Matron: As I say, I haven't thought it through.

Peterson: Well, we can't make a decision tonight then. Recommendation 2.13 looks at whether medical secretaries should be devolved to directorates or not.

Elms: Medical secretaries should be trained by Medical Records staff.

Silver: I am biased for I might be accused of flying my own banner. We have a good reputation for maintaining high standards for medical secretaries throughout the unit and beyond. We have secretaries wanting to work here that are willing to wait until opportunities arise. The main issue is one of whether Clinical Directors will sort out their own problems if their secretary is sick

having gone down the route to devolvement.

Williams: The Gyneacology case a few years back proves that doctors need to know what it means to run a service for themselves before going down that route.

Peterson: It seems that directorates should buy this service from Medical Records.

Toms: Leave medical secretaries with Medical Records and keep the option for the directorates to buy them in.

Tatum: Is resource management going to provide doctors with a better choice or not?

Dukes: What do you mean by choice? There has to be choice within the rules.

Silver: It is important to remember that if we have Clinical Directors massaging the service that this ultimately means making people redundant.

Williams: I think most doctors won't want the problems of employment law to deal with and will leave that to the Medical Records staff.

Gilbert: This could leave directors more powerful without being the direct employer.

Toms: I shall suggest that we don't devolve medical secretaries but that directorates may have their own view on this.

Peterson: It's 7-30, let's move on...time is defeating us.

CONCEPTUAL BREAK.

The fact that Toms' proposals lack any 'bite' is revealed in the fifth part of the drama. Toms' recommendations reflect the importance of the medical community at Camblewick in that the basis of the proposed change in management structure is to be based around clinical specialties. However, Toms rather neglects the supporting services in his recommendations. In particular, nurses are not given the same status as doctors in the report and it is recommended by Toms that nurse managers become managerially accountable to Clinical Directors (ie. doctors). Rather than object to this idea, Matron chooses to play a similar part to Williams and not support either the protagonists or become an antagonist. Instead, Matron admits to not having 'thought through' the proposals. In refusing to take a stance, Matron continues the theme of problem avoidance. She is able to avoid making a positive commitment to the proposals. This disarms Peterson who is reluctant to make a decision on the future of the nursing profession without Matron playing an important part in the discussions.

9.1.6 Part six: The Management Board.

Toms: I am assuming that recommendations 3.1 to 3.3 are O.K. (see append 25)

Gilbert: I think that 3.6 could be strengthened by inserting a clause about minimum standards.

Toms: Yes, although it does mention quality.

Silver: There seems to be an omission here - what happens if the Clinical Director overspends?

Gilbert: There should be some rules about the UGM being able to sack the Clinical Director.

Peterson: I think the powerful forum will be the Management Board.

Cherry: This is a good way to get out of the job!

Toms: Yes, some thought needs to go into this question of penalties.

Peterson: It's the same with consultants now. If they fail to fulfill their duties then there are no penalties.

Toms: Part (c) - accountability of staff - I think we have ruled out 3.7.

[recommendations provoke little discussion].

Toms: Now for section 4. I hoped Don [Duncan] might have gone by this time [laugh].

Duncan [seriously]: My department does not fit into 4.1 (see appendix 25).

Gilbert: There are two methods here. Can't service departments with consultants in be managed by consultants?

Duncan: Yes with the same structure as 3.1.

Peterson: I don't think we are far apart.

Duncan: We should be in a sub-group that is identified as not part of the Clinical Services Group.

Toms: Section five considers my role - should I leave the room? [laugh].

Silver: Recommendation 5.5 (see appendix 25) seems a big task (monitoring effectiveness of internal contracts on behalf of the Management Board). Should this be part of the Management Board's function?

Toms: I was thinking that someone should pull it together so that it can be presented to the Management Board for their view.

Peterson: Section six involves the real nitty gritty. Simon proposes that the UAB be phased out and replaced by the Management Board by November 1st. Paul Hart's comments about this are that the board of thirty is too big. He suggests we have eight Clinical Directors and the UAB.

Toms: The reason I proposed the Board the size it is was so that purchasers and suppliers could sit round the same table and plan and discuss problems. However my estimate of the Board with this set up would be twenty-four to thirty. This is too big so I thought that we should have another tier. I called this the Management Executive Board which will have five members and is very much in line with the 'White Paper' suggestion for a board if the hospital goes self-governing. So the choice is to prune below the Management Board and have reduced numbers sitting on that board or prune above the Management Board by having an Executive Board.

Peterson: It is interesting that in the District, purchasers and suppliers are not going to sit round the same table in the future. This is because UGMs' will not be able to sit on the District Executive Board when the District is purchaser and the units are suppliers. Are there any thoughts on the future of the MEC?

Williams: If it goes, it goes. With the Chairman of Clinical Directors, it is difficult to envisage how one chap can

speak for the rest of us. We should not make a ruling on this now and such a position may evolve. Have the big committee - why not! Let the board evolve. It's too soon to be worrying about this.

Peterson: There will be only one doctor on the Board if we go self- governing and that will be chosen by the Trustee Board!

Williams: I think I'll go away for six months and let my predecessor decide! [laugh]

Peterson: There will still be a medical committee.

Williams: Yes, we like to talk about different things.

Peterson: Theatre closures will still be dealt with by the Management Board and rightly so. There will not be many Clinical Directors at the start sitting on the Management Board and I think the MEC should run on in tandem - we shall see how it evolves. I assume we should take off the representative members of the UAB in the new era.

Gilbert: Yes, their position would be compromised otherwise. How would the Community Health Council react to the issue of theatre closures?

Peterson: The Management Board is to meet once a month. Is the first of November too early to work towards?

Gilbert: Keep it as a target for the moment.

Toms: So we are having a Management Board of the UAB minus the reps. plus the pilot directorates' leaders as appointees. The MEC will continue in tandem to phase in the other resource management areas.

Silver: The representative members of the UAB could be invited annually to an open day meeting of the Management Board.

Peterson: I will have to clear this structural change with DIxon (DGM) and talk to the reps. after that.

CONCEPTUAL BREAK.

Comedy is reintroduced by Toms at the start of part six. Following Duncan's earlier complaint about Radiology being a clinical support service, the specific recommendation suggesting this idea is used by Toms to joke about the 'stock' part played by Duncan. True to managers' conception of the 'typical' doctor, Duncan has exhibited 'awkward' and 'difficult' behaviour and this is recognised in the comment 'I hoped Don would have gone by this time'. Don Duncan does not see the funny side and reconfirms his position in relation to the recommendation.

The action then focusses on the proposal to create a Management Board and an Executive Board at Camblewick. Whilst these two groups appear to have been set up to strengthen the line of managerial responsibility running through the unit, members of the middle management alliance expose the fact that powers to influence the activities of Clinical Directors have not been considered in Toms' report. Whilst Silver and Gilbert assume that the UGM should exercise some control over Clinical Directors, Peterson is reluctant to take responsibility for this part. He suggests that 'the Management Board' will be the 'powerful' forum. In keeping with the Camblewick culture, the whole issue of enforcing stronger managerial action at the clinical level is avoided by the Steering Group.

Throughout the sixth part, the protagonists use the Government's plans for the NHS as a way of justifying their proposals at the local level. The formation of the Executive Board reflects the composition of a board for a self-governing hospital outlined in the 'White Paper'. Peterson is clear that the Management Board will take decisions of a sensitive nature such as operating theatre closures. Both medics and managers are to be represented on the Management Board and so Peterson is attempting to maintain a cooperative style of management at the unit. By suggesting that the MEC should be maintained until the Clinical Directors are represented on the Management Board, the UGM takes further action to allay doctors fears. In keeping with Camblewick tradition, the medics still require an important say in the management of the unit and the UGM upholds this 'right'. The idea that one doctor will sit on the Executive Board and represent all his colleagues

is rejected by the protagonists.

9.1.7 Part seven: Agreeing to disagree.

Peterson: So we need a revised paper soon and another meeting to discuss it.

Cherry: Since we cannot sell this document, do you want us to help you change it - or would you rather I shut up and rubbish it next time?

Toms: We'll write up the notes and look at it.

Gilbert: The document will keep improving as it keeps coming back. The Steering Group can discuss the views and decide if that is what the Steering Group agreed to. You could send the notes about and ask people if that is what they agreed to at this meeting.

Toms: Lastly, there is the issue of the HISS report (Enclosure D). The Operational Requirement needs to be completed by November. The other sites have finished theirs and they are nine inches thick. The suppliers say that they cannot meet the order in the alloted time of six weeks. Our OR is slimmer and more portable. Still, coming up with the best OR in the country is providing headaches...I am preparing a balance sheet for the project but the revenue for the project has not been agreed upon yet. The Department of Health have said

that they have allocated money to us for HISS but the problem is getting at it. Region have kept twenty-five per cent of our allocation for supporting 'Doctors in Management' leaving us with seventy-five percent. We have been done but I am asking for our full allocation.

[Players shuffle papers and prepare to leave the room. By now, it is 8-10pm].

Cherry: Thankyou for your clear English. I could understand what I didn't agree with [laugh].

Peterson: Oh - Peter Fenton has been appointed at Region to oversee resource management. I think we should invite him to the next Steering Group meeting.

Gilbert: Yes, he can explain about Region holding our twenty-five per cent.

Peterson: When shall we have our next meeting?

Silver [sarcastically]: Not in August, the doctors will be on holiday.

Peterson: How about the 25th of September?

This is agreed and the meeting is over. The narrator is left on his own for a moment. Steve Gilbert comes over to me and asks if I got all that down and I said 'every word'. Gilbert then has a

short conversation with Simon Toms. He hopes that Toms is 'not too bruised by the experience'. Toms replies that a lot of issues seem to have been 'thrashed out and simplified'. He exclaims that 'it is no good sitting around and no one saying anything.' Colin Peterson briefly joins the discussion and suggests how 'stupid' that business with Don Duncan was. Peterson then departs. The narrator also says his 'goodbyes' and departs. In the corridor, Jill Dukes has the last word. The Para-Medic Manager suggests that 'there is a PhD in that meeting alone, Philip'. I agree with her and shuffle off to consider what it all means.

CONCEPTUAL BREAK.

In the concluding part, the significance of comedy as a cathartic medium is once again revealed. Throughout the play, comedy sporadically creeps into the arena to relieve the tension between the protagonists and antagonists. This is particularly noticeable in the final sequence of action where Cherry jokes about his performance throughout the drama in terms of 'rubbishing' Toms' document. Cherry's intervention is more positive than it first appears for he offers an 'olive branch' in saying that he will help amend Toms' proposals. He can afford this gesture given that the antagonists appeared to have deflected the protagonists appetite for change.

Cherry makes another lighthearted comment following Toms' brief account concerning the development of HISS (enclosure D). The doctor thanks the Project Manager for making it clear what he did not agree with. Thus, the part played out by the antagonists is

now turned to making peace with the protagonists. The atmosphere becomes more harmonious. Silver plays a complementary part to Cherry for the middle management alliance. The General Services Manager makes a quip about the medics playing truant throughout August. Whilst the protagonists do not make a positive contribution to the comedy theme at this time, the meeting ends on a fairly amicable note. Another day of contest is announced.

9.2 Conclusion.

This episode followed the reaction of Steering Group members to Toms' recommendations for developing resource management at the clinical level. During the meeting, the doctors emerged as the main antagonists to the Toms' proposals. The tension reached a climax in relation to Duncan's dispute with Peterson. Whilst the UGM supported Toms in conceptualising Radiology as a Clinical Support service, this was a political issue for Duncan. The Consultant Radiologist interpreted the concept of a Clinical Support Service in terms of a lower status department. This was unacceptable to Duncan who wanted to preserve 'first class' status with other medical specialties. With such conflicts surfacing, the protagonist's recommendations were eventually sidelined and the Camblewick culture maintained through a number of devices. These are considered below.

Medics' and managers' decisions about the future management structure of the unit are shaped so as to protect the power base of the medical community. The incident between Duncan and Peterson has already illustrated that, once faced with structural

divisions, medics will 'close ranks' and protect vested interests. Doctors in management (ie Peterson and Williams) also play their part in reinforcing the position of medics at Camblewick. The idea of establishing an Executive Board is rejected by both these actors in favour of a large Management Board of managers and doctors. In stating this preference, the chain of managerial accountability is weakened and the management structure has no strategic apex. Similarly, deciding that the MEC should continue in tandem with the Management Board reconfirms the status quo in ensuring that the medics continue to have an important 'voice'.

Another factor which reconfirms the status of doctors in the Camblewick culture is the reactions of the UAB managers to Toms' recommendations. Toms, Matron and Silver all display their willingness to postpone problems for the sake of harmony. The Project Manager does not attempt to 'take on' the antagonists after Duncan's clash with the UGM. He is quite ready to cooperate with the doctors and rethink his proposals. Similarly, Silver deflects attention away from crucial issues by trying to 'patch up' differences through rephrasing recommendations. Matron also adopts for a policy of problem avoidance and will not express an opinion on where nursing might fit into the new regime. These tactics reduce tension but do not tackle the fundamental conflicts between managerial and professional action.

The final theme is one that has been present in all four episodes and relates to the use of comedy in the ongoing drama. The final part of this episode illustrates how important comedy is in

reconciling conflicting and divergent opinions. After having 'rubbished' Toms proposals, the doctors use comedy as a way of restoring management's faith in the alliance with the medical community. This is a necessary process if reconciliation is to be achieved and the traditional Camblewick culture maintained.

9.3 Tailpiece: The serial goes on and on and on...

Whilst the resource management proposals were rejected by members of the medical community in July, the other arm of the CIP was also to suffer a setback. In October, it was reported in the Health Service Journal that the Government's commitment to HISS was 'evaporating'. A Department of Health bid for Treasury funds to extend HISS beyond the three pilot sites had been abandoned. Government concerns about HISS appeared to have been concentrated on the complexity of the operation and the 'sheer size' of the project. The Health Service Journal speculated that the Department of Health now favoured concentrating on simpler systems to obtain basic management information which could be used to price services for the future internal market.

The reaction of members of Camblewick to this media speculation was more optimistic. According to Martin, there would be funding for HISS at the hospital for the next three years. Work was still going on into finishing the Operational Requirement for the Central Team. The major debate was over how much money Camblewick would receive for the initiative. Having returned to the unit, Hart was now convinced that HISS would cost nearer ten million pounds to implement rather than the Central Team's original

estimate of one and a half million pounds. The other two pilot sites also claimed to need several million pounds to install. The Accountant thought that the huge amount of investment needed for one information system development had apparently 'alarmed' the Government and that they had got 'cold feet'. Consequently, there would not be a national 'roll out' of HISS.

In November 1989, the newly formed NHS Management Executive (1989) announced it had set up a Steering Group to undertake a study of the likely information requirements of districts, together with the potential costs and benefits from additional investment in information technology. This seemed remarkably similar to the Korner studies commissioned by the DHSS ten years earlier. Another cycle had begun...

Chapter ten: Conclusion.

10.0 Introduction.

Having undertaken an exploratory case study into the organisational implications of MIS development, this final chapter does not attempt to make any sweeping generalisations. As Bryman argues (1989:173), 'the aim [of a case study] is not to infer the findings from a sample to a population, but to engender patterns and linkages of theoretical importance'. However, whilst this case study should be judged in terms of the adequacy of theoretical inferences, the strong emphasis on context may lead the reader into feeling that they 'know the organisation'. Consequently, the case study may provide a sufficient and appropriate level of detail for those working in a similar situation to 'relate' their decision making to that described in the study (Bassey, quoted in Bell, 1981). With Bassey's point in mind, this chapter does not overstate the uniqueness of the case.

Chapter ten is broadly divided into two parts. The first section (10.1) outlines a number of emergent themes surrounding and contributing to the process of MIS development in the case setting. The next section (10.2) makes a secondary analysis of the case material and suggests what the implications of the study might be for Camblewick Hospital (10.2.1) and the NHS (10.2.2). Finally, the chapter is concluded by specifying the contributions this study has made to Organisational Theory (10.2.3).

10.1 Emergent themes.

This case study has focussed on the design and implementation of information systems as an organisational issue. This account has not given primacy to the 'technical' aspects of developing computer-based information systems in the 'organisation' so that 'cultural' and 'political' considerations can be concentrated upon. Nine themes have emerged from the inquiry and these are considered in turn. The central duality running through the chapter is the way in which MIS developments both constitute and reflect organisational 'reality' (Hopwood, 1983, 1985, 1990).

10.1.1 Management innovations find their meaning in the social context of the 'organisation' of which they are part.

It was suggested in chapter one (1.1) that members of the Government and the top tier of the NHS believe that developing information systems will lead to 'better' management and 'better' care. This statement has been shown to be too simplistic. At Camblewick, the development of ward budgeting and the CIP were constantly constrained by 'cultural' and 'political' considerations (see below). Whilst both initiatives displayed elements of a strategy to extend managerial control to the clinical level, there existed considerable uncertainty over how the initiatives would take shape, if indeed they ever would and what the precise effect would be.

At the organisational level, the first episode illustrated that attempts by the Accountant to control spending at the ward level

were rejected by practitioners (6.1.5). Equally, movements towards developing a management structure for resource management were sidelined by members of the medical community in the final episode (9.1.7). At the 'environmental' level, there were moments in the development of the CIP when Camblewick could have been dropped from the HISS initiative. This seemed most likely in episode three (8.1.7) when members of the Central Management Team were frustrated by actors at unit contesting the definition of HISS and failing to meet project deadlines.

This study has illustrated that there are considerable problems associated with designing and implementing MIS. This may well be due to the fact that embryonic management ideas (for example, Hart's three tier plan (6.1.1) and the Unit Team's White Hart Plan (7.1.3)) can become manifest through the introduction of MIS which in turn may lead to the challenges of organisational change (see Dent, 1990:19). However, whilst a product champion may have notions which stimulate the movement towards information system development, stronger managerial action does not necessarily follow from the attempt to implement these innovations. Ideas are not easily translated into practice. As Child (1984) has noted, developing MIS may not extend management control but facilitate organisational choice. In this respect, the important issue becomes one of who has the power to shape the direction of the initiative. In the case study context, it was the members of the clinical practitioner coalition who held this power and chose not to support information system developments.

The burden of the above argument is that management innovations (such as MIS developments) find their meaning in the social context of the 'organisation' of which they are a part. In the case of Camblewick, the plans of senior management were frequently frustrated. Of course, the theme of unintended consequences is not a new one. It can be located in the work of Weber (1968) who was well aware that the 'technical superiority' of highly rational bureaucracies were a necessary but not sufficient guarantee of an 'efficient' achievement of goals. As Watson (1987) puts it, the basic paradox of 'organisation' is that:

> ...the means used by the controlling management of the organisation to achieve whatever goals they choose or are required to achieve in an efficient way do not necessarily facilitate the effective achievement of these goals since the 'means' involve human beings who have goals of their own, which may not be congruent with those of the people managing them.

As some of the following themes show, too often, systems are designed so as to augment and reinforce existing inequalities within the 'organisation' (Markus and Pfeffer, 1983: Willcocks and Mason, 1987).

10.1.2 Constructing organisational 'reality': Backstage contributions from members of the political coalition.

The study illustrated how different groups of actors intervened in the process of MIS development to shape organisational 'reality'. To reintroduce the 'soap opera' metaphor, the ongoing action at

Camblewick was not identifiable in terms of any one actor's or group's contributions to the script but all of them. Furthermore, meanings were mediated between the backstage and frontstage (and vice versa) as well as within the frontstage. This section looks at the relationship between the two stages.

Beginning with the political coalition, members of the Government were particularly significant in setting the agenda for health service managers in the backstage and the frontstage. For example, the White Paper publication 'Working for patients' (Department of Health, 1989a), set out the Government's plans for 'reforming' the NHS (see chapter eight) and this was coupled by the extension of central funding for managerial projects which were intended to make the new vision a 'reality'. These projects focussed on developing information systems (HISS) and extending managerial control at the clinical level (ward budgeting and resource management) in the search for greater economic utility. All these initiatives were important in providing a framework within which the 'champions' of management innovation (in the case study context, Hart and Toms) could campaign for change in the frontstage.

The NHS Management Board (now, the NHS Executive) has largely been an agent of the Government and allied to the political coalition. Being charged to deal with 'operational matters' within the strategy and objectives of the NHS Supervisory Board (now, the Policy Board), backstage managers seduced actors at the unit level with funding for projects (the cash nexus) and then interpreted their part as being to guard public money. For example, in the

third episode, the Central Team intervened at the local level in an attempt to centralise the development of HISS (8.1.6). These central demands transformed the nature of the CIP to an accountability exercise which led to an increase in the level of 'political' activity in the backstage (8.1.7). Thus, backstage NHS Managers were particularly significant in distracting protagonists at the hospital level from the local needs of players in the frontstage.

Of course, contributions to backstage scripts also occured as a result of fronstage intervention in the backstage. This was most noticeable in the third episode when Toms and Badger were able to shape the Central Team's understanding of the HISS project (8.1.7). However, for the large part, this case study focussed on actors in the frontstage rather than those playing out other dramas in the backstage.

10.1.3 Constructing organisational 'reality' from within: Members of the managerial coalition.

The contributions of Camblewick's managers to the ongoing action varied somewhat. Senior managers (primarily, the Unit Team and the UAB) were expected by the Government to 'police' the use of resources throughout the hospital. Having been set strict cash limits by members of the DHA who had a legal obligation to balance their budget, this prompted senior managers at Camblewick to consider how resources could be worked harder. Developing MIS seemed one way to discover where further efficiencies could be made. In supporting the principle of information system

innovation, senior management shaped the organisational script. It was through the ongoing debates about MIS design and implementation that the Government's concern for economic utility entered the organisational domain and became increasingly important to these managers.

The senior managers' concern for utility was counterbalanced by a desire to accomodate existing rationales such as individual patient need and protecting the service developments of clinical practitioners. Camblewick had a long tradition of medical innovation and service expansion. It 'went against the grain' to reduce the level of clinical work even though the hospital could not afford it. To use examples from the case, budgets related directly to patient treatments were the last to be scrutinised by senior managers (6.1.1). Monies had been saved in the other supporting services to help fund increases in the number of patients treated. Furthermore, operating theatres were closed with reluctance and only had a minimal impact on reducing clinical workload (7.1.2).

The main protagonists (Hart and Toms) were central to creating local visions within the case setting and developing and implementing management innovations such as ward budgeting and the CIP. These managers were also aware of the need to balance financial constraints with service developments. It was their task to search for a workable script which could balance the conflicting demands of the political coalition in the backstage and the practitioner coalition in the frontstage. Indeed, the contribution made by these players to the drama could be summed up

in terms of this balancing act. In this sense, the study confirms in practice the opinions of Ackroyd et al (1989:607) on the wider subject of public sector management. These theorists claim that the 'special feature' of public sector management is that the task is one of 'reconciling the sometimes diametrically opposed demands of external 'controllers' and internal 'carers'.

Senior managers and middle managers at Camblewick also reaffirmed existing organisational arrangements by being prepared to 'put off' difficult decisions and adopt a policy of problem postponement. Compromise led to harmony and continued organisational performance. For example, in episode one, Hart allowed Matron to sideline ward budgeting. Hart also postponed budgetary training for the ward sisters and avoided tackling 'messy' areas such as how budgeting would be monitored, whether there would be any penalties for overspending, the part to be played by Divisional Managers and how to improve the financial statements (6.1.5). In short, the problems of implementation were less attractive to the accountant than devising new strategies. Equally, problem postponement was also at work in episode three when support group members allowed Toms to suppress their anxieties and worries about how the CIP was unfolding (8.1.5).

10.1.4 Constructing organisational 'reality' from within: Members of the clinical practitioner coalition.

In sympathy with the dramatic theme running throughout the thesis, clinical practitioners (nurses and doctors) shaped the ongoing script by acting like a Greek chorus, willing to watch and wait

for an opportunity to judge MIS innovations. These judgements tended to be measured against the extent to which the management schemes were likely to inhibit clinical autonomy; that is to say, how they restricted the practitioner's ability to treat patients.

Throughout the case, practitioners intervened in the process of MIS development to reconfirm the importance of professional action. For example, in episode one, the nurses reacted strongly to the Unit Accountant's attempt to introduce ward budgeting. The plans were shelved due to the level of anxiety that the proposals caused throughout the nursing hierarchy. There were fears that budgeting would mean less time for 'hands on' care (6.1.4). Budgets were not seen as a way to free up purchasing power which might be diverted to increase the level of clinical activity.

Likewise, in episode four, recommendations on introducing resource management at the unit were rejected by medical representatives (9.1.3). Furthermore, in the same meeting, Matron was asked to comment on the position of nurses in the new era and failed to give an opinion. In adopting a policy of problem postponement (ie a management trait), discussions were avoided and for the time being, the nurses were protected from any further intrusions (9.1.5). These examples illustrate how clinical practitioners ensured that MIS developments would 'not get in the way' and preserve the status quo.

This is not to say that there were no practitioners 'enthusiastic' towards management innovations at Camblewick. There were consultants eager to take part in the task groups to pursue their

own political projects (8.1.3). In Cardiology and Renal, consultants shaped the ongoing script by 'chasing the budget' in an attempt to extend their power over the specialty. In Orthopaedics, early interest was shown in the idea of resource efficiency in relation to operating theatres. Status was another motive. Radiology was included because it did not want to be a 'boring old support department' whilst the MIU wanted to become more visible at the hospital and influence resource allocation. Having said that, consultants in Maternity and Radiology acted 'politically' by arranging only one task group meeting, two months into the project. This would be more in keeping with the findings of Pollitt et al (1988) who argue that doctors demonstrate a 'reluctance' to get involved in management.

10.1.5 Managerial versus professional action.

It can be deduced from the above two subsections that another major theme surrounding the introduction of information systems at Camblewick is the tension that exists between managerial and professional action. This may be illustrative of a general movement running throughout society in which managers are in the ascendancy and the status of the professional expert has been challenged and devalued (Sanderson, 1989). In the case study context, the tension between these forces can be understood in terms of the two different groups pursuing competing projects; those of economic utility and clinical autonomy. Tension threatened to degenerate into conflict when protagonists pursued innovations intended to extend management control in the area of clinical practice.

At Camblewick, episodes were linked through a recurring episode where actors played out the tension between managerial and professional action. In episode one, the key intervention was when Hart attempted to start budgeting for ward sisters at very short notice (6.1.3). This proposal to combine the parts of manager and nurse at the clinical level sent shock waves through the nursing divisions. Divisional Managers and Matron resisted this movement towards managerial action and protected the sisters from formal management responsibilities (6.1.5). The vital incident in the second episode was the UGM's decision to close operating theatres. In taking this 'strong' form of managerial action, the UGM had his opponents in the medical community. The drama of the Medical meeting (7.1.2) provided the ideal arena to enact the tension between managerial action (defended by Peterson) and professional action (defended by Cooper). In the final episode (9.1.3), recommendations to extend resource management to the clinical level also led to conflict between those protagonists supportive of managerial responsibility (Peterson and Toms) and those seemingly against it (Duncan and Cherry).

It is to the temporary resolution of conflict between managerial and professional action that the chapter now turns. There were at least three principle mechanisms for easing the tension between management and clinical practice at Camblewick. The first of these was the political use of language.

10.1.6 Creating continuity: The political use of language.

Pondy (quoted in Colville and Tomkins, 1989) has said that people have to translate visions into a language that they find meaningful in order that it may become shared and believed. Whilst Pondy emphasises the power of symbols to produce new organisational realities, it is equally possible that continuity can be created through the very same processes. In the case of Camblewick, this meant 'translating' management initiatives into gentle, almost superfluous exercises that were of secondary importance to clinical practice. Language served to mediate the meaning of information system developments so that they were less threatening to the medical and nursing communities.

The political use of language was particularly noticeable as a way of 'softening' and 'weakening' the original intentions behind management innovations. For example, in episode one, Matron reshaped the language of 'strict budgetary control' in terms of doing the 'housekeeping' (8.1.4). Similarly, having learned a lesson from the failed ward budgeting initiative, Hart reinterpreted 'Mark III' of his strategy in terms of an 'education exercise' rather than aimed at 'management control' (7.1.1). In episode two, the theme was continued. Toms transformed the intentions of the White Hart Plan from 'control' of the budget and the market philosophy of 'buying' of services to that of 'technical' exercise in information provision (7.1.4). In the last episode, Silver also acted 'politically' in attempting to 'soften' Toms' recommendations on resource management. For example, the General Services Manager preferred the title Clinical

'Manager' to that of Clinical 'Director' (9.1.2). All of these examples illustrate how potential conflict between managerial and professional action was temporarily resolved in the favour of the latter.

10.1.7 Creating continuity: The importance of comedy.

For the most part, comedy was used by managers in the case study setting to reduce tension. This tension was mainly that which existed between managers and doctors. Whenever doctors played out a 'stock' characterisation of the 'awkward', 'difficult' and single-minded practitioner, this was a trigger for comic relief. This was particularly noticeable in the UAB meetings. In episode two (7.1.4), senior management found some light entertainment in the comments of doctors on the Guy's video. Furthermore, the same group were amused by the fact that doctors in the Endoscopy department demonstrated a lack of cooperation in not wishing to take part in the CIP. Another significant example of managers laughing at the 'awkwardness' of the ongoing situation was in episode four (9.1.6). Towards the end of the steering group meeting, Toms made a joke about Duncan's antagonistic attitude toward his proposals.

This comic theme was not only to be found in relation to the UAB. Middle managers also used comedy to relieve tension caused by uncooperative doctors. In episode three (8.1.2), Martin provoked much laughter in the second support group meeting. This was in response to Duncan's letter which proclaimed that the Radiology Consultants' Group would be the appropriate task group structure

for discussing the CIP. Later in episode three (8.1.6), support group members started to use comedy to resolve tensions in other directions. Being increasingly subject to the central demands of backstage managers, their mishandling of previous national initiatives provided another source of comedy.

Comedy has been shown to be useful in helping actors come to terms with the great diversity of opinion to be found in the organisational world. In particular, comic acceptance enabled the UAB and the support group to 'manage' difficult relationships with clinical practitioners. However, doctors also used comedy to help to reconcile managers following a conflict situation. In episode four (9.1.7), Cherry was particularly active in this respect, attempting to 'heal the scars' of contest at the end of the Steering Group meeting. Silver accepted this amicable gesture on behalf of senior management, entering into a more frivolous mood by making sarcastic comments about consultants being on holiday throughout August. Thus, the comedy made sure that opposing groups could 'get along' once again.

10.1.8 Creating continuity: Manipulating management structures.

Management structures provided a third resource for temporarily resolving tension and maintaining the status quo at Camblewick. In episode three, members of the MEC lobbied Toms, the CIP Project Manager, to drop Endoscopy (a doubter amongst enthusiasts) from the task group list. In securing this change in the design of the project, the MEC condoned those in their community who did not want to take part in the scheme and reduced the status of the

management programme. This process was taken a step further when the Radiology Consultants' Group were quick to contest the official structure of the task group so as to accomodate their own desire for continuity rather than those of managers for a standardised approach.

Decisions supporting the representation of doctors at senior levels (as opposed to managers) were made in the final episode. Toms recommendation to the steering group was for the formation of a Management Board and an Executive Board. Members of the MEC rejected the Executive Board, arguing that the medical community could not be represented by one person. The outcome of this dispute was the formation of a Management Board. It was also agreed that the MEC would continue to meet for the time being. In sum, it seemed that large numbers of medical representatives at the senior level would spawn management accountability throughout the unit. Once more, management structures had been reshaped according to the wishes of the most powerful group; the medics.

10.1.9 MIS innovations are interpreted to reflect rather than transform organisational 'reality'.

The above three organisational processes pervaded MIS development at Camblewick and reaffirmed traditional rationales for action. Rather than stimulating new possibilities for organisational action, members' use of language, comedy and structure reflected a culture used to facilitating and protecting the activities of clinical practitioners. Despite the flurry of MIS innovation on site, ideas were transformed and projects postponed. Professional

action remained the primary concern at Camblewick and managerial action secondary.

In making this conclusion, it can be argued that managers were not guided by matters of economic utility but active in shielding the clinical core from too many intrusions. Matters related to efficiency and effectiveness were often overlooked and senior managers demonstrated a commitment to 'ecology' (Fisher, 1990:9). In Fisher's words, the ecology project 'takes into account the demands of the various interest groups involved with the service. The greatest weight will be given to the most significant or powerful groups'. At Camblewick, organisational processes surrounding MIS developments served to reconfirm the practitioner alliance (doctors and nurses) as the most powerful grouping.

10.2 Implications of the study.

Conclusions can be drawn from the study in at least three important areas; Camblewick Hospital (10.2.1); the NHS (10.2.2) and organisational literature (10.2.3).

10.2.1 Camblewick Hospital.

Having witnessed the development of two MIS initiatives at Camblewick, it appears that the practitioner led culture is highly sophisticated at maintaining itself. The historical position of the hospital has been that of not allowing financial controls to intrude into the management of clinical practice. Despite

pressures for change operating through the finance department, ward budgeting and resource management did not 'get in the way' of direct patient care.

An important factor contributing to the demise of the two MIS projects was that members of the Unit Team and middle management were still very much influenced by the traditional Camblewick culture and could see little possibility for change without the support of the clinical practitioners. Whilst members of the Unit Team accepted the logic of the financial situation facing the hospital, they showed a lack of commitment to MIS initiatives when confronted by objections from doctors or nurses. Having secured financial resources for the CIP, problem postponement, compromise and the need to maintain harmonious relationships seemed to be uppermost in the minds of these actors. At the middle management level, UAB members considered themselves powerless to affect the outcome of ward budgeting, HISS and resource management and often resorted to cynicism. It was as if these middle managers believed that clinicians would necessarily defeat the objectives of projects such as resource management.

With the majority of managers enacting and reenacting their relative powerlessness compared to the influence of the clinical practitioners, the events contributing to the development of both ward budgeting and the CIP often appeared to be little more than 'play acting'. To develop this interpretation further, the action portrayed in the four episodes could be understood in terms of a conspiracy; managers providing themselves with a purpose in life by phantasising about an unlikely scenario - that of

extending a sense of thrift to the clinical level. If this is indeed the case, then HISS may prove to be an expensive illusion for the Government!

Whilst the above may be an extreme view, the 'reality' of the situation was that the nurses and doctors were able to 'rebut' both the ward budgeting and resource management initiatives. A major problem remains that models such as resource management have yet to gain the support of the medical community. With this in mind, should the model of management be changed or the organisational culture? Of course, the reader would not expect the author to suggest mechanisms to change the culture for this sounds far too instrumental given the approach taken in this thesis (see 1.2.3). However, it may be appropriate to change the model of management being pursued so that it complements rather than contradicts the social context of the 'organisation'. Clinical audit would seem a more evolutionary step towards involving the majority of doctors in management rather than resource management.

Clinical audit involves bringing the financial consequences of professional medical practice to bear on decisions concerning future medical practice. It is a 'systematic, critical analysis of the *quality* of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient ('Medical Audit' Working Paper 6, Department of Health, 1989b:3). As such, matters related to the economic management of resources are not divorced from the context of the practitioner's work. At Camblewick,

developing HISS to support clinical audit from within the medical community may well reap more long term benefits than attempting to use Clinical Directors (and Directorates) for the management 'of' other clinical practitioners. This would be a matter for further research.

10.2.2 The NHS.

Taking a more general view of the Government's plans for the NHS, information systems are vital if an internal market in health care is to be established. Without more accurate information, hospital managers will not be able to price their services for trading purposes with any confidence. Given that Camblewick hospital is the 'flagship' of the HISS development, the problems experienced at the hospital do not bode well for a Government intent on rapid change throughout the service. As yet, the Camblewick case has shown that there is still a long way to go before the technical and social networks can work together.

In light of the Camblewick story, it would seem sensible for the Government to slow down its programme of reforms and face the fact that the reforms present hospitals with a number of practical challenges, of which MIS development is just one. Doctors, nurses and managers all have to be persuaded that there is a need for change if they are to make the new system work. It is all to the good that six health districts have recently been selected as demonstration sites to test the health service reforms. As Peter Griffiths (Deputy Chief Executive of the NHS Management Executive) commented:

> If this practical explanation helps reduce the level of anxiety people have about how they are going to cope with change, it will be beneficial (Brindle, The Guardian, 4th April, 1990).

Whilst it is far from clear whether findings from one pilot site (such as Camblewick) are transferable to another, these districts would be rich settings for further research into information system development in the health service.

10.2.3 Organisational Literature.

This case study makes important contributions to the literature on organisations in a number of ways. First, the case provides a rich description of two MIS initiatives in the same organisational context. This study adds to the growing stock of works looking at the cultural and political ramifications of implementing MIS (see section 1.5). In particular, the story of Camblewick Hospital is closely allied to the inquiry undertaken by Berry et al (1985) into the National Coal Board (1.5.3). In both the Berry study and this report, pressures for change became intertwined with information system innovation but these were resisted by a key group of actors. In the National Coal Board, colliery members at the 'coal face' rejected the 'logic of the market' in favour of the 'logic of production'. Similarly, doctors and nurses at Camblewick were able to defeat the 'logic of the market' with the 'logic of clinical practice'. Consequently, these studies tend to confirm that MIS developments as more reflective rather constitutive of organisational endeavour. Such a conclusion balances the studies of researchers such as Dent who have shown

that accounting systems are often suggestive of new possibilities for organisational action (see Dent, 1986, 1990).

Secondly, the case study contributes to the literature on organisational studies and research methods (eg. Bryman (ed.) 1988, 1989) by providing an account of the entire research process 'warts and all'. The theory underlying a qualitative research strategy was contrasted with doing the research in practice. It was emphasised that negotiating and maintaining access to people, documents and events was a continuous problem to be faced by the fieldworker. Different tactics to overcome this problem were put forward in relation to such areas as interview technique, the management of interpersonal relationships and the need to foster goodwill by writing management reports.

The Camblewick story makes a third contribution in terms of adding to the variety of models theorists have used to depict social processes in organisations (see Morgan, 1986). The 'soap opera' metaphor has been introduced as a way of portraying and analysing these processes. The metaphor is distinctive in that it extends the dramatic analogy beyond the theatre, concentrating on continuous action, the routine and unexpected aspects of everyday conduct, the interweaving of plots and moments of conflict resolution.

Adopting the 'soap opera' analogy does not preclude commenting on other organisational images. For example, the case study can provide a fourth contribution to the literature on organisational cultures. Harrison (in Wigley (1989)), describes three types of

culture that can be found in organisations; the power culture, the achievement culture and the support culture. Camblewick would seem to be pulled in the direction of a support culture. The attributes of the support culture are that people trust and care for one another and can be extremely loyal and committed to serving the 'organisation'. At its worst, the support culture demonstrates the tendency to avoid conflict in order to preserve harmony and decisions may be avoided out of regard for people's feelings. Thus, consensus may be overvalued. Camblewick exhibited many of these characteristics, reluctant to make changes which would upset the practitioner coalition. Indeed, from a philanthropic point of view, this may have been a fortunate tendency. Clinical work carried on inspite of the 'organisation' around it and management were made ineffective at restricting clinical activity in line with financial constraints.

The above discussion can also lead into speculations about managerial effectiveness. McNulty (forthcoming thesis) suggests that managerial effectiveness will largely depend on the relationship between the official and unofficial culture and structure. One of McNulty's ideal type states is that of 'dualism'. This is where there a strong official culture and structure and a strong unofficial culture and structure. In the case of Camblewick, there appeared to be a movement towards a 'dualistic' state in the tension that was exhibited between managerial and professional action. This needs further explanation.

The official stance of Camblewick's UGM (a doctor who was starting to act like a manager) was that the budget should be balanced and practitioners at the clinical level take an interest in managing resources more efficiently. Thus, information systems innovations were undertaken (ie. ward budgeting, the CIP) which were part of the official structure and suggested a strengthening in the official managerial culture of the hospital. However, the hospital's strong unofficial culture was based on the tradition of supporting clinical practitioners and particularly the doctors. It was this uneasy relationship which threatened the managerial effectiveness of the unit. Management projects were continuously hampered by the majority of consultants who either did not get involved in projects or if they did, lost interest in the development or sought to exploit them to suit their own projects in life.

In conceptual terms, both ward budgeting and resource management are about combining the part of manager and practitioner in one person rather than keeping them separate. McNulty's notion of 'dualism' can be extended by drawing a distinction between 'specialised' dualism and 'generalised' dualism. Specialised dualism promotes the continuation of people doing one task and not trying to combine duties. Thus, management and clinical practice would remain distinct performances. Conversely, generalised dualism promotes the idea that people should be a master of all trades and combine different parts. In the health service, this model is in vogue and illustrated by the increase in ward-managers and doctor-managers. At Camblewick, the development of information systems was one innovation which could take the

hospital away from specialised dualism and towards generalised dualism. The case study demonstrated that this evolution was constantly being delayed and postponed. This finding is in keeping with other studies of the implementation of hospital information systems. For example, Bourn and Bourn (1987) conclude their investigation of the development of a Regional Information Strategy by saying that:

> People refused to be dominated by the system and either ignored it, sabbotaged it or used methods of expedience to counteract it (1987:26).

This study makes a fifth and final contribution to the literature on organisational change. The development of ward budgeting and the CIP are clear examples of morphostatic change (Smith, 1982, Laughlin, 1988, 1989b). Morphostatic change is a first order change and involves 'making things look different while remaining basically the same' (Smith, 1982:318). Laughlin (1989b) explores two pathways of morphostatic change which leave the 'interpretive scheme' or culture of the 'organisation' in tact. The first is 'rebuttal' in which changes in management structure or decision processes are deflected so as to maintain the organisation exactly as it were before the intrusion. In the case study setting, the drama associated with ward budgeting demonstrates an effective 'rebuttal' of attempts to change the decision process. Nurses deflected the accountant's attempt to extend managerial control to nurses at the clinical level (see episode one). Similarly, the development of resource management (as one part of the CIP) was 'rebutted' by medical representatives in the fourth

episode. The Project Manager's recommendations included alterations in decision process and management structure and these were not acceptable to the medical lobby.

Laughlin (1989b) names the second pathway of morphostatic change a 'reorientation'. Reorientation involves changes to the subsystems (ie buildings, workers, machines, systems) but these are internalised into the workings of the 'organisation' in such a way as to protect the 'sacred' parts of the culture. At Camblewick, this 'sacred' place is the clinical level where patients receive treatments. Given the experience of ward budgeting and resource management, it is possible to speculate that the development of HISS may eventually constitute a 'reorientation'. This pathway would be traced if computing machines were installed in such a way that changing the subsystem of the 'organisation' did not challenge the traditional culture and protected the clinical core of the hospital. This is another matter for future research.

To end this discussion on organisational change it would seem appropriate to recall the conclusion made by Pettigrew (1985:439) in relation to his longitudinal, processual case study on ICI:

> ...continuity is a good deal easier to see than change. What is apparent is the continuity of existing dominant ideas in the [organisation], of existing frameworks of thought with their associated structures, systems and power relations all being used to interpret changes in external and internal context and continue the existing patterns of thought and action about strategy.

10.3 Conclusion.

This study has concentrated on providing an 'in-depth' analysis of MIS innovations in one case setting rather than researching the topic across a number of institutions. Having made the decision to opt for 'depth' rather than 'breadth', the question still remains as to whether the findings that have been drawn from this study are in any way transferable to other settings. This question is one that the author hopes to pursue in the future. The recent Government proposals for 'reforming' the NHS ('Working for Patients', Department of Health, 1989a) provide an excellent opportunity for conducting a comparative case study into the relationship between information system developments and organisational behaviour.

Appendix 1.

Exploratory interviews (January, 1988 to September 1988).

List of interviewees.

Unit Team:	Paul Hart (Unit Accountant) Kathy Silver (General Services Manager) Mrs Minter (Matron) Dr. Colin Peterson (UGM / Pathologist)
Consultants:	Dr. Blount (Renal Physician) Professor Bolton (Pathologist) Dr. Phil Smith (Radiology Manager)
Divisional: Managers	Tony Raymond (Acute) Pat Mooney (Health Care of the Elderly) Miss May Hooper (MIU) Mrs Barton (Theatres) Mrs McKay (Midwifery)
Ward Sisters:	Sister Thomas Sister Jenkins Sister Bell Sister Noakes
General : Services	David Lewis (Catering Manager) Edward Sharp (Laundry Manager) Brian Stranger (Estates Manager) Harriet Elms (Personnel Manager) Sally Martin (Medical Records Manager)
Departmental: Managers	Steve Gilbert (Out-Patients Manager) Jill Dukes (Paramedical Manager) Simon Toms (Medical Physics Manager / I.T. Adviser)
Assistant to: the UGM	Katie Wilcocks
Total:	25.

Appendix 2.

Research Proposal for Unit Team.

Background.

Nottingham Polytechnic is building up its research base in the School of Business. I joined the group in September to continue the research already begun in the health service. You will no doubt be aware that Terry McNulty has already undertaken a study throughout Northtown District Health Authority into management structures and organisational cultures. A natural progression from this comparative study is to focus attention on one particular hospital and observe, at close quarters, how management practices are changing.

The opportunity to carry out a detailed case study of the Camblewick Hospital arose through consultancy work contracted out to Neil Taylor and Bill Murphy of the Polytechnic. They have been assisting Paul Hart with the task of developing specialty costing in response to the 6th Korner Report.

My particular objective is to establish a legitimate role within the hospital as an information collector (rather than an interpreter or instant expert!) I am NOT in the business of making judgements about the effectiveness of the unit or individual managers.

There are two main thrusts to this data collection process:

1. Hospital Task.

Since Griffiths and Korner, there has been a growing awareness within the NHS that information is a resource that needs to be managed. In fact, the general approach of the Korner reports was to propose:

> ...the routine collection of a series of minimum data sets to provide, at reasonable cost, the basic information without which authorities and their officers would not be adequately informed when fulfilling their responsibilities.

Furthermore, the introduction of General Management has provided a focus for the use of such information. However, the emphasis of Korner appears to have been on data collection rather than data use. In an attempt to redress the balance, I envisage my task as collecting views on information needs from managers / budget holders / clinicians.

In conducting a personal interview, it is intended (subject to interviewee permission) to use a tape recorder. In doing so, complete confidentiality and anonymity is assured. I expect interviews to last about one hour.

The types of questions I would need to ask would cover broad areas and be open ended...for example:

What is their role? How do they fit into the organisation?
What are their responsibilities / main activities?
What information do they have?
What information do they use to carry out their activities?
What are their information needs?

Such broad questions allow ample opportunity for personnel to inform me of their perceptions about the most effective ways of using information to deliver health care.

Subsequent to the interviews, a report will be prepared for the Unit Team at a time to be agreed. This report will examine how information can be better tailored to user requirements. However, I shall be commenting upon themes which emerge from the data as opposed to catering for individual needs.

2. Research Task.

My role at the Polytechnic is that of Research Assistant whose main activity is to undertake a PhD over three years. Thus, for my purposes, the task outlined above can only act as a pilot study for identifying the ways in which information is used in the hospital and the perceived problems associated with such use. Rather than be content with this snapshot view, I envisage the need to conduct further 'in-depth' research to discover how management information processes are developing over time.

My doctoral research aims to assess the reasons why managers use data the way they do. Ultimately, it is people who determine whether certain information is regarded as essential to the control of health care. Therefore, it is important to adopt a cultural perspective towards the implementation of any information systems. It is my intention to look at how beliefs about what is 'relevant' or 'irrelevant' information are formed, developed and changed. Of particular interest, is whether new information shapes the style of management activity? Alternatively, does the dominant culture limit the use of new data?

The value of good cooperation is vital if I am to complete my thesis and this must not be overlooked. Indeed, the level of cooperation will partly determine the methods of research that are adopted. I hope I can gain a commitment from you to help me with my study.

I look forward to hearing your response to these proposals.

PHILIP MUNSON. 11th December, 1987.

Appendix 3.

Interview with Pat Mooney (17/2/1988).

An extract from the original transcript (page 10 of 15):

Philip Munson: With the medical doctors, you say they are a 'law unto themselves'...

Pat Mooney: Yes, I think the doctors, the senior registrars, ought to be monitoring more closely the junior doctors and they themselves be more mindful of the expenditure they are accruing because they don't ever see anything. I don't know if they think things are free. Certainly there is some incredible expenditure on drugs. I was able to raise it with the UGM. The General Manager thought I should raise it with one of the consultants on the Drugs and Therapeutic Committee but I didn't think it was my job to be doing that. So I raised it with the Pharmacy department [saying] 'I don't think that they should be jumping into the most expensive anti-biotic straight off. Would you like to bring it to the consultant's notice through the right channels?' Often, the outcome is very short lived.

COMMENT:

No head on debate with doctors about the prescribing of drugs. There is a sort of fear from managers to challenge them, so they pass it on to a committee and the informal practices continue. Lack of managerial action. This seems to be an example of problem postponement? Nobody is grasping the nettle. Given that the medics are not being told, are the doctors ignorant of the financial pressures the unit is under? Parochialism?

END.

Philip Munson: It does not look as though there is that openness where you can go and discuss these issues with doctors.

Pat Mooney: They see it as a threat. It's their professional credibility you are questioning...

Appendix 4.

Two unedited extracts from my field diary.

14/4/1988: I talked with Harriet Elms today. She was tartier than I expected and quite detached when she wanted to be. Early on, she started to gossip about some of the doctors. Apparently, Professor Bolton has a strong power base but she did not know why for he is not represented within the formal management structure. Elms said that Williams always consults Bolton if there is an important decision to be made. This ties in with what Terry said about Bolton encouraging Peterson to take the UGM's job. I should question Bolton on this matter next week. There was also some mention of Blount who is supposed to be into patient information but intolerant of management. This connects with my own interview with Blount (see transcript, particularly closing questions)...

7/3/1989: I've been thinking about my access at the hospital once again. I seem to have got myself into a spot of difficulty. Richard said to 'mine away at the coal face' and yet I have only been to 3 task group meetings so far. This isn't satisfactory for this is the key level of inquiry and is the point where the project touches the shoulder of the clinician. The problem stems from my personality in that I feel rather marginal at the hospital and don't want to 'push' for access. I think Toms has largely mismanaged the rotating role of the external trio (me, Tandy and Carter). I thought that my role would involve visiting all task groups but Tandy has latched onto Radiology and Carter to Renal - no rotation has occured. I have managed to get to 3 other task groups which is fine but I have misjudged the time scale. Still, I can always rely on secondary sources (hearsay at the support group meetings). Anyway, to try to rectify the position, I have asked if I can sit in on the remainder of the meetings with Sally and Simon's task group. I know these two well so they should do their best to include me...

Appendix 5.

Information - Sources, Uses and Needs within Camblewick Hospital.

A Research Report by Philip Munson.

Nottingham Business School, Nottingham Polytechnic.

A. Introduction.

In November 1987, I drafted a paper for the Unit Team which described my research interests. Put simply, the project aims to investigate how 'formal' information (eg financial, workload and manpower) is being absorbed into management processes at the hospital. Since the Unit Team gave this study the 'go ahead' in January, I have undertaken a total of 25 interviews with senior managers, nurses and medical staff. This report is a summary of my findings from the pilot study. However, one word of caution; it must be remembered that this paper is written by a newcomer to organisational life at Camblewick. In the likely event of having misled, misunderstood or ignored certain points, I would appreciate any comments that will 'put me right'.

The Problem.

A current problem for management at the Camblewick is that there are 'more wants than money' when it comes to delivering health services. As one senior manager said to me, 'the biggest problem is to contain increasing activity within a cash limited budget.' Given this practical problem as a focus, how is this situation to be managed? Who needs information? What information is required? How often? These questions are very difficult to answer. All I can hope for is that this paper be seen as a discussion document to help people ask appropriate questions eg. how do health service professionals keep informed? To what purpose?

Plan of paper.

The paper begins by highlighting the distinctive features of the Camblewick's 'culture'. Typical methods of keeping informed at the hospital are then contrasted with more formal approaches. The next section of the report concentrates on formal information as a topic of interest. Common information sources, uses and needs throughout the hospital are presented. Some general themes are raised at this stage which pose the question about what role computer-based information should play in the organisation. Finally, some tentative conclusions are made and future research areas suggested.

B. Camblewick Organisation.

How computer-based information penetrates daily work activity in the hospital depends very much on the culture of the organisation. One thing that is very noticeable upon entering the hospital is its tradition and the loyalty staff feel towards the place. The initial impression is one of people being

'chatty' and 'cooperative' with the hospital 'doctor and nurse led' rather than directed through any tight administrative system. Camblewick's strong sense of identity appears to be linked to antithetical comparisons with the Grand. To paraphrase, Camblewick has a long history, is benevolent and feels rather neglected whilst the Grand is precocious and demanding, seeking the public gaze. Consider the following images of the two hospitals which I created from a selection of the respondents' comments:

Mother Nature:

Camblewick is sprawled across a green campus but, despite its size, is said to retain a 'cottage' feel to it. Patients are thought to prefer Camblewick to the Grand because the atmosphere is more friendly. In fact, the hospital has been portrayed as a 'family' or 'village' where relations are informal, favours are frequently traded and people pull together 'making silk purses out of sows ears' (a reference to the belief that Camblewick is underfunded compared to the Grand!). In short, it seems common for decisions to be made on the main corridor or over lunch rather than being the sole province of formal meetings.

The Spoilt Child:

The Grand (which I have heard referred to as 'the gin palace', 'the concrete monstrosity' and 'the other side of town') is pictured by some respondents to be a modern, flashy multi-storey block with a maze of corridors. Indeed, I have been told that it is easy to get lost in the building and seemingly, there is nobody there to help you. The atmosphere in the hospital has been described as impersonal and unfriendly. A lot of decisions are thought to be taken through formal committee structures in a rather regimented manner and the staff, particularly the medics, are characterised by some to be arrogant and individualistic compared to those at Camblewick.

Of course, the above is a distorted picture. I am told that the jealousies between the two acute hospitals have lessened since the arrival of the latest general manager and that the two hospitals have a more cooperative relationship than the past.

Informality versus Formality.

What does seem to be significant is that the Camblewick style of managing health services is very much more informal than the Grand. Consequently, staff have argued that 'the formal channels of communication are not used as well as they might be'. Staff cited examples of poor communication between the planning group and the Unit Team and how you have to read the Northtown Post to find what is happening in Northtown Health Authority! Another common illustration was how major changes in consultant practices (eg. the prescribing of drugs or the arrival of new consultant staff) are, on occasions, only picked up 'post' the event.

It is only recently that the technology has been available in the health service to provide more formal data. This is not to say that collecting data is a new undertaking. Before Korner, hospitals had a number of statutory returns that they were required to keep (ie. Stat 1 and SH3) and these statistics would be made available to unit administration. However, despite such facilities, staff at the Camblewick seem to prefer to do business by 'word of mouth'. Formal data (eg. Korner, financial statements) has had to be collected against a tradition of informal practices. Those staff more resistant to change are still inexperienced in using 'hard' information at the local level. Others are learning quickly. As more information becomes available from the PIS and from the finance department, staff need to become aware of what information is available and decide what questions they want answered, which data can help (ie which data will be transformed to information) and which data shall remain 'dumb'.

C. Information Sources, Uses and Needs.

A summary of my findings from the study are given in the table below. Common information sources, uses and needs are tabulated.

Common Sources.	Common Uses.
Patient information.	Managing patient care.
Budget statements	Budget-setting, cost monitoring, appeals.
Bed-state returns.	Tracking patients.
Walk the territory.	Identifying problems, testing the climate.
Meetings.	Deciding & reporting action.
Ward stock lists.	Monitoring use.
Measures of activity.	Making appeals & defending your patch.
Informal networks & gossip.	Influencing others.

Information Needs.

More timely and accurate financial statements for those managers keen to keep costs of a service within cash limits.

Training for ward budgeting / housekeeping.

Quality measures (eg. readmission rates of patients) and not just costs.

A Note on Information Sources.

Budget information includes the staff establishment.

Meetings refers to UAB, Unit Team, Medical Committees, Divisional & General Services etc.

Examples of activity measures (ie outputs) are the no. of patient treated, no. of tests performed, no. of meals served, no. of sheets cleaned etc.

A Note on Information Uses.

The Bed-state report is used by nurses to confirm the contents of the PAS. This check should pick up any patient details not routinely captured by the PAS.

In addition to review meetings, the budget and supplementary financial information is increasingly being used by managers to monitor the cost of providing services.

Some measure of activity is essential to the presentation of cases of need and the defending of present levels of expenditure.

Informal networks are being used to educate medical and nursing staff towards financial responsibility...this is working more successfully with nurses than with doctors who still sit outside the management structure to a large degree.

A Note on Information Needs.

There can be no universal prescriptions for the information needs of health service professionals. Needs are difficult to specify, especially if managers are not used to handling formal, computer-based data.

It is, of course, much easier to criticise the information that is being provided. The complaints concerning financial information (inaccurate and late) could be raised for different sorts of reasons. Firstly, there could be frustration at not having regular information which reflects a manager's perception of the service. Secondly, there may be a reluctance to get involved in the management problem and maintain existing arrangements in the hospital. Despite criticism, there is a general feeling that the budgetary information is improving. A question worth asking is 'What if the information was right?'

D. <u>General Themes.</u>

Roles in the unit are slowly being redefined.

There is a strong informal network at the hospital. Some know the rules whereas others do not. Apparently, consultants used to the rules and regulations of the Grand who try to 'throw their weight around' find that 'that isn't the way to do it' at Camblewick.

Better use could be made of formal gatherings such as the UAB. There is a feeling of mystique about the activities of the Unit Team which leads to unease about the corporate direction of the hospital. Since I started my interviews, this problem has been recognised and thought through at a Unit Team 'time out', culminating in the White Hart Plan.

Patient information is competently tracked through a combination of Medical Records staff, nurses checks and the PAS. Checking the bed-state appears to have been accepted as a 'necessary' task by nursing staff but not one they relish. This duty is still perceived to be primarily for the benefit of others (eg. Medical Records Department) rather than the nurses themselves.

The use of Korner data is limited at this stage. Comparisons with services in other institutions may not be relevant. Without a detailed knowledge of how the figures are constructed, can you be sure you are comparing 'like with like?' Caution is required when making in-house comparisons using Korner and pre-Korner data.

With regard to the presentation of information, senior managers expressed a desire for summarised, graphical information rather than raw figures which are difficult to interpret. Further investment in computer technology is needed before this can be done. There were, however, surprisingly few comments made in relation to the need for financial and patient related data packs. This could well be due to a lack of awareness as to what information is available and inexperience in manipulating computer-based data.

Two major themes emerged from the study. These are:

(1) A well developed external orientation.

Formal reports detailing cases of need are commonly made to Unit management but the financial position is such that this is insufficient in itself to secure funding.

(2) An underdeveloped internal orientation.

Internal cost control within tight budgets is a relatively new phenomena to staff at Camblewick. Some areas have been more exposed to controlling pressures than others eg. competitive tendering has meant tougher cost control management for the managers of Domestics, Catering and Laundry. In clinical circles, this process towards internal cost control has hardly begun. The resource management initiative *, as detailed in the White Hart Plan, aims to get clinicians more involved in the budgetary process.

* recently renamed the Clinical Information Project

E. Conclusions.

Nurses, doctors and administrators cannot be expected to become resource managers overnight because of their training. Getting

the technical information accurate may be one problem but an equal one is to make data 'meaningful' to people in terms of the nature, context or effects of their work. It is important to note that information cannot be considered neutral because it may well be used to support a particular set of interests whilst neglecting others. To take an example, figures on bed-occupancy may suggest to a manager that improved performance is necessary and new working practices appropriate. Doctors could, understandably, see such information as a management tool to weaken their autonomy as individual operators. Thus, the 'political' element needs to be recognised when selecting and using information in any situation. I would welcome the opportunity to explore such issues further as staff at the Camblewick decide how significant formal, computer-based information is going to be in managing health services.

F. Further Research interests.

Before the creation of the White Hart Plan, I had listed three areas of research which seemed particularly fruitful from a practical and theoretical point of view. These three areas were:

1. At a strategic level, to plot how the Unit Team use the new information package to make or justify decisions.

2. At a middle management level, to follow the development of a multi-professional body, such as the Drugs Therapeutic Committee, as it attempts to define its role in curbing spending.

3. Follow up on the information dissemination which is being planned via Sally Martin. This would involve asking a selected sample of recipients (particularly medical staff) for their reactions to the information and why they take the position they do?

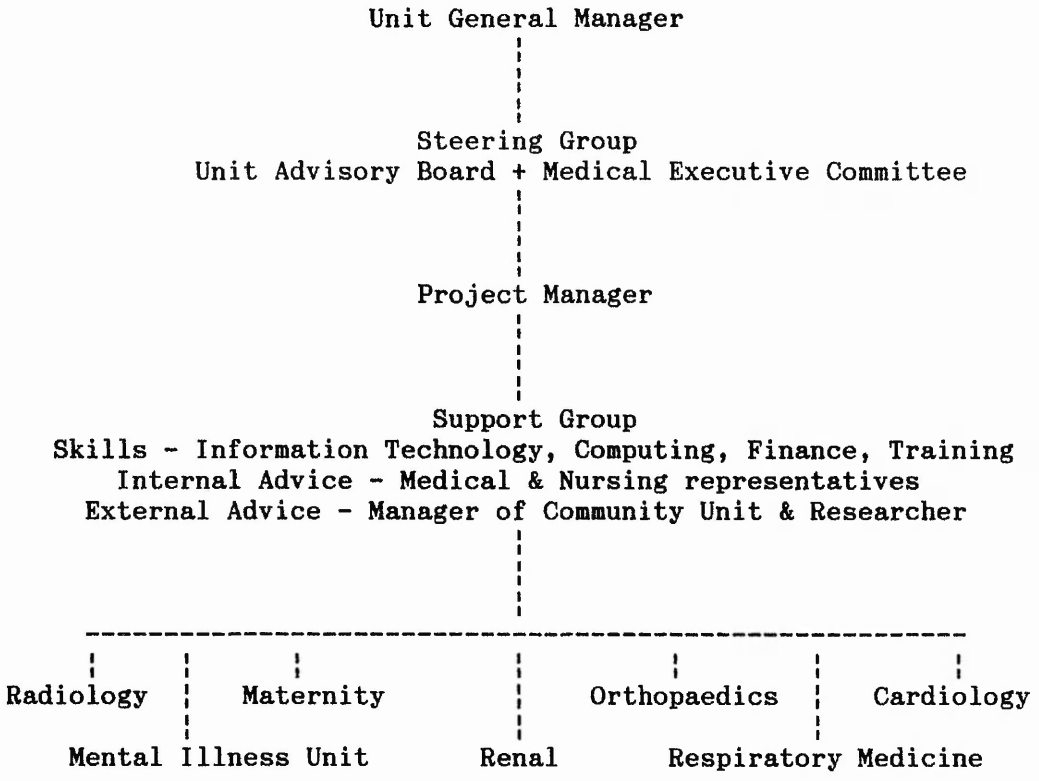
Thus, the idea was to follow the various journies of this 'new' information to the point of use.

The above suggestions now need to be reviewed in light of the White Hart Plan. It may be that the Plan provides a new set of opportunities for 'action research'. This approach involves the researcher (ie. myself) collaborating in solving problems of the organisation (ie. Camblewick) in such a way that problem-solving and knowledge-acquisition gain from one another so that advantage accrues to the organisation and the researcher. Obviously, I am running ahead of myself here because any proposals would need the support of the Project Manager and the UAB. However, I had intended to spend 3 days a week for the next 6 months in the hospital (this time period is negotiable) and it would seem far preferable for me to become involved in the Clinical Information Project rather than take a more passive role and risk 'getting in the way'. I look forward to further discussions on this subject.

Philip Munson. 3/11/88.

Appendix 6.

Structure of the Clinical Information Project.



* Each task group is made up of a Consultant, a Departmental / Nurse Manager and a Support Group member.

Appendix 7.

Support Group Members.

Simon Toms (CIP Project Manager)
Paul Hart (Unit Accountant)
Sally Martin (Medical Records Manager)
Keith Leighton (Pharmacy Manager)
Phil Smith (Radiology Manager)
Tracey Tandy (District Training Officer)
Carl Carter (Manager of the Community Unit)
Mrs Vale (Assistant to Matron)
Harry Abbot (Information Officer)
Barry Carling (Deputy Unit Accountant)
Rosemary Roper (Medical Physics)
Norman Old (Computer Specialist)
Fiona Young (Administrator)
Philip Munson (Researcher)

Appendix 8.

Extract from Transcribed Notes.

Support Group Meeting 5 (24/1/89).

Venue: PGMEC.

Time: 11 o'clock.

Present: Barry, Fiona, Simon, Rosemary, Norman, Tracey, Phil, Sally, Harry & myself. Also Ted (a guest from District).

I entered room 2 to find Tracey and Phil sitting together and exchanging polite conversation with regard to Tracey's possible attendance at the Radiology 'task' group meetings on Mondays. Phil was saying she would have to wait until a week after next until he had checked with all the consultants. I sat opposite them and wondered whether to jump in and get an appointment myself to see Phil. I thought this rather a hasty move and waited. Norman, Rosemary and Ted came in - Rosemary looked particularly cheerful and smiled at me. She was talking to Ted and I overheard her say that he should try the command control P...technical chatter. Tracey was looking around and wondering what to say...luckily Simon arrived and greeted us with a booming 'morning'.

He was accompanied by a young girl (Fiona) who looked as though she would rather be anywhere but here. I assumed she was the secretary / administrator by her dress (jumper and slacks rather than the suits of Sally and Tracey and white coat of Rosemary) and this was later confirmed by Simon.

Tracey went over to see Simon and presented him with more publicity on training day seminars on Clinical Information Systems. Simon looked over it with mild interest. He then offered the Guy's video out for further consumption and there was little response from the group until Phil said he would take it for Mr Hall - he didn't want to see it. Phil started firing a question at Simon - would anyone like to come along to a meeting he was having about purchasing an Xray computer on the 1/2/89...he was meeting somebody (I didn't catch the name) to discuss 'different models' for tackling the CIP. He looked about him but only Simon and myself seemed to be listening. Simon suggested perhaps one of the 'external advisors' could attend - myself, Tracey or Carl (latter not at the meeting) - Phil noticed I was paying attention and was pleased to have an audience and someone taking an interest in his own patch. I grabbed the opportunity to see him, saying I would be delighted to go along - such a meeting is a chance to further my acquaintance with Phil - Phil's office at 2 o'clock.

Simon had handed out us a report (Supp5/1) in the meeting. Barry had not got a copy and asked for one..Simon joked that he hadn't given him one because weren't any £ signs in it (actually there are in the appendix!) Simon wanted to talk through the report. It was the submission that went to Dr Dixon at District and then

onto Region putting the case for financial support for the CIP at Camblewick. Interestingly, this is dated the 13/12/88 - before any meetings of this group and Simon never floated the ideas put forward other than as an informing exercise. Since he had run throught the arguments in a previous meeting of the Support group, Simon turned attention to the revised management structure of the UAB. He pointed out that Medical Physics was not represented, also not Medical Records according to Sally which ruffled her feathers. Simon joked about how they must have been deviants not to be included. The scheme is helpful to me because it highlights who I should I try to contact during my discussions for Simon.

After the chart, the report focuses on the two aspects that Regional officers had pointed out when considering the bid when visiting Camblewick. Nurse Management System (NMS) and the costs of the project. Simon discussed these. The paragraph on NMS was, according to Simon, really a cover for the fact that 'we don't know what to do yet'...this 'we' includes District. Simon stressed that Camblewick needs to evaluate plans in consultation with District plans in order to 'be seen' by Region to be developing a nursing management system. Simon mentioned that there were problems associated with systems such as FIP in paramedics. Theatres had rejected the FIP model. Simon had included a money allocation for NMS in the bid as a contribution to a District wide system. He needed to talk further with Alan Badger at District. Simon stressed the need to be 'doing something' on the NMS. Simon added that he was going to see Matron about a senior nurse joining the group and having specific responsibility for the nursing system.

Phil suggested Simon might be hiding some of the problems associated with nursing systems...Simon denied this but enlarged upon the fact that in the past, there had been worries about nurses access to test results which had yet to be confirmed. Phil talked of problems in Xray to do with outflows not inflows...ultimately, he was looking to have requests on line into Xray dept. [I found this conversation a trifle confusing].

Sally piped up with a series of what were termed 'pessimistic' comments by Simon. She suggested that you could already access the bed state on screen and that this could go out to the wards if the equipment was installed. However, there was a quality control problem if nurses were to use terminals and actually input data since 'they don't get the paperwork right as it is'. Putting terminals on wards was a big 'cultural change' - a big step. Accuracy of information was important if the project is to be credible. Phil suggested that we get in specialist trained operators rather than have nurses doing the computing. Sally said that we already had them - they were called Medical Records staff (laugh). Simon wanted to establish that a NMS involving ward terminals and ward budgets was only a distant goal - an 'end result'. Rosemary, said how in maternity, midwives had improved their computing skills considerably after a poor start. However, Sally saw midwives as a different kettle of fish to nurses on the wards... Simon agreed that sometimes unqualified nurses were left in charge of the ward and may well not have the training to operate any ward-based system. Sally said that such a project as

NMS would need money put into training staff and a commitment on behalf of the nursing staff. She seemed worried at the prospect.

Phil asked what does a ward based management system actually mean? Simon stated that there were 2 tiers of information - ward-based information that nurses need and management information that a senior nurse would need. This did not seem a satisfactory answer...where is the cut off point? Simon did admit the distinction may be blurred between the two... [I felt this conversation was too abstract]. Phil did try to pin Simon down...would management information mean DRG, case mix data? Simon said that that would be the goal. Phil seemed keen to ensure the direction of the project would be towards seperate ward-based clinical cells. Simon said that that was a general direction that the group had emerged with in the early meetings. Simon moved the debate on, saying that he thought that there 'aren't any differences between us' on this subject.

Turning to costing, Simon said the bid was for 1/2 million or so over 3 years. He infered that Region were guessing at the amount available since they themselves had only heard snippets of information from the DHSS. Simon is to have 60% of time into project which would represent a cost. Region wanted to know how much time this represented. Simon looked over the bid, remarking on the 3 skilled members who were needed on the project - Information (Harry), finance (Barry) and computing skills (Norman). So the emphasis was on using 'in house skills' and sending monies to depts. rather than taking members such as Barry away from unit accounts...ie. he would need the support of his dept. and need to keep up with developments in it.. We later learned from Simon (in response to Barry's question) that the 3 posts above requested in the bid were full time equivalents.

Simon stated there was a need to improve clinical coding since the accuracy of that would be vital to the credibility of CIP's information. He asked Sally if she agreed - she did. In year 2, Simon saw the terminals going out and that a post had been created for Computer Services Officer whose job would be to help users in difficulty and train staff. In addition to secretarial support, there would need to be a link between the group and services developments. This would be for the first year when Simon saw the main difficulties of coordination arising. Training services would also needed to be bought. Simon had put down the help of NHSTC given that a consultant had been brought in to help the unit team when they went for their time out. Tracey asked if the consultant was Tony Terrel...it was. Simon would get him to come down for a talk.

There would be a lot of effort put in early into discovering what info would be sent out to the user so that 'we would know where we are going and what we are doing' (Simon).

Offices...still no date for moving into Dr Aires building (HCE) between Barnard and Harvey House.

The cost of the bid had had to be scaled down from support group members original estimates...apparently Keith had been asking for

a 'fortune' (Simon). Simon mentioned that District was buying another VAX - Simon asked Ted if this had been bought yet - Ted said that no but the money was on one side.

Simon then did the intro's (better late than never - he had been waiting for Carl to arrive). Simon introduced his secretary (Medical Physics) Fiona who would provide us with support until the secretary allocation had been sorted out. Simon said that we would all know Ted and then remembered me and introduced me to him. Ted is working on DRG's at District. Simon remarked at how there was some 'interesting' stuff emerging. He had been with Paul who was looking over a report on DRG's. Apparently, there were some consultants (general medicine) that were keeping patients in 2 times as long as need be (Simon)... these consultant 'spent a lot of time at HQ' (are they refering to Dr Dixon?) and would have 'problems if funding eventually is allocated on DRG basis'. Sally said that there were probably individual factors to consider in such a case (ie patient). Simon asked if Ted would do a talk on DRG's for the group. Ted said a lot of it was confidential...Simon said we could blank out the consultant names. Sally said we could have a game guessing the consultant. Harry made a rare contribution saying that Ted should leave the consultant numbers on. Simon laughed and said that this was childish humour...

Appendix 9.

The Task Groups.

1. Renal Services:

Dr. Blount (Renal Physician)
Brenda White (Nurse Manager)
Norman Old (Support Group Member)
Carl Carter (Observer)

2. Maternity Services:

Mr. Barnes (Obstetrician)
Mrs. Mackay (Divisional Manager)
Rosemary Roper (Support Group Member)

3. Mental Illness Unit:

Dr. Owen (Consultant)
May Hooper (Divisional Manager)
Barry Carling (Support Group Member)
Philip Munson (Observer)

4. Orthopaedics:

Mr. Ball (Consultant)
Mr. Monkton (Consultant)
Mrs. Dent (Nurse Manager)
Harry Abbot (Support Group Member)
Philip Munson (Observer)

5. Cardiology:

Dr. Marshall (Cardiologist)
Jill Dukes (Para-Medical Manager)
Sally Martin (Support Group Member)
Philip Munson (Observer)

6. Respiratory Medicine:

Professor Tatum (Head of Department)
Andrea Morgan (Nurse Manager)
Keith Leighton (Support Group Member)

7. Endoscopy:

Void.

8. Radiology:

Don Duncan (Consultant Radiologist)
Mr Hall (Technician)
Phil Smith (Radiology Manager)
Tracey Tandy (Observer)

This group merged into the Radiology Consultants Group.

Appendix 10

Interviewees (UAB): Inspection Period (February - March, 1989)

Paul Hart (Unit Accountant)
Steve Gilbert (Out-Patient Manager)
Kathy Silver (General Services Manager)
Jill Dukes (Para-Medical Manager)
Harriet Elms (Personnel Manager)
Mrs. Minter (Matron)
Phil Smith (Radiology Manager)
Christine Docks (Pathology Coordinator)
Mr. Williams (Surgeon, Chairman of the MEC)
Tom Jones (Planning Manager)

Total: 10

Appendix 11

The Clinical Information Project:
Commenting on feedback from members of the Unit Advisory Board.

A Report by Philip Munson,
Nottingham Polytechnic, April 1989.

The purpose of this paper is not to put forward a definitive list of views that can be said to be held by the majority of members on the Unit Advisory Board (UAB). It is simply to use the discussions that I have had over the last two months to suggest some issues which need to be taken into account when evaluating the Clinical Information Project (CIP).

Conceptualising the CIP.

The original aim of the CIP was to 'provide clinicians with information about their services and the resources that they use, and ultimately, to involve them in the management of those resources'. The project is, therefore, clinician centred and this has been borne out by the focus of the discussions that have taken place during meetings of the task groups. This paper attempts to redress the balance by gathering and interpreting the views of managers of the support services.

The CIP can be conceptualised in terms of a matrix organisation. Six of the task groups (ie. Maternity, Renal, Orthopaedics, Respiratory Medicine, Cardiology and the MIU) can be thought of as representing the 'delivery' side of the health service (ie the vertical axis of the matrix). These clinical services rely on a number of support services (eg. Nursing, Pathology, Radiology, Pharmacy, Paramedical services, Personnel, Finance, Domestics, Catering, Laundry, Portering, Works etc) in order to carry out treatments and these can be thought of as 'supply' services (ie. the horizontal axis of the matrix).

Theoretically, each delivery and supply department could be designated as a responsibility centre whose director has clearly defined authority and responsibility. However, the CIP seems to have been set up with the objective of providing those individuals with control over the costs of delivering health services (ie. clinicians) with information which shall reveal the impact that their actions have on the level of these costs. Consequently, only the delivery departments can strictly be considered as responsibility centres. However, purely considering the delivery side of the matrix would be a gross mistake. It is important to contemplate the horizontal side of the matrix which provides the environment in which patient and doctor are brought together. This paper shall contemplate the implications of the CIP for managers of the supply services.

Supply Groups and the CIP.

The development of the CIP was a topic of considerable interest to members of the UAB. Not surprisingly, there was a considerable

variety in reaction to the project. For clarity, I shall discuss this reaction in three sections. The first section explores the nature of the change envisaged by supply service managers as a result of implementing the CIP. The second part focuses on the manner in which the medical profession will be represented in the new arrangements. Lastly and by no means least, the final section examines how the project will 'fit' with the other professional groups in the hospital.

The CIP reconsidered. What is the vision?

Given the experimental nature of the CIP, there appeared to be a high level of uncertainty surrounding the CIP. At times, this provided a healthy tension to the discussion but at others, verged on total apprehension. Taking the comments of managers as a whole, the CIP represented another structural change. It was perceived that a number of task groups (estimates ranged from ten to twenty) would be set up based primarily around specialties. These groups should ideally consist of a medical, nursing and administrative representative. The leader of the group needed to be elected from the three and many thought that this would be the medic. The triad's priorities should be to monitor and plan for its own activities in light of its budget. Delivery units would pay for services received from supply departments with the latter remaining largely as they are now.

Given this skeletal model, further questioning uncovered a certain amount of confusion. Was the CIP solely about the provision of information to clinical directors? ie anticipated, standard and actual patient costs with an overhead figure for general service provision. Alternatively, was the project more about the use of this sensitive, patient-based information. If so, who would be using this information eg. would managers use it to expose differences in clinical practice or would clinicians use it to educate themselves?

For many I spoke to, changes in the use of information seemed to imply changes in the management of the hospital. Assuming that the delivery groups would be managed by clinicians, how much autonomy would such a clinical director enjoy? What authority would this individual have? What rules would there be to govern budgetary provision and control, service provision and the use of supply departments? Furthermore, what happens when the money runs out? Apart from these concerns, much discussion focussed on the 'people' aspects of managing change and how this was thought to be neglected in the negotiations concerning the CIP. There was considerable agreement that the CIP was set up as a 'technical', 'costing' and 'computing' exercise rather than confronting the real problem; - that of changing attitudes (ie. particularly medic's ideas about the nature of management) within the hospital.

There were a number of unintended consequences that some UAB managers anticipated as a result of developing the CIP in a very short time scale. Of these, the most significant one related to one possible objective of the CIP, namely, to increase the control over those costs which could be influenced by clinicians eg. drugs and laboratory tests. Such a movement was thought likely

to undermine the tight control that has been achieved over other support services. If, for example, the paramedical services were split up and no longer controlled by the head of the profession, would this mean an increase in the costs of providing services to delivery groups? ie any increase in cost could be charged out to the director of such a delivery group. On a more optimistic note, at least it was considered that the buying and selling of services between different departments would make clinicians start to think about their actions.

With regard to the future of the CIP programme, there was some agreement that the review of the task groups would produce a basic, standardised model. If the project was extended to other departments on the campus, such a model could be adapted to suit the opinions of professionals within each department. Any plans to extend the project throughout the campus would need a campaign with the remit to deliver a clear and simple message to all staff as to the purpose of the project and why it is important to support it.

The Delivery Side of the Matrix: Medics and the CIP.

From talks with members of the UAB, it seems clear to me that there a two distinctive cultures within the hospital. Put simply, these are the medical community and everybody else. Despite the various disciplines of members represented on the UAB, all of them had a clear vision of the medical culture. Senior medics were considered to be powerful personalities that could introduce service developments and were secure in the belief that 'no one can take any decisions without me'. In light of this, doctors would turn up to committee meetings if they did not like some new change in the way the hospital was managed and stay away if they were happy, many content to offload problems onto managers. In essence, the majority of medics still remain outside the management structure believing that 'doctors should do the doctoring' and concentrate on their own patch, maintaining a 'stand off' approach to management. It was even suggested on more than one occasion, that some members of the medical community may not know anything about the CIP.

Given these opinions of doctors, there was disquiet about whether those medical staff involved in the CIP had been picked because they were the interested ones who wanted to 'run their own show'. This was thought to leave many medics uncommitted to the project. Given that the CIP involves the clinicians having to make the biggest changes in their behaviour, is it still 'better to be outside [the management structure] than in'? A policy of being outside of management, hiding under vague notions concerning the protection of clinical freedom, allows doctors to continue to take managerial control out of the system. As a result, project innovations present no real challenge to medic's ideas that 'resourcing constraints are unacceptable'.

On the whole, UAB members considered doctors to be 'bad administrators' and poor at man management. If clinicians were to become clinical directors of delivery groups in the CIP, it was said that they would manage 'without responsibility and

accountability.' Such a thought led some UAB members to raise the legitimate question - What is the role of the clinical director? Further questions follow on from this - What would directors be responsible for? Who would they be accountable to? What authority would be vested in them? For example, would they be able to have the final say on which services they wanted to opt in or out of and overlook the advice of supply service managers? Would clinical directors be left free to pursue their own pet projects?

The above debate does not confront the problem of how feasible it is to appoint a clinician as director of a group over other senior doctors in a specialty. For example, in Pathology (a supply department), appointing a clinical director to manage the profession would be resisted on the grounds that there are many different strands within Pathology and no one person could control all of these without 'managing in ignorance'. Consequently, if such a director found resistance to establishing this new found power base from his / her colleagues, would the appointment of a clinical director to a delivery group give the appearance of change without significantly influencing the direction of doctors' actions at the clinical level? Many I talked to thought that this issue would be fudged in the review because it was an unresolvable problem.

On a more positive note, it was suggested to me that doctors are interested in resource utilisation eg. CT scanner and theatre time. Rather than managers questioning doctors' use of such facilities, it was considered that medics should be encouraged to do this questioning themselves and monitor their own performance through a form of medical audit.

The Supply Side of the Matrix: The Professions and the CIP.

Funding the support services on the supply side of the matrix was a particular topic of interest amongst UAB managers. Services such as Finance, Planning and Personnel, favoured an approach whereby money was top sliced from the unit's budget and given direct to the supply service. This could be regained by apportioning a fixed overhead charge across the delivery groups given that they all benefit from such services. The main problem envisaged over this method of funding was that the services of, for example, the Planning department, may not be split equally amongst the delivery groups over the financial year. However, such a scheme was seen as preferable to that of administrative functions having to charge out a specified sum for any help given. eg. Personnel charging X pounds for recruiting a member of staff to a delivery group.

With the introduction of a Hospital Information System, supply services such as Radiology, Pathology and Pharmacy could, in theory, charge directors of delivery groups a fixed charge for providing a specific Xray, laboratory test or drug respectively. Since these items can be controlled directly by clinicians, then the costs would need to be identified in any information system for clinical directors. Services such as nursing and paramedical services, could also be bought in by managers of the delivery groups. However, would this mean supply managers having

individual contracts with the heads of delivery groups and would they need to be reviewed on a regular basis (ie. monthly). Such a mechanism certainly seems clumsy administratively and would be very costly.

For other services such as Catering, Domestics and Laundry, competitive tendering has prepared them for having to provide a service at a certain cost at agreed standards. These could be charged out as a general overhead rather than trying to allocate them to specific delivery groups. Apart from being a complex procedure, clinical directors cannot influence such expenditure and it was thought that they have no desire to. There has also been talk of the domestic staff (as well as the porters and Medical Record's staff) becoming accountable to a ward manager (eg. a ward sister) in the new structural arrangements. Would such a move sever these services connections with the general services department?

Clearly, it would appear naive to believe that a ward manager could have sufficient knowledge to manage such services and push the frontier of the profession at the same time. Consequently, if you allow porters to be employed by a delivery service and become accountable to a ward manager, there is still the need for the Portering Service Manager to select, train and monitor the standards of portering throughout the hospital. This sets up a situation of dual responsibility; a managerial line in the foreground and a professional line in the background. The question that arises is - Is the situation in which a person has two bosses a confusing one? Can balance be achieved?

Under present organisational arrangements, the professional view counts. For example, the Pharmacy manager can convince the Unit General Manager (UGM) that a particular service is necessary, (eg Drug Information Service) then funding will be found. The introduction of the CIP was seen by some to jeopardise this lobbying system. In the future, would permission to introduce such a scheme as the Drug Information Service be transferred from the UGM to the directors of the delivery teams? If so, what would this mean for the Pharmacy profession if a number of directors did not see the importance of such a service. Also, would splitting the budget between the different clinical groups mean that professional heads were less motivated to control the costs of providing their service, given that responsibility had been devolved downwards?

Understandably, professional heads of the supply services were anxious that the CIP would fragment their profession and they could lose all that they had been striving to achieve. The Paramedical service is a prime example. Physios and Occupational Therapists have been attempting to achieve independent status and not be under the control of a consultant once patients have been referred to them. There were fears that the CIP could destroy the profession's career path if the top management posts became redundant. Furthermore, the splitting of responsibility between staff, who could be hired or fired by clinical directors, would make the paramedical professionals accountable to the consultant once more.

The debate considered in this third section suggests that there is a need for the supply service professions to continue to have a say in the planning, training and monitoring of professional standards. Professions such as nursing must be represented on the management teams of the delivery groups if they are not to be clinical directors themselves. The nursing profession should not be relegated to the ranks of an agency, serving the whims of the medical profession.

Given the importance of 'supply' professions in making it possible for clinicians to undertake their work, it has been suggested that the UGM specify rules about the minimum level of support provision that should be given to the delivery groups. Departmental heads should continue to draw up guidelines and offer advice about how directors on the delivery side of the matrix should usefully use their departments without 'unnecessarily' wasting resources. Moreover, there should be penalties imposed on directors who consistantly ignore the advice of professional heads.

Conclusion.

This paper has outlined the problems encountered when attempting to change the worked out interdependencies between different professional groupings. All professional staff have identities in which a desire for autonomy plays an important part. Little will be achieved by imposing a management structure which tries to force people to combine their efforts to further projects and improve performance. Better management must be an enabling one not a dictating one. There needs to be leadership and vision from management who also provide the structure and the resources within which people will choose to perform better.

In practice, this means creating meaningfully-sized groups of staff. These groups will need to be accountable and, to be meaningful to members, will have to have a clear and visible logic to their existence. This logic would be a task based one carried out by a group of individuals who have relative freedom to choose how to do it and how to allocate the constituent tasks amongst themselves. If these tasks are to be located within a matrix structure, then the problems of over bureaucracy could be solved as long as people know who to talk to, have a sense of direction and are willing to liase across professional boundaries. There needs to be a careful definition of the organisational roles, a modification of organisational culture through training and development, the setting up of practical guidelines and a creation of appropriate management systems to support these if matrix organisation is to work.

Appendix 12

Steering Group Members.

Colin Peterson (Chairman)
Simon Toms (CIP Project Manager)
Phil Smith (Radiology Manager)
Paul Hart (Unit Accountant)
Harriet Elms (Personnel Manager)
Steve Gilbert (Out-Patients Manager)
Alan Badger (Director of Information Services, Northtown DHA)
Tracey Tandy (District Training Officer)
Mr Williams (Chairman of MEC)
Don Duncan (Chairman of Radiology Consultants Group)
Mrs Minter (Matron)
Kathy Silver (General Services Manager)
Jill Dukes (Para-Medical Services Manager)
Dr. Owen (MIU consultant)
Christine Docks (Pathology Coordinator)
Tom Jones (Planning Manager)
John Cherry (Secretary of the MEC)
Professor Tatum (Head of Respiritory Medicine)
Mr Barnes (Obstetrician)
Dr Holmes (MEC representative)
Dr Short (MEC representative)
Dr Robinson (MEC representative)

Total: 22

Appendix 13

Structure of the National Health Service: 1989.

Top tier.

Department of Health:

Secretary of State for Health

NHS Policy Board (formely, NHS Supervisory Board)

NHS Management Executive (formerly, NHS Management Board)

Regional Health Authorities:

Regional General Manager

Regional HQ and Staff

District Health Authorities:

District General Manager

District HQ and Staff

Bottom tier.

Units of Management (Hospital and Community Services):

Unit General Manager

Unit Staff

Appendix 14

Members of the Unit Team.

Colin Peterson (Unit General Manager)
Kathy Silver (General Services Manager)
Mrs Minter (Matron)
Paul Hart (Unit Accountant)
Mr Williams (Surgeon and Chairman of the Medical Executive Co.)

Appendix 15

Members of the Unit Advisory Board.

Colin Peterson (Unit General Manager)
Katie Wilcocks (Assistant to UGM)
Simon Toms (CIP Project Manager & Medical Physics Manager)
Kathy Silver (General Services Manager)
Paul Hart (Unit Accountant)
Mrs Minter (Matron)
Mr Wilkins (Chairman of the MEC)
Steve Gilbert (Out-Patient Manager)
Christine Docks (Pathology Coordinator)
Phil Smith (Radiology Manager)
Jill Dukes (Para-Medical Services Manager)
Harriet Elms (Personnel Manager)
Tom Jones (Planning Manager)

+ Members of the Unit Co-opted to Advisory Board:

(Community Health Council Representative)
(Staff Representative)
(University Representative)
(Information Technology Representative)
(Social Worker)
(General Practitioner)

Medical Executive Committee Members.

Mr Williams (Chairman)
John Cherry (Secretary)
Professor Tatum (Head of Respiratory Medicine)
Don Duncan (Consultant Radiologist)
Dr Barnes (Obstetrician)
Dr Holmes (General Medicine)
Dr Short (Pediatrics)
Dr Robinson (General Surgery)

Total: 8

Appendix 17

Report to Medical Executive Committee: 7th March. 1988.

Financial Situation.

1. The current expectation is that we will break even or be around £50,000 overspent at 31st March 1988. However, this is an artificial situation. We have received specific earmarked funds in 1987/88 for the following schemes that we will not have to pay for until 1988/89:-

	£000
Blood Bank	100
Breast Cancer Screening	130
OPD/Main Entrance	70

The true underlying position is therefore an overspend for the year of around £300,000. If we do nothing we will end up at the close of 1988/89 £600,000 overspent.

2. The causes have been previously discussed; to recap:

(i) Short-funding of pay awards passed on by District (£150,000 in 1987/88).

(ii) Failure to achieve the full Capital Investment Programme (£120,000 in 1987/88); there is a further £100,000 coming in 1988/89.

(iii) Growth in caseload in the hospital which has led to overspends on drugs, theatres, M&S sundries. (By and large, all departmental budgets controlled by managers are in balance).

3. The way forward:

Immediate Measures

(i) The MEC's M&S equipment budget to be completely frozen for 1988/89, apart from breakdown replacement.

(ii) Sherbert Ward to remain closed, but for financial reasons, not because of staffing shortages.

Over the next few weeks

(i) Agree a theatre's budget that we can afford (ie less than we are spending at the moment) and apply strict financial control in 1988/89.

(ii) Reduce the budget for M&S sundries, allocate down to ward areas and apply strict budgetary control in 1988/89.

(iii) Consider closing a medical ward and re-opening between say December and April.

Longer Term

Continue to press District for more money (earliest is 1st April, 1989).

P. Hart, Unit Accountant.

Appendix 18

The White Hart Plan

1. The Current Problems

The single most difficult issue to address is the Unit's financial position. Although clinical activity in the Unit has increased considerably since 1986/87, there has been no corresponding increase in the Unit's overall budget. Parallel to this has been a policy change which required units to pay award shortfalls. In recent years this has only been made possible by huge savings on those services affected by the Competitive Tendering process. During this time it has been possible for most managers, particularly in service areas, to contain expenditure within a given budget; this has been coupled with strict managerial control of pay expenditure. It is the clinical non-pay budgets that are currently overspent and which prove the most difficult to contain, e.g. drugs expenditure, medical and surgical sundries. This is largely due to the fact that the managers who are currently responsible for overseeing these budgets, are not in a position to influence the actual expenditure.

2. The Vision - Resource Management

In order to overcome one of these difficulties, it is proposed that a Consultant and Operations Manager should be appointed for each specialty. They would then be jointly responsible for the compilation of their annual budget, based on an agreed level of activity, and would then control the daily operation of this budget.

It is envisaged that this will involve the 'buying in' of all the necessary services, both clinical and non-clinical, that are required for the efficient running of their specialty. However, this system could only be implemented following a re-organisation of budgetary management, and the way the necessary information would be made available to the various specialties.

As regards the question of pay-award shortfalls, this is still a 'policy' decision which is outside of Unit Management control.

3. The Task - Towards 1990

i) Review of current overall service provided relative to resources, and implement pilot schemes in selected areas e.g. Health Care of the Elderly, Maternity, General Surgery, Medical Specialty.

ii) New Planning Department to formulate long-term plan towards the year 2000 and for Capital Expenditure, related to service demands and resources.

iii) G.U. Medicine - Using the information gained in pilot schemes (i), integrate and commission into the Unit.

iv) X-Ray - Produce detailed action plan for both commissioning and take-up of new department.

v) Evaluation of new telephone system.

vi) Ensure that all local computer networks are fully operational and integrated.

vii) Implement Theatre Management System.

viii) Integrate the current Unit Team Decision Making into the Unit Advisory Board.

ix) Appoint Project Manager to manage the change plan (see 4).

4. Management of Change - The Plan

1. UGM to appoint Project Manager.

2. UGM winds-up Unit Team.

3. General Services Manager to produce White Hart Plan.

4. Present Plan to UAB / Hospital Medical Co. et al.

5. UGM present plan to DGM.

6. Unit Accountant / District to identify resources to implement plan.

7. Project Manager to set up Resource Management Steering Group.

8. Project Manager to arrange 'time out' with other key players, Tracey Tandy, Tony Turrell.

9. White Hart Team to give details of 'key tasks' to Steering Group.

10. Steering Group to set up task force for:

    - Training, planning, financing the project
    - Information Technology needs
    - Communications network during and after the transition
    - People problems

11. Set up tandem groups.

12. Commence pilot in HCE, Maternity, General Surgery

13. Arrange a visit to Newcastle to assess their approach to resource management

14. Project Manager to arrange for 'key groups' to visit Newcastle, Huddersfield and Lincoln.

15. Task force and Steering Group to produce monthly update for UAB, Hospital Medical Co.

16. White Hart Team to take 'time out' and review progress of the Plan.

Mrs K. Silver, AHSM, Cert. in Employment Law

5/10/88.

Clinical Information Project.

The project will be managed at three levels:

Steering Group

Members: UGM
Project Manager
MEC Members
UAB Managers
Task Group Leaders

Objectives: Define policy and timetable for project
Monitor progress
Review outcome of Task Groups

Task Groups

Task Groups will be established for each of the specialty areas to be studied.

Members: A consultant from the specialty
A manager from the specialty
An adviser from the Support Group

Support Group

This Group will provide support services to the Task Groups and Steering Group, such as secretarial, computing and financial advice. In time, the Group will be responsible for the purchase, installation and commissioning of equipment and services.

Members: Project Manager
Computing Adviser
Financial Adviser
Information Advisers
Secretariat

Proposed Pilot Task Groups

The following specialties are proposed for the initial pilot studies.

1. Renal Services
2. Maternity Services
3. MIU
4. Orthopaedics
5. Cardiology
6. Respiratory Medicine
7. Endoscopy
8. Radiology

In general, these are well defined specialties which either have established information systems or will be able to identify deficiencies in the information available. They are expected to provide rapid assessment of the feasibility of the project.

Simon Toms (4/12/88).

The Government's White Paper, 'Working for Patients'.

(a) The White Paper (Department of Health, 1989:3-5) says:

This White Paper presents a programme of action...to secure two objectives:

- to give patients, wherever they live in the UK, better health care and greater choice of the services available; and

- greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.

The Government's Proposals

Key changes

The Government is proposing seven key measures to achieve these aims:

First: to make the Health Service more responsible to the needs of patients, as much power and responsibility as possible will be delegated to local level. This includes the delegation of functions from Regions to Districts, and from Districts to hospitals...They include a greater flexibility in setting the pay and conditions of staff, and financial incentives to make the best use of a hospital's assets.

Second: to stimulate a better service to the patient, hospitals will be able to apply for a new self-governing status as NHS Hospital Trusts. This means that, while remaining within the NHS, they will take fuller responsibility for their own affairs, harnessing the skills and dedication of their staff. NHS Hospital Trusts will earn revenue from the services they provide. They will therefore have an incentive to attract patients, so they will make sure that the service they offer is what their patients want. And in turn they will stimulate other NHS hospitals to respond to what people want locally. HHS Hospital Trusts will be able to set the rates of pay of their own staff and, within annual financing limits, to borrow money to help them respond to patient demand.

Third: to enable hospitals which best meet the needs and wishes of patients to get the money to do so, the money required to treat patients will be able to cross administrative boundaries. All NHS hospitals, whether run by health authorities or self-governing, will be free to offer their services to different health authorities and to the private sector. Consequently, a health authority will be better able to discharge its duty to use its available funds to secure a comprehensive service, including emergency services, by obtaining the best service it can whether from its own hospitals, from another authority's hospitals, from the NHS Hospital Trusts or from the private sector.

Fourth: to reduce waiting times and improve the quality of service, to help give individual patients appointment times they can rely on, and to help cut the long hours worked by some junior doctors, 100 new consultant posts will be created over the next three years. This is in line with the number of fully trained doctors ready for consultant appointments in the relevant specialties. The new posts will be additional to the two per cent annual expansion of consultant numbers already planned.

Fifth: to help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to obtain a defined range of services direct from hospitals. Again, in the interests of a better service to the patient, GPs will be encouraged to compete for patients by offering better services. And it will be easier for patients to choose (and change) their own GP as they wish.

Sixth: to improve the effectiveness of NHS management, regional, district and family practitioner management bodies will be reduced in size and reformed on business lines, with executive and non-executive directors. The Government believes that, in the interests of patients and staff, the era in which a £26 billion NHS is run be authorities which are neither truly representative nor fully management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability.

Seventh: to ensure that all concerned with delivering services to the patient make the best use of the resources available to them, quality of service and value for money will be more rigorously audited. Arrangements for what doctors call 'medical audit' will be extended throughout the Health Service, helping to ensure that the best quality of medical care is given to patients. The Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies.

(b) In the concuding chapter, the White Paper (Department of Health, 1989:100-102) says:

The proposals in this White Paper put the interests and wishes of the patients first. They offer a new, exciting and potentially rewarding challenge to all who work in the NHS. They add up to the most significant review of the NHS in its 40 year history. And they amount to a formidable programme of reform which will require energy and commitment to carrying it through.

The Government is planning to implement the programme in three main phases:

Phase 1: 1989

The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board and a Management Executive.

The Health Departments, and Regional Health Authorities (RHAs) in England, will identify the first hospitals to become self-governing as NHS Management Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

The Government will introduce Regulations to make it easier for patients to change their GPs.

The first additional consultant posts will be created; Districts will begin agreeing job descriptions with their consultants; and a new framework for medical audit will begin to be implemented.

The resource management initiative will be extended to more major acute hospitals.

Preperations for indicative drug budgets for GPs will begin.

The Audit Commission will begin its work in the NHS.

Phase 2: 1990

The changes begun in Phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

'Shadow' boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

RHAs, District Health Authorities (DHAs) and Family Practitioner Committees (FPCs) will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for the work they do for each other.

Phase 3: 1991

The first NHS Hospital Trusts will be established.

The first GP practice budget-holders will begin buying services for their patients.

The indicative drug budget scheme will be implemented.

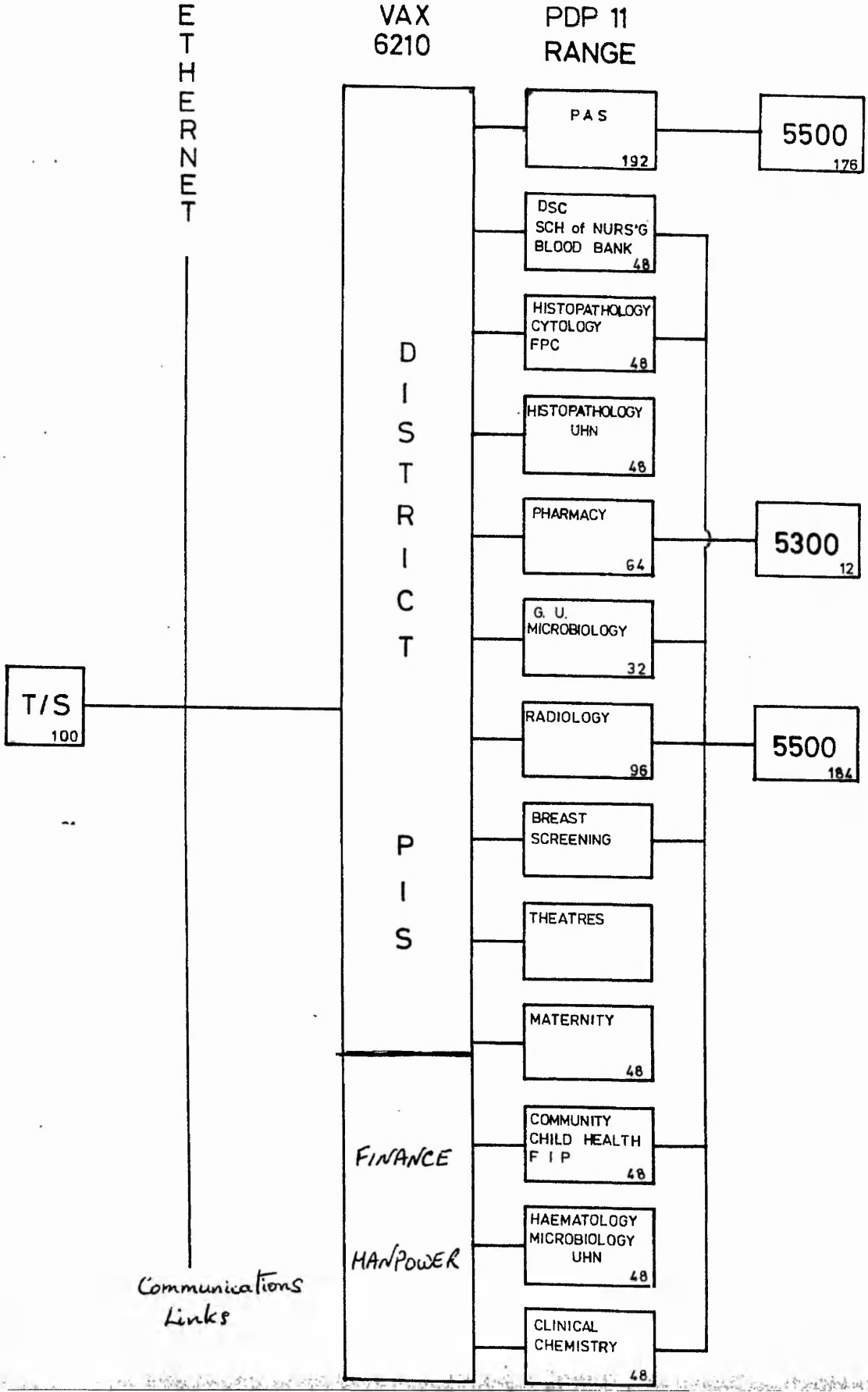
DHAs will begin paying directly for work they do for each other.

The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989-90, announced in the Autumn Statement, included the likely costs of preparing for the reforms and for the legislation which will give effect to them. Over time, any extra costs should be offset by the improved efficiency which will stem from them. The total provision for spending on health will take account of the progress made in implementing the

reforms - including the increased efficiency savings. The costs of implementing the reforms in future years will be considered as part of the annual public expenditure surveys.

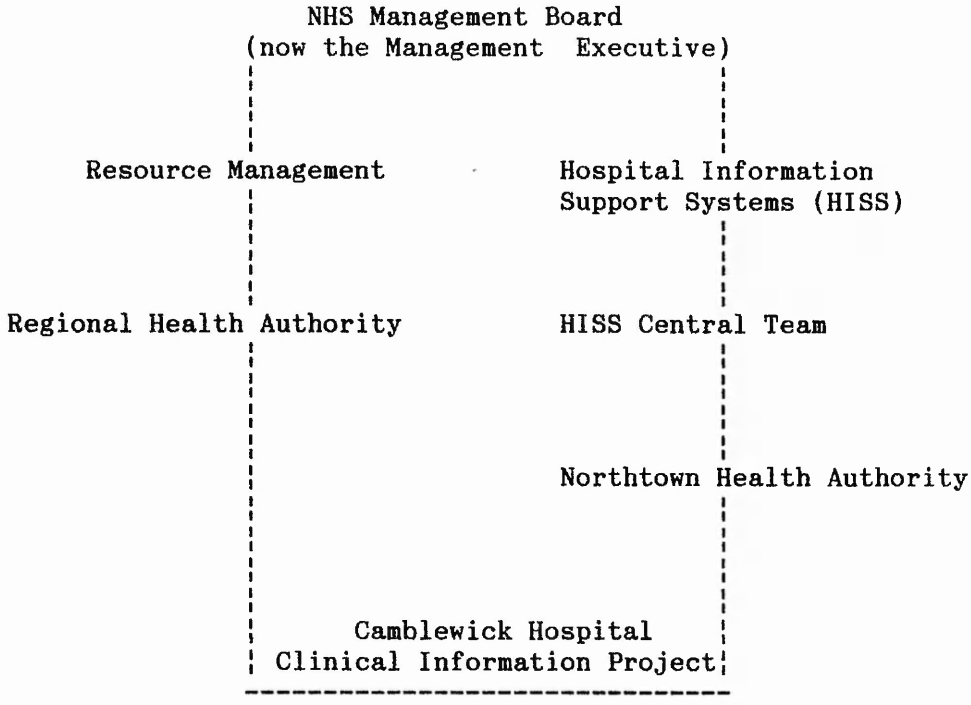
A number of the changes proposed will require legislation, which will be introduced at the earliest opportunity.

Feeder Systems for the District Patient Information System.



Appendix 22

Management Structure of HISS and Resource Management.



(HISS Project Management Arrangements on next page)

HISS Project Management Arrangements.

Management Board:

Dr Alan Badger (Chairman)	Director of Information and Computing Services, Northtown Health Authority
Dr Colin Peterson (User)	Consultant Pathologist / UGM of Camblewick Hospital
Mr Plumb (Business)	Regional Treasurer, North Regional Health Authority
Dr Neil Minor (Technical)	Computing Services Manager, Northtown Health Authority

Project Manager:

Mrs Mary Budd	Information and Computing Services Nottingham Health Authority

Project Coordinating Team:

Mr Williams	Consultant General Surgeon / MEC Chairman at Camblewick Hospital
Mr Steve Gilbert	Management representative from UAB Camblewick Hospital
Dr Ted Staines	Project Manager Clinical Information System, Northtown Health Authority
Miss Karen Mint	Data Protection Manager, Northtown Health Authority

Project Technical Team:

Mr Brian March	Network Manager, Northtown Health Authority
Mr Keith Leighton	Pharmacy Manager / Pharmacy Computer System Manager, Camblewick Hospital

Plus additional Management Consultants.

Appendix 23

Tom's Newsletter.

Clinical Information Project

This Unit has been treating more patients year by year for effectively the same cost. In any other industry this would be regarded as improving efficiency leading to more profit to be used for further improvements of the service. But the NHS is cash limited, which means that we cannot overspend and as the treatment of patients causes all expenditure we need at times to restrict some of our services. Last year some operating theatres were closed for a few months. A decision that everybody tried to avoid. An overspend in one financial year results in us starting the following year with a deficit and unless the cause of the overspend has been tackled we then head for an even bigger overspend that year. However, it is known that such closures only result in short term savings.

One of the major difficulties facing managers is the lack of easily accessible information about our activities. Northtown has better information systems than almost any other District because of its large commitment to information technology. At the present time, though, detailed information can be obtained by some departmental managers but not easily by most consultants and senior managers.

The Clinical Information Project was initiated by the Unit General Manager last October. It aims to provide clinicians with accurate and timely information to help them treat their patients and to understand the resources they are using. In turn, the clinicians will be able to propose modifications to their practice which will continue to improve patient care and provide an indication of cost. Of course, not all improvements cost money, some save money and some simply shift resources from one place to another. We believe that we must involve clinicians far more in the understanding of where we spend money and how it can be best used to benefit patients.

Seven clinical specialties have been identified to pilot this project and we expect to consider their reports in May. In addition, many discussions have taken place with clinicians and managers to plan the project's programme.

An application has been submitted to the Regional Health Authority, with the full support of District, for additional funding for this project. We evidently impressed Region with our application because Camblewick Hospital has been selected to be one of twenty hospitals to receive special funding to introduce Resource Management. This was followed by the news that we have also been selected to be one of only three hospitals in the country to pilot the introduction of a Hospital Information System (HISS).

Both of these projects combined are, in effect, our Clinical Information Project. The exact details of funding and timetable

are not yet known, but clearly the investment at this time is to enable the proposals in the Health Service Review to be put into practice.

Although the Camblewick Hospital has been named as the pilot site, Northtown uses common databases and computers and it is the District's intention that other units will follow our lead very quickly.

Life has been further complicated by the District being chosen to pilot the integration of Health Authority and Family Practitioner Committee computing services and links to GP surgeries.

To achieve all these goals, there will be hundreds of additional computer terminals installed, all having to communicate with the computer equipment at the Grand Hospital. This is where the new telecommunications system fits into the jigsaw. It has been designed with the Hospital Information System in mind, although we did not anticipate it all happening so quickly.

So the building blocks are now coming together and it is a credit to our planning, our clinical services and our management that we should be chosen for these prestigious projects.

S Toms
Project Manager
23 February 1989

Appendix 24

An Analysis of the Task Group Reports.

Task Group	No. of meetings	Boundary of mgt.	Manager	Services managed	Services bought	Information needs
1	3	Diverse 32 beds	Dr & Admin. Asst.	Staff	Domestics Porters Dietician	Staff costs
2	2	Maternity Division (not Gynae-cology)	CCo. & Business Manager	Porters Laundry Catering Staff	Clinical services Works	Costs
3	3	Distinct Block of 160 Beds	Dr & Nurse Manager	Staff MR Domestics Porters	Clinical services Training Laundry	Costs
4	4	36 Beds & Plaster Room	?	Staff	Clinical services	Costs
5	4	CCU, Cardiac & Cardiology Patients	Dr	Staff Training Equipment	Clinical services Domestics Porters MR	Patient Staff Costs Standards
6	1	Dept. (not Thoracic Surgery)	Business Manager	Senior Staff	Clinical services Junior staff Domestics Catering	?
7	3	Distinct Dept., Ante-natal & MP	CCo. & Business Manager	Staff Porters Equipment	Works Domestics	?

Key:

Task Group 1 - Renal Services
2 - Maternity Services
3 - Mental Illness Unit
4 - Orthopaedics
5 - Cardiology
6 - Respiratory Medicine
7 - Radiology

Dr - Doctor
CCo - Consultant Committee
CCU - Coronary Care Unit
MR - Medical Records
MP - Medical Physics

Key (continued):

Clinical services are support services (eg. Paramedical, Pathology, Pharmacy and Radiology). Staff include medical, nursing / midwifery, secretarial and technical.

The table in this appendix indicates that there were a sufficient number of meetings to suggest that doctors were interested in the 'idea' of resource management. Improved financial information was requested in five of the seven groups which seemed to imply that the doctors were in favour of improving information and developing systems. When it came to managing the resource centre, there was a considerable amount of difficulty specifying the management boundaries of groups allied to general medicine (eg Cardiology and Respiratory Medicine). This was largely a result of the fact that each of these specialties treats patients managed by other physicians. For example, the Cardiologist treats any patient with cardiological problems if an investigation is requested by the patient's consultant. However, the management boundaries of surgical specialties were more clear (eg. Orthopaedics). Generally, divisions did not want to merge their resources together (eg. Respiratory Medicine and Thoracic Surgery, Maternity and Gynaecology).

How the resource centres would be managed was often fudged in the Consultants' reports. Whilst members of the medical community wished to be involved in management, they often wanted a Nurse Manager, Business Manager or Administrative Assistant to help them. This Manager would not be tolerated as a Director of a group and be expected to report to a doctor or group of doctors. No medic proposed that they be the Clinical Director over and above their colleagues. If the Manager was a Nurse, lines of responsibility to Matron or the UGM were expected to remain.

As a general theme, the resource group wanted to manage its own staff and equipment but preferred to 'buy in' clinical support services (ie. the investigative and treatment departments). Whilst two groups entertained the idea of managing their own Porters and Domestics, the majority thought that the present unit-based arrangement for managing Laundry, Catering and Works should be maintained.

Proposals for the Introduction of Resource Management (RM) (Enclosure C).

Recommendations:

1.1 Clinical specialties which admit patients to hospital beds, established for the purpose of RM, be known as Clinical Directorates.

1.2 Other specialties or services which contribute to direct care of the patient but which do not generally admit patients to hospital beds be known as Clinical Services.

1.3 Other services enabling the care of patients be known as Support Services.

2.1 The Renal Transplant and Dialysis Unit should become a Clinical Directorate.

2.2 The establishment of other Clinical Directorates within General Medicine should be discussed further with the Camblewick Physicians.

2.3 The Surgeons, Anaesthetics and Theatre Manager be invited to consider a proposal for a single Clinical Directorate encompassing Anaesthetics and Theatres.

2.4 Mental Illness Unit be established as a Clinical Directorate.

2.5 Maternity Unit should be established as a Clinical Directorate.

2.6 No changes be made to the Radiology service at this time and it should be known as a Clinical Service.

2.7 The Pathology departments be asked to review the role of the Coordinator and give consideration to the appointment of a Manager of the Pathology Clinical Service.

2.8 A review of Medical Physics and related services should be undertaken to advise on its future management within RM.

2.9 At this time, supporting services should not be fragmented.

2.10 Nurses working in a Clinical Directorate should be managerially and professionally accountable to the Nurse Manager.

2.11 Nurse Managers should be managerially accountable to the Clinical Director and professionally accountable to Matron.

2.12 The Matron should ensure an equable distribution of nursing skills throughout the Unit.

2.13 Medical secretaries should be managed by the Clinical Directorate if required, but there must be consultation with the Medical Records Manager to ensure maintenance of standards and procedures throughout the Unit.

2.14 Devolvement of other aspects of Medical Records to Clinical Directorates should not be considered at this time.

3.1 The Clinical Director should be a consultant appointed by the UGM after consultation with the specialty.

3.2 A Nurse Manager be appointed by the Director after consultation with the Matron.

3.3 The Director considers the need for supporting staff to enable the Director and Nurse to manage the Directorate.

3.4 The Clinical Director should manage the Directorate within the resources allocated by the UGM.

3.5 The Clinical Director should monitor the quality of services provided and received.

3.6 The Clinical Director should agree by negotiation the services and quality to be provided from suppliers external to the Directorate.

3.7 Where appropriate, a Manager from the profession should be managerially accountable to the Director for services to the Clinical Directorate and professionally accountable to a senior manager of the profession in the Unit.

3.8 In other instances, staff should be managerially and professionally accountable to a senior manager of the profession in the Unit.

3.9 Where appropriate, similar professions could be grouped together.

3.10 All staff should be encouraged to identify with the Clinical Directorate in which they work.

3.11 The transfer of the management of services and resources should be agreed and approved by the Management Board.

4.1 The UGM should appoint the most appropriate person to manage a department(s) or profession(s) providing a clinical service.

4.2 The UGM should appoint the most appropriate person to manage a department(s) or profession(s) providing the support service.

4.3 The Manager should manage the service within the resources allocated.

4.4 The Manager should monitor the quality of the services provided and received.

4.5 The Manager should agree by negotiation the services and quality to be provided to Clinical Directorates and other services.

5.1 The CIP Manager should direct the implementation of RM into Camblewick Hospital and provide a support function to Directors and Managers.

5.2 The CIP Manager should be the interface to external initiatives such as RMI and HISS.

5.3 The CIP Manager should manage the specification, development and implementation of information systems to support RMI.

5.4 The CIP Manager should present summaries of contracts for approval by the Management Board.

5.5 The CIP Manager should monitor the effectiveness of contracts on behalf of the Management Board.

6.1 A Unit Management Board should be established and the proposed membership could be the UGM, Chairman of the MEC, Clinical Directors, Clinical Service Managers and Support Service Managers.

6.2 The Management Board should replace the Unit Advisory Board on 1 November 1989.

6.3 The Management Board approves contracts for service between Clinical Directorates and Services.

6.4 The Management Board approves transfer of resources between directorates and services.

6.5 A Unit Executive Board should be established and the proposed membership could be the UGM, Chairman of Clinical Directors, Matron, Finance Manager, Chairman of Clinical Services and General Services Manager. The Chairman MEC and CIP Manager would attend by invitation.

7.1 <u>Proposed Clinical Directorates</u>

Directorates which can be established now:

Renal Services
Mental Illness Unit
Maternity Unit

Directorates which appear to be able to be established soon:

Health Care of the Elderly
Paediatrics

Directorates which require more detailed consideration:

General Medicine
Surgery
Radiotherapy

7.2 Proposed Clinical Services

Anaesthetics (if not included in Surgery)
Theatres (if not included in Surgery)
Nursing
Para-Medical
Radiology
Pathology
Out-Patient Services
Pharmacy
Clinical Genetics

7.3 Proposed Support Services

Finance
General Services (eg. portering, medical records, security)
Personnel
Planning
Clinical Information Project

S Toms
Project Manager
4 July 1989

Appendix 26

Agenda for the Second Steering Group Meeting, 24th July, 1989.

1. Apologies

2. Minutes of Previous Meeting, Enclosure A

3. Matters Arising

4. Progress Report, Enclosure B

5. Resource Management Project Plan for Region previously circulated. Members who did not receive a copy please contact the Project Office

6. Proposals for the Introduction of Resource Management at Camblewick Hospital. To be circulated separately as Enclosure C

7. Report on the HISS Project, Enclosure D

8. Funding for the Project, Enclosure E

9. Project Timetable, Enclosure F

10. Any Other Business

11. Dates of Future Meetings

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