Strategic Management and National Health Service Hospital Trusts: Empirical Evidence from the West of Scotland

BY

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ABSTRACT

This research examines the development of strategic management within five National Health Service Hospital Trusts (NHST's) used as case studies in the West of Scotland between 1994 and 1997. The rationale for the study was the 1990 NHS Reforms, which created an internal market in health care by separating the purchasing of health care from its provision via the purchaser/provider split. In Scotland, Area Health Boards (AHB's) and General Practitioner FundHolders (GPFH's) became purchasers of health care and hospitals became providers of health care as NHST's. Purchasers and provider relationships were mediated through the use of contractual agreements over services. The NHST's, now freed from AHB management and control, began to develop their organisations both internally and externally to compete with other providers within what they considered would be a competitive market. This involved the development of a strategic management role for NHS managers within their hospitals where previously none had existed, and the setting up of groups of clinical specialisms into devolved management structure known as clinical directorates. These clinical directorates had their own management teams consisting of a senior clinician as clinical director supported by a business manager [and] or service manager. Strategy was examined at a macro level (NHST senior managers) and at a micro level (clinical directorate) as was the relationship between the NHST senior managers and their clinical directorates. The thesis examined three broad areas in relation to strategic management within the five NHST case studies. These were as follows:

The Development of the Internal/Quasi Market within the NHS in the West of Scotland

Although there were relatively large numbers of providers, there were limited numbers of purchasers in the shape of both AHB's and GPFH's. Relationships formed between the AHB's and the NHST's which although were supposed to be mediated through contracts, often developed using 'softer' characteristics such as trust and reputation. The NHS quasi-market in the West of Scotland could be better described as a relational market that was socially and institutionally embedded.

Although in general there was not much in the way of a fully competitive market operating within the West of Scotland NHS, some examples were identified. The Scottish Office indicated that there should be some degree of stability within this market with no 'surprises'. Purchasers in the shape of AHB's, and to a lesser extent GPFH's very often did not have accurate information on service quality and price to allow them to make rational purchasing decisions. This led to the relational market developing which allowed some stability within the new arrangements. A confusion could be observed within all the NHST case studies concerning the operation of a market and competition. The idea of competition at the margin as a sign of competitive behaviour was not always understood, and instead the competitive process was often envisaged as necessarily involving frequent shifts in purchasing and supply behaviour.

The Development of Strategic Management at Senior Management or (macro) Level Within the Five NHST Case Studies.

All of the NHST case studies had engaged in some form of strategic planning which included objective setting and strategic analysis in the *expectation* that a competitive market was going to take off in the West of Scotland. The strategic analyses varied in their sophistication between each NHST. A strategy process could also be seen to emerge from each NHST depending on their individual contexts. In general, the NHST case studies began to develop their strategy based upon generic approaches with the perception that there would be a competitive market. After time, (3-4 years), they realised that this type of market was not developing, and the new system was to have a degree of stability and control from the Scottish Office and AHB's. The NHST case studies then began to build their strategies upon developing relationships with other NHST's and AHB's within a process which took into consideration history, culture, politics, and the power distribution between the NHST's and AHB's within the new arrangements. This led the NHST case studies to learn, adapt and manage their strategies within the new system. This learning process was dependent upon the individual contexts of each NHST.

Two distinct approaches to strategic management were also observed, the positional approach and the resource based approach. The resource based approach, although more implicit, could be seen in relation to each NHST's core competencies and distinctive capabilities. In many ways the strategies that emerged were based upon the resource endowments of each NHST hospital case study. The NHST case study hospitals had actively considered strategic options based on Porter's generic strategies and other options including market development and penetration, new service developments, strategic alliances and joint ventures.

The Development of Strategic Management at Clinical Directorate (micro) Level Within the Five NHST Case Study Hospitals.

In each of the NHST case study clinical directorates, the commonest form of strategic analysis was undertaken using SWOT and PEST analyses. Strategy could also emerge when a clinical director came up with an idea and asked their business manager to develop a case for funding, or find a way to incorporate the idea into the Directorate's existing portfolio of activities. However the involvement of the Directorates in their NHST strategy and decision making processes were limited and the control over many key strategic issues remained strongly vested with NHST senior managers. This was related to the limited time that was made available to clinical directors to enable them to carry out a strategic role at both Directorate and NHST management level and the fact that the senior NHST managers did not want the Directorates to upset the stability of the new arrangements. The conflict of professional and business values of the clinicians and managers within the Directorates undoubtedly diminished the potential of strategic management at a micro level. There also seemed to be a difference in expectations of the roles and responsibilities of the clinical directorates at each of the NHST case studies by both the NHST senior managers and the Directorates themselves. This led to problems in attempting to integrate strategy at a macro and micro level.

In summary this thesis illustrates how NHS managers within NHST's for the first time were in a position to develop strategy for their organisations. The key to understanding strategy development within the NHST case studies was the relational market in the West of Scotland, and the strategic processes that unfolded over time as the NHST's moved away from generic strategy approaches to approaches based upon collaboration and co-operation. This was seen at both senior NHST manager level (macro) and at clinical directorate level (micro). There were a number of similarities that all the NHST case study managers were considering in their individual strategies, but also a number of differences. It is also to be remembered that the NHS is a political organisation. There was therefore a limit to the extent to which NHS managers were be 'free' to develop a full strategic management agenda given that resources in the NHS were limited and because of the political implications that could arise if certain strategic decisions were made. Strategic management concepts and models have a place in the NHS, although they may have to be adapted and modified, particularly with regard to the processes involved in reaching strategic decisions.

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Chapter 1: NHS Management, Origins and Development

Introduction

The British National Health Service (NHS) came into existence on the 5th July 1948. The NHS has become a major piece of social engineering. With respect to the healthcare systems of other countries, it is the only system to offer a fully comprehensive, centrally funded, free at point of use service. However this was only achieved through a bargaining process with strong pressure groups such as the medical profession and the friendly societies who provided a form of medical insurance which paid for treatment (Klein, 1989). The NHS is also a centralised unitary healthcare system based on a nationalised hospital sector which encourages equality of care throughout the country. The Beveridge Report of 1942 laid the foundations for the NHS Act of 1946. The Beveridge Report advocated a decentralised and pluralistic healthcare system based on voluntary and local authority hospitals. Aneurin Bevan, who was the father of the NHS, was in favour of a national system of healthcare based on Hospitals and a network of general practitioners. Bevan's concept was adopted and remains to this today.

This chapter will lay the foundations for the remainder of the thesis. The chapter will be in four sections. Section 1 will examine the NHS from its inception in 1948 until its first major re-organisation in 1974. Sections 2 will examine the major changes and re-organisations that the NHS underwent between 1974 and 1988. Section 3 will examine the ideological circumstances which have led to the public sector in the UK, including the NHS, undergoing major change in the last ten years. Finally, Section 4 will examine the 1990 NHS reforms which introduced an internal market into the NHS, and set up hospitals as National Health Service Trusts to compete with each other for resources from health authorities. Managers in these hospitals were now freed from health authority control and managed their organisations strategically within this internal market.

Section 1: The Early Management Structure of the NHS

Introduction

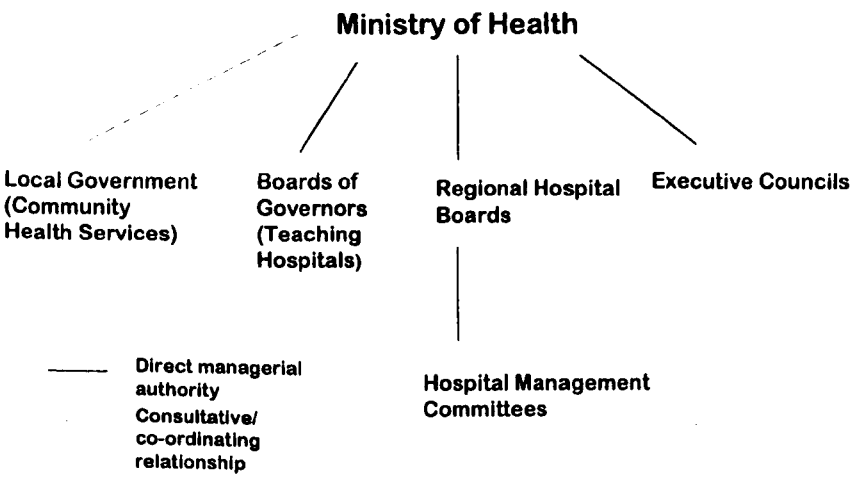
The UK NHS emerged from the Second World War political consensus. The Beveridge Report had the support of all political parties that the people of the UK should have access to a comprehensive healthcare system. The subsequent development of the NHS was also based on a compromise between the Labour Government of the time, and the medical profession. The agreement reached with the doctors gave the medical profession complete clinical freedom and autonomy over their decisions, free from political interference. The medical profession also succeeded in attaining the separation of the hospital services from the community health services, as they feared the NHS would become part of Local Government and thus subject to political changes.

The NHS was also built on several key founding principles (IHSM, 1988):

- **Comprehensiveness**: There has been much debate to what actually constitutes a "comprehensive health service", however the idea of providing appropriate care for most presenting conditions is still generally taken to mean "comprehensive" (Op Cit.);
- **Equality of Access**: Equal access to services according to need only;
- **Equity**: Equal services for equal need and;
- **Services free at the point of delivery**: Everyone is eligible to use the NHS, by virtue of being a citizen of the UK. Charges for certain services were introduced early in the life of the NHS, but the criterion still applied today is that inability to pay should not prevent access to services.

When the NHS was established, it consisted of three distinct and separate administrative structures (Klein, 1989). The first structure consisted of Regional Hospital Boards, Hospital Management Committees, and Boards of Governors[1] who administered the hospital services. The second structure administered the community health services, which included maternity services, health education, and child welfare. These services were under the control of Local Government. The third structure administered the family health services (FHS's) and included General Practitioners (GP's), dentists, and pharmacists. The FHS's were administered through Executive Councils, which administered their contracts and also handled patients complaints. Figure 1 illustrates the structure of the NHS from 1948 to 1974.

Figure 1. The Structure of the NHS 1948 - 1974 (Source: Klein, 1989).



In the years after 1948 the NHS prospered, and any problems were self generated. The NHS was a run-away success, but it became apparent that it had developed an appetite for consuming resources. The incoming Conservative Government of 1951 was concerned of the resource implications of the NHS, and indeed considered reverting back to the pre-NHS pluralistic provision of healthcare in the UK. However, the popularity of the NHS was such that it would have been political suicide to do so (Webster, 1994).

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[1]. The Boards of Governors managed the teaching hospitals in the large Cities who were given special status by the Government.

It was argued over the years, that the separation of the hospital and community health services inhibited any strategic direction and planning of healthcare services (Klein, 1989, Ham, 1992). Klein argues that the case for merging and re-organising the hospital and community services was boosted by the inability of all Government's since 1948 to control the costs of the NHS. There was no mechanism available to control costs, although prescription charges had been introduced and abolished several times over the years. There was also concern with the rising staff levels, professional and non-professional, who were now working in the NHS, as this also had resource implications. From 1948 onwards, there was a plethora of Government reports published concerning the operation and management of the NHS. Table 1 summarises the main reports in the period 1948-1972. Increasingly all Governments from the 1960's onwards were faced with the difficult issue of attempting to create a capacity within the NHS for *strategic change* and *direction*. However, it was not until the late 1960's that all the main political parties in the UK accepted that the time was now right for a complete re-organisation of the NHS. There was a need to develop a *strategic capacity* through better integration of the NHS, and this emerged as a dominant theme of the NHS debate at the end of the 1960's. This would involve a unification of the tripartite structure, and the creation of a *strategic tier* (Op Cit.).

The First NHS Re-organisation

In 1974, the NHS was re-organised and there was a merger of the existing tri-partite structure and a new NHS was born. The 1974 re-organisation had three main aims (Ham, 1992):

- It intended to unify health services by bringing under one authority, all of the services previously administered by the tri-partite structure;
- It was intended to lead to better co-ordination between health authorities and related Local Government services and;
- It aimed to introduce better *management*. Key concepts included multidisciplinary team working and consensus management. The medical profession was also given a more explicit role in the 'new' management system.

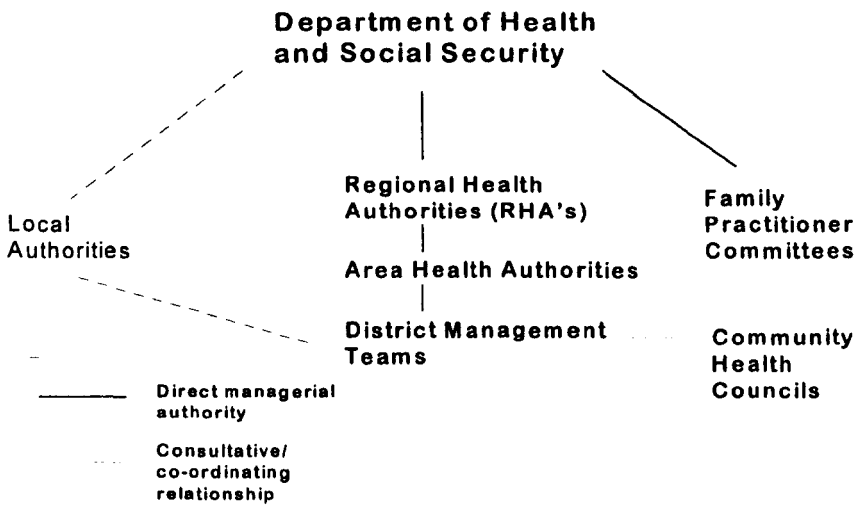
Table 1. Main Government Reports on the Management and Operation of the NHS 1948-1972.

Year	Report Title	Subject of Report
1954	Bradbeer	The internal administration of hospitals.
1956	Guillebaud	The cost of the NHS.
1962	Porritt	Health services should be unified and placed under the control of Area Boards.
1962	The Hospital Plan	To bring about a equitable distribution of hospital beds based upon centrally determined criteria for matching resources to needs. District General Hospitals (DGH's) to be established having between 600-800 beds serving populations of between 100,000-150,000.
1963	Lycett Green	NHS recruitment, training, and promotion.
1966	Farquharson-Lang	Practice of Area Health Boards in Scotland.
1966	Salmon	The structure of senior nurse staffing levels.
1967-1972	'Cog-Wheel'	Three reports examining the organisation of medical work in hospitals.
1969	Bonham-Carter	Proposed even larger DGH's than the 1962 Hospital Plan serving even larger populations.
1972	Hunter	Examined the work of medical administrators.
1972	Grey Book	Examined the management of what would become the 'new' re-organised NHS.

Fourteen Regional Health Authorities (RHA's) were created in England as executive agencies which would oversee the now identified strategic planning role for the NHS. The RHA's were at the top of a strategic apex. Immediately below the RHA's were ninety Area Health Authorities (AHA's) whose role was the operational administration of the NHS, and also to administer the newly created Family Practitioner Committees (FPC's) which replaced the Executive Councils. The RHA's were the link between the DHSS and the AHA's in the chain of command. Figure 2 illustrates the new organisational structure. In Scotland 15 Area Health

Boards (AHB's) were created who remain to this day, and they carried out the same functions as the English RHA's and AHA's.

Figure 2. The Re-organised NHS structure from 1974 onwards (Source: Klein, 1989).



There were two significant changes brought in by the 1974 re-organisation. Firstly, the AHA's were given responsibility for administering the community health services which previously had been administered by Local Government. Local Government was now removed from the operational area of the NHS. The second significant change that the 1974 re-organisation brought was the creation of District Management Teams (DMT's) within the larger AHA's. Each DMT was run by a team of officers on a consensus basis thus giving each member, which included the local consultants and GP's, a right of veto over management decisions (Op Cit.).

These DMT's varied in size within the AHA's. DMT's provided a structure through which all NHS staff could be represented and participate in management. Every tier in the management hierarchy from RHA to AHA had a plethora of professional advisory committees to ensure decisions would always be made with 'expert' opinion. The 'expert' opinion would come from doctors, nurses and other healthcare professional groups.

The DMT, gave the medical profession in particular, the right of veto over decisions. *Management*[2], for the very first time, had arrived in both the language, and the operation of the NHS. The 1974 re-organisation gave the NHS, for the first time, the capacity for strategic direction. This was achieved by the integration of the tripartite structure into one unified organisation, but in many respects this was a compromise between competing demands.

> *"Essentially, the 1974 re-organisation can be seen as a political exercise in trying to satisfy everyone and to reconcile conflicting policy aims: to promote managerial efficiency but also to satisfy the professions, to create an effective hierarchy for transmitting national policy but also to give scope to the managers at the periphery"*
> (Klein 1989, p 99).

Harrison (1991) has argued that the 1974 re-organisation can also be seen as a culmination of a long standing trend towards managerial specialism. Specialised finance and supplies officers had emerged in the 1950's and 1960's as had specialist managers in laundry, catering, and domestic work. A professional building and engineering function had developed during this period together with the complexities of building construction and technology as had specialist planners and the NHS personnel function. These two areas arose both as a response to the 1962 Hospital Plan (see table 1), and the increase in unionisation and legislation surrounding employment (Bernard and Harrison, 1986). The 1974 re-organisation formalised these trends, and added managerial hierarchies in the professions allied to medicine[3].

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[2] . Keith Joseph, the then Health Minister, who was aware of efficiency problems in the NHS, enlisted the help of management consultants McKinsey and Company as part of the 1974 reorganisation. This was an early attempt by the Government to borrow management ideas from the private sector (see later).

[3] . Which included groups such as physiotherapists and radiographers.

However, before the new system had had the chance to settle down, the re-organised structure became the subject of criticism. There were delays in decisions being taken. There were difficulties of establishing good working relationships between the administrative tiers, and there was a widespread feeling that there were too many tiers of administration and administrators (Op Cit.). Another re-organisation loomed on the horizon.

Section 2: The Emergence of Strategy and Planning in the NHS

Introduction

The period 1974-1979 was a turbulent one for many Western European Countries, with the problems of the 1974 oil crisis, followed by high inflation and recession. These issues were compounded with rising demand for public services, especially welfare services such as healthcare. In particular, the UK's financial problem at the time became a threat to the principles of the NHS on which the 1974 NHS re-organisation was based upon (see section 1).

The 1974 re-organisation was designed to create a *strategic* intent for the NHS, and in 1976, the DHSS began to operate a planning system designed specifically for the NHS. Health Authorities were to produce strategic plans which would reflect DHSS National Priorities and guidelines for different healthcare services (DHSS, 1976). The NHS strategic planning system was one of the main methods through which particular patient grouping policies were to be implemented. The planning system did not involve the acute sector, but rather focused on services to groups of patients which had not developed as well as services in the acute sector. These services included:

- The elderly;
- The mentally handicapped, patients with mental illness and;
- Maternity and child services.

The system was introduced to ensure greater compliance with central government priorities. Strategic plans were to be constructed at RHA and AHA level for a ten year period, and provided the context for annual operational plans prepared by AHA's and the DMT's which would be for a three year period (Op Cit.).

The Planning Cycle

The planning was designed in a cycle. DHSS guidelines and resource targets were issued to RHA's. The RHA's added their own plans, and issued them to the AHA's. The AHA's then added their own priorities and issued the plans to the DMT's. Finally the DMT's were then responsible for preparing District operational plans. These District plans were then passed back to the AHA, and then to the RHA, and then back to the DHSS for final approval. Also in 1976 a new funding formula was devised for the NHS in England to allocate resources within the NHS. The new funding formula was to assist in the strategic planning process. There also was the emergence of annual planning and priority guidance which was issued each year to RHA's and AHA's. This planning guidance set out the Government's targets for health and included specific areas where spending should be targeted, for example, heart disease and stroke.

The funding formula was devised by the Resource Allocation and Working Party (RAWP)[4] set up by the DHSS (DHSS, 1977). The RAWP formula established target funding allocations based on a series of variables including population age, sex, and social deprivation. Its immediate impact was to switch resources away from the London area, and had as its long term objective, to increase the *strategic* direction of the NHS (Op Cit.). The NHS planning system was seen by the Government as an important mechanism for *strategic* control of the NHS. This system was also typical of the approach to corporate planning in Government, and the private sector of the 1970's (see chapter 4).

However, the NHS planning system was not particularly successful, and did not operate in the manner intended by the DHSS (Ham, 1992). Not every Health Authority prepared plans. There was an absence of the relevant planning skills, which together with NHS spending constraints led to the lack of commitment to planning.

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[4] .RAWP only covered England. Scotland, where the research for the thesis was conduced developed its own funding formula. This will be discussed in chapter 2.

Where planning was carried out, each tier of the NHS considered itself capable of making strategic judgements and did not want to be dictated to by higher tiers. Expectation of the system were also very high, and the complexities involved with a comprehensive rational planning model laid down by the DHSS became very apparent, such as a lack of flexibility and the power of interest groups to veto decisions. The Government began to realise that strategic planning had problems. The design of the planning system attempted to challenge the power of the acute sector, especially doctors. This led to it being challenged by vested interests which resulted in the system being changed in 1982. Barnard et al (1980) stated that the changes made to the planning system was a recognition that planning is often subject to adaptation, bargaining, negotiation, and a reconciling of conflicting interests.

The second re-organisation

In 1979 a new Conservative Government was elected which was committed to reducing public expenditure, gave a manifesto pledge to decentralise the NHS, and had a political ideology which challenged the welfare state. This new Government was not committed to an ideology of rational planning, but instead supported the principles of minimal government involvement in the state and a market economy.

The Conservative Government's first White Paper on the NHS was 'Patient First', published in 1979 (DHSS, 1979). The NHS was to be re-organised again. This took place in 1982, and its most important feature was the removal of the AHA tier, to be replaced by District Health Authorities (DHA's). The central role of the DHA's in the new NHS reflected what Klein (1989) has called the 'public philosophy' which emerged during the 1970's and 1980's. The DHA's were to make decisions as close to the patient as possible. DHA's would be established in the smallest geographical area within which it would be possible to allow them to carryout the planning, provision, and development of health services. This resulted in the creation of 192 DHA's across England and Wales. The 1982 re-organisation also saw the removal of the

expertise factor so prevalent in the 1974-82 period. The Government's priorities for planning were the same, but the significant change was not policy *aims*, but policy *means* (Op Cit.).

The 1979 White Paper no longer used the language of financial targets, but instead emphasised the importance of developing better tools of analysis and information systems designed to assess the quality and efficiency of the services being provided. The NHS Planning system was changed and simplified as part of the 1982 re-organisation. This saw the DHA developing as the basic planning unit. The operational annual plans were replaced by short-term programmes covering two years. Strategic plans were now to be prepared every five years, and covered a forward period of ten years. From 1982-1988, the Government enacted a series of initiatives primarily aimed at reducing expenditure. We saw for the first time, a concern over efficiency within the NHS which was to continue until the mid 1990's. Some of these built on existing public sector initiatives, but other were developed specifically for the NHS. These are illustrated in table 2.

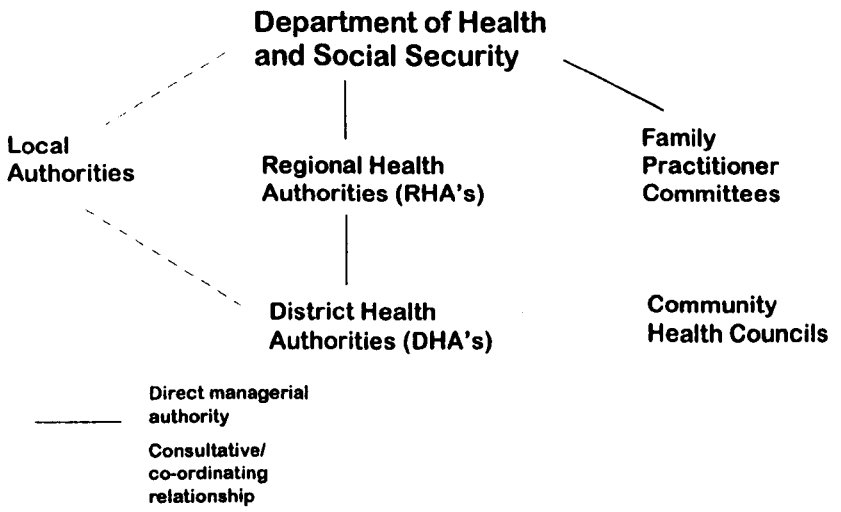
Within DHA's, the emphasis was placed on the delegation of power to units of management. The main change of the 1982 re-organisation saw the loss in many parts of the country of the principle of co-terminosity between Health Authorities and Local Government. FPC's were also separated from mainstream NHS management, and given the status of employing authorities in their own right. A number of Special Health Authorities were established to manage the teaching hospitals in London. The new structure is illustrated in figure 3.

Table 2. Policy initiatives Designed to make the NHS more Efficient and Effective.

Year	Report/Initiative	Subject of Report/Initiative
1982	Rayner Scrutinies	Examined NHS transport, service recruitment, advertising, and collection of payment following Road Traffic Accidents.
1982	Accountability Reviews	Annual review process between Secretary of State for Health and RHA Chairs, RHA's and DHA's to monitor and review NHS operations against plans.
1983	Compulsory Competitive Tendering (CCT)	CCT of NHS catering, laundry and portering services.
1983	Performance Indicators established	To give comparisons between the performance of hospitals, and Health Authorities, (e.g.) cost per patient treated, waiting lists, and availability of particular services to any given population.
1984	Limited Prescription List established	An attempt to force doctors to use generic drugs thus reducing the NHS drugs bill.
1988	Hospital and Medicines Act	Enabled hospitals, and other NHS organisations, to generate additional income.

The 1982 re-organisation, much in the same way as the 1974 re-organisation, represented a compromise between competing ends and values. The 1982 re-organisation also left unresolved the dilemma of the relationship between the centre and the periphery. Decentralisation was the principal aim of both the 1972 and 1982 re-organisations, and this was augmented by managers being accountable for their actions to higher tiers of the NHS.

Figure 3. The 1982 Re-organisation of the NHS in England (Source: Klein, 1989).



Holiday (1992) argues that the NHS up until 1983/84 was run on the two main areas of consensus management and strategic planning. Prior to 1982, managers in the NHS had acted in a diplomatic manner attempting to reduce the tensions between the many professional groupings within the service. These groups had developed their own particular hierarchy, both internally and externally, within the NHS. There were problems which arose because of these hierarchies, mainly in relation to the medical profession, because there were no formal mechanisms to make doctors responsible to non-doctors. The strategic planning model, to be successful, needed to have objectives developed nationally, fed down to Regional and District level, and then implemented. However, the lack of a well functioning managerial hierarchy, and the lack of political will, made this impossible.

> *"The NHS was an essentially collegiate system run by a series of professional groups. This made it well equipped to deal with a static environment in which little changed, for existing medical practices could be handed down from one generation to the next. It was less well equipped to deal with a changing environment in which strategic choices needed to be made, the NHS did not have a system for implementing any strategic choices that might be taken"* (Holliday, 1992, p 14).

The Griffiths Report

Immediately after the 1982 re-organisation in England, the Government appointed a team headed by Roy Griffiths the Deputy Chair of Sainsbury's to examine and advise the Government on the effective use of management, manpower, and related resources within the NHS. The team visited a number of hospitals in England and reported within six months. Griffiths made a number of recommendations relating to the NHS and gave suggestions for remedy (Griffiths, 1983). The Government accepted the report and its recommendations, implementing them in full in 1984, although in Scotland this was a year later (Hunter and Williamson, 1991). Table 3 summarises the Griffiths Report's diagnosis on the NHS and its recommendations.

Table 3. The Griffiths Report: Diagnosis and Recommendations (Source: Griffiths, 1983).

Griffiths Diagnosis	Griffiths Recommendations
Lowest common denominator of decision making, no-one in charge	General Managers in place of consensus management
Lack of concern with policy implementation	Extensive review process and incentives for managers
Lack of performance orientation	Extension of review process, cost improvement programmes, and management budgets
Lack of attention to consumers	More concern with consumers and market research

The report recommended that General Managers be appointed at all levels within the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff, and develop a more dynamic management approach. In a move which would be continued into the NHS reforms of the late 1980's and early 1990's, Griffiths suggested that doctors should accept the responsibility for management which went with clinical freedom, and should be more involved with management. Griffiths also expressed concern over the way the centre had become involved in the detailed and operational affairs of the NHS.

There was both too much and too little intervention, and the NHS suffered from many directives on operational matters, with little clear direction on overall strategy. To strengthen the management of the NHS at the centre, Griffiths recommended an NHS Supervisory Board, and an NHS Management Board be established. The Supervisory Board was intended to provide strategic leadership, and the Management Board was to provide policy direction.

The Impact of Griffiths

The impact of the Griffiths Report was uneven. The Supervisory Board rarely met, and it did not provide the strategic leadership suggested by Griffiths. The Management Board was more effective in for example, introducing Individual Performance Review and Performance Related Pay for senior NHS managers. However, it did not give the policy direction that Griffiths argued was needed at the centre. The main reason for these failures was that the responsibility for management and policy were separated within the DHSS. Because of this separation it was not possible to develop a coherent approach to NHS management and strategy as a whole (Harrison, 1988).

At the local level, there was also variation of the impact of Griffiths. Managers were appointed on short-term contracts, and this did indeed lead to what Harrison (1988) has called a more purposeful management style. However, there was not a new approach to management at the centre, and the DHSS still intervened on operational issues. The DHSS continued to issue guidelines and priorities which had the effect of forcing managers in the periphery to spend their time dealing with the dictat of the centre, rather then being innovative. There was a major concern among managers for efficiency and keeping within their budgets. Griffiths argument for a more consumer responsive NHS was not met as the overall concern was one of financial control. Ham (1992) argues that the implementation of the Griffiths Report offered two lessons for the NHS. The first was that attempts to apply business principles and practices to an organisation such as the NHS were problematic because of the political environment in which the NHS operated. As a result NHS policies were determined and

shaped ultimately by political forces, and these political forces inevitably acted as a constraint on NHS managers. Secondly, NHS managers did not find it easy to develop more effective working relationships with healthcare professional, especially hospital doctors.

Management Budgeting and the Resource Management Initiative

Griffiths stated that doctors should become more involved with management, and the management of resources. This was to be achieved through the use of management budgets which would involve relating clinical workloads and service objectives to financial and manpower allocations. In this way management budgets would provide the means for General Managers to analyse clinical inputs to outputs. Four management budget pilot sites were set up in 1983, with a further thirteen in 1985 (Packwood et al, 1991). Management budgets were not introduced with any consideration of the needs and interests of clinical staff. As a result they failed to link costing and budgeting developments with the hospital management process and particularly with individual patient activity (Op.Cit). Because this link was not present management information systems provided little benefit to healthcare professionals. This resulted in lack of support from healthcare professionals and the management budget pilots failed.

Management budgets developed into the Resource Management Initiative (RMI), which was introduced in 1986 to take forward the principles outlined with management budgeting (Op Cit.). This change in terminology from management budgets to RMI signalled a shift in emphasis away from a system of budgeting in isolation, to an approach intended to win enthusiasm from healthcare professionals for a new kind of management within hospitals. The RMI was now to be a bottom-up approach, rather than the top-down approach used with management budgeting. The RMI, in much the same way as management budgets, was intended to provide, not only doctors, but other healthcare professionals, a complete and immediately accessible picture of the costs and resources used for treating hospital patients. It was a system designed to enable doctors to look ahead at intended clinical decisions, their

resource use, and required doctors to conduct regular reviews of expenditure against an allocated budget (Levitt and Wall, 1992). Initially set up in 1986 within 6 hospital sites in England, it was subsequently expanded to cover more of the English NHS and some parts of the Scottish NHS.

The RMI was based on a number of assumptions:

- Cost consciousness between doctors and nurses would lead to economies in care;
- Involving doctors in hospital management would lead to a greater commitment to the hospital's goals;
- Providing accurate information concerning clinical activities would improve the quality of care given to patients and;
- Management and information systems would allow managers to plan and control their hospital activities on a much improved basis.

The RMI also saw the development of decentralised management structures within NHS hospitals. These structures were allocated a 'resource' to be managed by clinical professionals. These decentralised management structures and the RMI will be discussed further in chapter 5 in relation to clinical management. Before moving on to the next stage in the evolution of NHS organisation and management, we need to examine in more detail the rationale behind this evolution. This rationale affected the whole of the UK public sector including the NHS. Section 3 will now examine these changes.

Section 3: The Changing Public Sector

Introduction

This section will examine in detail the more recent changes arising within the UK public sector. These changes have emphasised the introduction of private sector management techniques into the public sector, and have provided the opportunity for public sector managers, including those within the NHS, to use private sector management practices for the first time.

The late 1980's saw an intense period of change in the public sector which was underpinned by legislation allowing these changes to become embedded in the UK. Glennerster et al (1991) have argued that these changes have represented a significant departure in Government policy which was not based on previous incremental change. These changes, taken together, were an attempt to make the public sector more 'business-like' with reform programmes going beyond structural change and involving new roles, organisational forms, and what Ferlie et al (1996) have called a 'new organisational culture'.

Hogget (1991) has argued that changes to the organisation and management of public services in the UK constitutes a 'paradigm shift' towards a post bureaucratic form. Three fundamental and inter-related strategies of control were implemented by the Conservative Government between 1979 and early 1990's:

- There was been a marked shift towards the creation of operationally decentralised units concomitant with attempts by the Conservative Government to increase centralised control over strategy and policy,
- There was the introduction of competition between these decentralised units based upon market relationships and the use of contracts and,

- Issues related to performance management and monitoring developed, such as audits, quality assessments and accountability reviews.

Hogget (1996) in his later work continued to state that taken together, these three areas were not a simple move from a bureaucratic to a post-bureaucratic public sector, but rather they combined strong elements of innovation with the re-assertion of what were essentially a number of bureaucratic mechanisms, one of which was control.

> *"There can be no denying the reality of the freedoms which many service managers now enjoy compared to the past - freedoms to vire moneys, to hire, fire and promote staff etc. But what has been striking about developments in the UK public sector over the last decade is the way in which the shift towards forms of operational decentralisation has been promoted by successive Conservative administrations which by 1988 had already created one of the most centralised forms of government Britain had experienced this century"*
> (Hogget, 1996, p 18).

The New Public Management

Taken together, these changes saw the emergence of a New Public Management (NPM) whose central theme has been the importation of a number of management techniques from the private to the public sector. The NPM has been seen by critics as a market based ideology invading public sector organisations previously infused by a counter culture of values (Laughlin, 1991). It has also been seen as a management hybrid with a continuing emphasis on core public service values, albeit expressed in an new way (Ashburner et al, 1996).

Since 1979, four NPM models have developed (Ferlie et al, 1996). While each of them represents a move away from traditional public administration, they also contain important differences and distinctive features.

- *NPM 1*: seen as an efficiency drive, and is perhaps the earliest model to emerge throughout the early to mid 1980's. It represented an attempt to make the public sector more business like, led by crude notions of efficiency. Government advisors drawn from

the private sector such as Griffiths, and bodies such as the Audit Commission, played an important role in diffusing these ideas within the public sector.

- *NPM 2*: downsizing and decentralising. This model can currently be seen as increasing in significance, undermining, and contradicting some of the earlier changes brought about as a result of NPM 1. It sprang from the argument that the historic shift towards large vertically integrated organisations apparent in the 1900-1975 period had gone into reverse. This resulted in some very general organisational developments including organisational downsizing and a search for greater efficiency. These trends were seen as common to both private and public sectors.
- *NPM 3*: in search of excellence. Originating in the "excellence" literature of the 1980's, in part it represents the application to the public sector of the human relations school of management with its strong emphasis on the importance of organisational culture. It highlights the roles of values, culture and symbols in shaping how people actually behave at work.
- *NPM 4*: public service orientation. The least well developed and still to reveal its full potential. It represented a fusion of public and private sector management ideas 're-energising' public sector managers by outlining a distinct public service mission, but one compatible with notions of high quality management derived from transferable good practice in the private sector.

These reforms perhaps have had more development in the NHS than in any other area of the public sector. For Ferlie et al (1996), the NHS and Community Care Act of 1990 put into place the latest stage of the NHS reform process representing an ambitious attempt to move the NHS from an essentially planned and line managed organisation to one where resources are allocated through a competitive internal or quasi-market. The development of DHA/NHS Trust Boards (see later), with the inclusion of senior managers was critical to this process. The new Boards were nurtured in the expectation of the development of a more central *strategic* role in the management of the service.

Table 4. The Evolution of New Public Management Models (Source: Adapted from Ferlie et al. 1996).

NPM Model	Characteristics of Model
1.	An increase in attention to financial control. A stronger general management spine. Increased stress on public sector organisations being responsive to consumers.
2.	An extension of the early stress on market-mindedness, to more a elaborate development of a quasi-market. A shift from central planning to quasi-markets as the mechanism by which resources are allocated in the public sector. A move from management by hierarchy, to management by contract. A split from a small strategic core and a large operational periphery. Market testing and the contracting out of non-strategic functions. The emergence of separate purchaser and provider organisations. Delaying and downsizing.
3.	An emphasis on 'organisational learning', which includes the recognition of organisational culture as a form of 'glue' which binds organisations together. Radical decentralisation with performance judged by results. Managed culture change programmes. More intensive corporate training programmes, and the growth of corporate logos. Mission statements and uniforms. A more assertive and strategic human resource function within public sector organisations.
4.	A major concern with service quality. A reflection of user, rather then consumer concerns, in the management process. Stress on the development of societal learning over and above the delivery of routine services. A desire to shift power back from appointed to elected representation on public sector Boards. A continuing set of distinctive public sector tasks and values, and the management of the distinctive politics of collective provision.

A change of language within the NHS was also significant, as General managers of hospitals and health authorities became Chief Executives, and senior managers in these groups became Executive Directors. The relative autonomy of public sector organisations brought with it greater management responsibilities for reaching the Government's externally set financial objectives and the setting up of an internal organisational *strategy* for the fulfilment of contracts and future developments (Op Cit.).

Up until the mid 1980's, the dominant problem was that of parochialism and isolation within the public sector (Gunn, 1989). Since the mid 1980's, the problem has been the over mechanistic transfer of concepts from the private to the public sector (Op-Cit.). There are however, similarities which make the application of broader analytical approaches to both types of organisation. It may also be the case that the changing nature of public sector work, the growth in size of public sector organisations, and the changing demands being made upon them, would inevitably lead to the need for change. Gunn (1989) viewed this process as occurring primarily from within the old administrative elite, rather than having been imposed from outside. The desirability of the development of public administration into public management is less of a contentious issue than is the means by which it was achieved. The balance of influence between internal and external forces will determiner the eventual ethos and form that the NPM will take.

Having outlined the rationale and discussed the broad set of changes that the public sector underwent in the 1980's and 1990's, we now turn our attention to the changes affecting the NHS.

Section 4: The 1990 NHS Reforms

Introduction

The 1980's saw a widening gap between the financial resources that the Government was providing to the NHS, and the level of resources needed to meet the increasing demand for health services. Further reform of the NHS had not been in the Conservative Party's 1987 election manifesto, but elected for a third term in 1987 the Conservative Government came under increasing criticism because of a perceived underfunding of the NHS (Klein, 1989, Butler, 1992, Ham, 1992). Many Health Authorities were cancelling non-urgent admissions and closing wards on a temporary basis to keep within strict financial limits. This, coupled with a growing public and professional discontent, continued to put pressure on the Government to act.

The Ministerial Review and White Paper

Prime Minister Thatcher took the opportunity this discontentment presented to her and announced a Ministerial Review of the NHS in January 1988, which would make its findings known within a year (Op Cit.). The review would consist of a small team of senior ministers chaired by the Prime Minister, and supported by political advisers and civil servants. Although the review took place in private, many organisations and individuals took the opportunity to make representations. Finding alternative ways of financing the NHS had been part of the review group's brief, but because of the structural and political problems surrounding this issue, this was quickly changed to a focus on how the NHS could use its resources more *efficiently*. This was to be achieved by changes to the *delivery* of health services.

In 1989, the Government published the White Paper (WP), *Working for Patients* (DoH, 1989), In the WP, the Government upheld the principles on which the NHS was founded (see section 1), and that funding would continue to be provided mainly out of taxation. The main changes to the NHS would be in the actual delivery of health services. *Working for Patients* (WfP) made a number of proposals for the NHS. The main proposals are shown in table 5. The NHS and Community Care Act of 1990 provided the legislation to allow these proposals to be implemented, and they came into force on April 1st 1991.

Table 5. A Summary of the Main Proposals in Working for Patients (Source: DoH, 1989).

The Separation of Purchaser and Provider Roles.
The Creation of an Internal market in Healthcare within the NHS.
The Creation of Self Governing NHS Trusts.
The Transformation of DHA's into Purchasers.
The Introduction of GPFH's as Purchasers.
The Use of Contracts to Provide Links between Purchasers and Providers.

The most important proposal was the separation of the purchasing function from the providing role, the purchaser-provider split, and the creation of an internal market. Markets and healthcare will be discussed in chapter 3. The purchaser provider split separated the DHA's from their hospitals. Acting on behalf their resident populations, DHA's would become purchasers of health services. The Conservative Government were concerned that DHA's would not bring about the necessary changes, and so created another group of purchasers. General Practitioners could opt to become FundHolders (GPFH's), and would be allocated a budget to enable them to purchase health services from providers.

Hospitals became providers of health services, and could apply for 'Self Governing Status' as National Health Service Trusts (NHST's). NHST's were to have a number of freedoms that non NHST's did not have:

- They could dispose of land and property;
- They could borrow money, within limits, from any source, although this would be restricted to borrowing at low rates of interest which meant ultimately from the Treasury and ;
- They could determine the working patterns and remuneration of their staff.

Because of these changes, the *management freedom* of NHST managers were more significant than previous hospital managers were allowed. In particular, they would be free to manage their own affairs without having to report to either RHA's or DHA's. This had had the effect of liberating hospital managers, both non-clinical and clinical, to make service improvements. Purchasers and providers were to relate to each other through the use of contracts. NHST's were to be held accountable for their actions through the contracts they negotiated with their purchasers, rather than in the past through a line management hierarchy to their DHA. Although originally intended for the acute sector, NHST's have developed since 1991 into a variety of forms. These forms include: the acute sector; District provider units, where an entire District provides an integrated range of health services in a single NHST; community and priority services; mental health and mental handicap services; specialist hospitals, such as dental services; and ambulance services (Ham, 1994).

NHS Contracts

NHS contracts were to determine the relationship between NHST's and DHA/GPFH's. They were not legally binding, unlike commercial contracts, and were perhaps better seen as Service Level Agreements (SLA's). The contracts specified what purchasers wished to buy in terms of clinical activity and health services, and included costs, quality and quantity of care (Ham, 1994). Initially, contracts were to be of three types, Block, Cost per Volume, and Cost per Case. The appropriate form of contract has been a major issue within the NHS and the subject of regular guidelines from the NHS Management Executive. Contracts were to be of one year in duration, negotiated between purchaser and provider, and as a result were of a short term nature (Chalkley and Malcolmson, 1996).

Block contracts involved purchasers buying a defined range of services. Payment would be in instalments and tied to agreed clinical activity levels. With cost per volume contracts, purchasers again bought a defined range of services at an agreed price linked to a specified volume of work. These contracts were used for small contract placements by DHA's, and by GPFH's who only wanted to buy a fixed level of activity. Cost per case contracts as the name implied, were to be used either for 'spot' purchases, or for purchasers that were not covered by any of the other two types of contracts. They could also be used for services purchased in special circumstances such as very specialised clinical care (Op Cit.).

General Practitioners (GP's) who were not GPFH's had to refer their patients to a hospital that their DHA had a contract with, although not exclusively. However, the right of a GP to refer his/her patients to which ever hospital consultant they liked was maintained by the use of Extra Contractual Referrals (ECR's). ECR's were referrals by GP's to a hospital with which their DHA did not have a contract. DHA's were responsible for funding ECR's, and as a result had to develop special arrangements for dealing with them. This meant top-slicing some of their budget for ECR use and negotiating with GP's who wished to use an ECR if it was

necessary for them to do so (Ham, 1994). GPFH's, on the other hand, could refer their patients to which ever hospital they wished since they had the resource to do so.

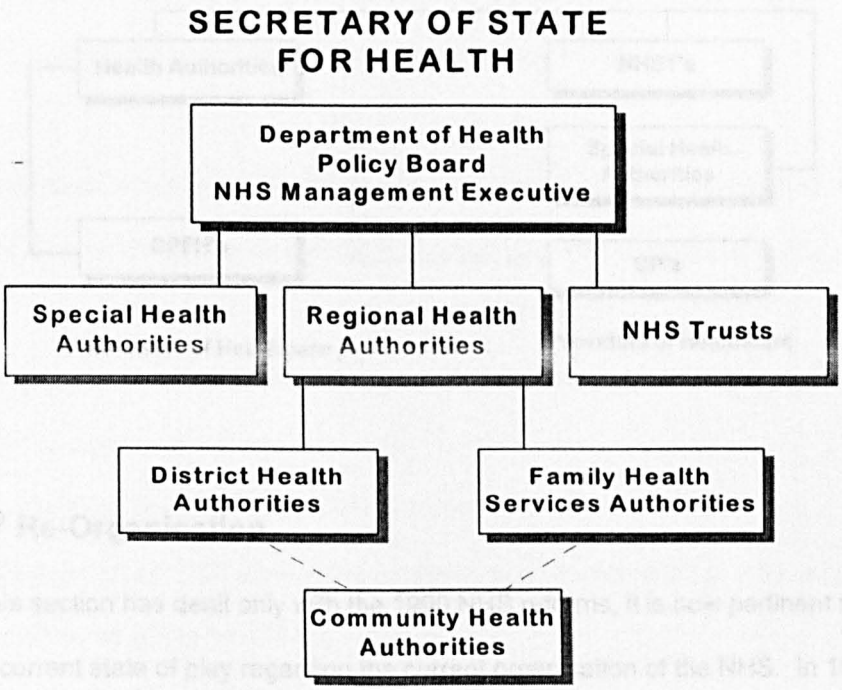
The 1990 NHS and Community Care Act also strengthened the management arrangements at the centre and periphery. Within the Department of Health, the old Supervisory Board was replaced by a Policy Board, and the Management Board was replaced by the Management Executive (ME). Health Authority (HA) members were replaced and reduced in number. No longer elected from particular organisations and the community, the new members formed a Board, which included for the first time managers from the HA's. The managers formed Executive Directors, and appointments were made to Non-Executive positions on the Board (Op Cit.). NHST's also had a similar structure and membership. This was intended to bring a more business like approach to the NHS. By introducing market principles to the NHS, the Government anticipated that services would become more responsive to patients, and that NHST's would be stimulated by competition between other NHST's and the private healthcare sector, to become more efficient in the use of resources.

Loveridge and Starkey (1992) have argued that radical and structural change, as occurred with the 1990 NHS reforms, can open access to resource control and define what are considered as resources in the pursuit of new strategies. NHS managers, according to Loveridge and Starkey, would now have to learn and interpret the 1990 NHS reforms which should see the development of new management theories and practices. These will include NHS managers having the opportunity to analyse the NHS in its total context, and to create *strategic options* which extend beyond the localised concerns of NHS healthcare professionals. These issues will be returned to in chapters 8 and 9.

> *"The potential leverage provided by the [1990 NHS] Act has to be transformed into actual strategic influence through educated analysis and an ability to persuade others of its appropriateness as a basis for action"*
> (Loveridge and Starkey, 1992, p 13).

The Government also stated that it would be a particular type of market, a 'managed' market which would be regulated to ensure that particular services continued to be available to patients. The market when implemented in 1991 was to have a 'smooth take-off' to give the system time to bed-in structurally, and any problem areas to be resolved. Purchaser's referral patterns, as a result, were to initially reflect the previous years patterns. The new structure of the NHS is illustrated in figure 4 below.

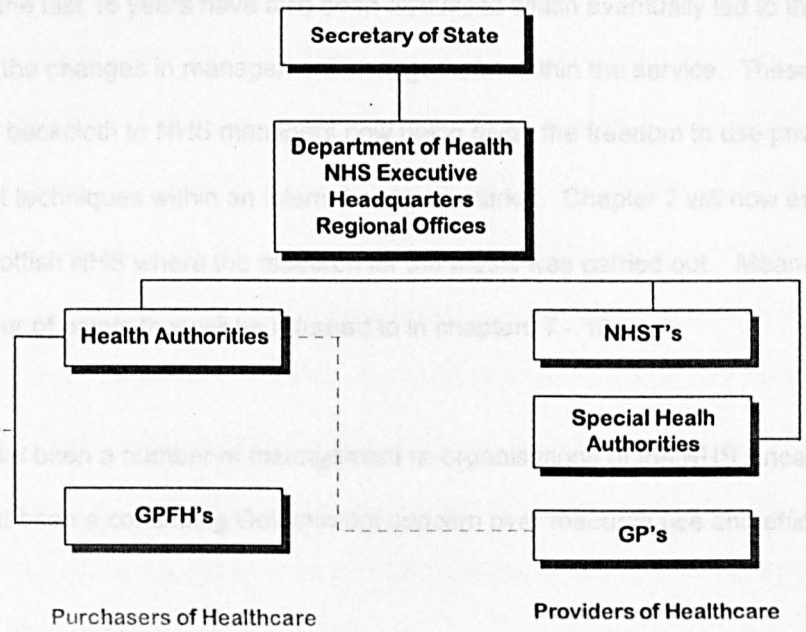
Figure 4. The New Structure of the NHS in 1991 (Source: Ham, 1994).



Pressure on Government spending and the continuing efforts for efficiency savings had the effect of a closer examination of NHS management costs. In 1996 the NHS in England and Wales was subsequently re-organised (Ham, 1997). This re-organisation resulted in the abolition of the RHA's, and in their place the setting up of eight Regional Offices. District Health Authorities and Family Health Services were replaced by 100 unified Health Authorities. NHST's in England and Wales were also affected by this re-structuring exercise and some were forced into mergers in an attempt to rationalise services. This in many ways

simplified the NHS in England and Wales, and indeed brought it into line with the structure in Scotland. The new structure of the NHS in illustrated in figure 5.

Figure 5. The Restructured NHS in England and Wales in 1996 (Source: Ham, 1997).



The 1997 Re-Organisation

Although this section has dealt only with the 1990 NHS reforms, it is now pertinent to briefly review the current state of play regarding the current organisation of the NHS. In 1997 a new Labour Government was elected to Parliament which produced a White Paper, *'The NHS Modern, Dependable'* in the Autumn of 1997 (DoH 1997). The NHS was to be re-organised again. The new White Paper heralded a 10 year rolling programme through which change will be achieved via gradual evolution which avoids much of the recent structural upheavals associated with previous re-organisations (Halpern, 1998). Some of the changes include, the abolition of GPFH, to be replaced with Primary Care Groups, and the internal market, to be replaced by a new funding agreement. However, the purchaser/provider split will remain. Scotland received its own White Paper, *'Designed to Care'* (SODoH, 1997). This will be discussed in chapter 2.

Conclusions

This chapter has examined the development of the NHS, its management and organisation, since the inception of the NHS in 1948. The major changes in public sector management occurring in the last 16 years have also been discussed which eventually led to the 1990 NHS reforms and the changes in management arrangements within the service. These changes provided the backcloth to NHS managers now being given the freedom to use private sector management techniques within an internal or quasi-market. Chapter 2 will now examine in detail the Scottish NHS where the research for the thesis was carried out. Meanwhile we note a number of points that will be returned to in chapters 7 - 10:

- There have been a number of management re-organisations of the NHS since 1948;
- There has been a continuing Government concern over resource use and efficiency within the NHS;
- The term 'management' and 'strategy' appeared in the NHS for the first time through the 1974 NHS re-organisation;
- Strategic Planning emerged in the NHS in 1976;
- The Griffiths report of 1983 allowed the formation of a strategy wing and an operational management wing within the DHSS;
- The Ministerial Review of 1988/89 carried out the most far reaching review of the NHS in its 40 year history and;
- The most significant NHS re-organisation since 1948 occurred in 1991 with the development of an internal market within the NHS, and the setting up of NHST's and GPFH's.

Chapter 2: The Scottish National Health Service

Introduction

Although part of the UK NHS, the NHS in Scotland (NHSiS) is structured, organised, and managed in a different manner to the rest of the UK NHS. The research for the thesis was carried out in the West of Scotland. The NHS in Scotland (NHSiS) provides a wide range of clinical services and is responsible for the provision of primary (community), hospital (secondary) and tertiary services. This chapter will outline and discuss these differences as they existed between 1994 and 1997. The chapter consists of four sections. Section 1 discusses the organisation of the NHSiS. Section 2 examines the composition and operation of the AHB and NHST management Boards. Section 3 provides an examination of the SHARE funding formula, which forms the basis of resource allocation to the Scottish AHB's. Finally, section 4 concludes the chapter with a discussion of the NHSiS in light of the 1997 White Paper *'Designed to Care'*.

Section 1: The Organisation of the NHS in Scotland

Introduction

The Secretary of State for Scotland is responsible for the organisation and delivery of healthcare in Scotland, with responsibility derived from Parliament. The Secretary of State is assisted by the Minister for Health and Home Affairs who is in turn, assisted by the Scottish Office Department of Health (SODoH). The SODoH consists of two parts (Management Development Group (MDG) et al, 1993):

- A Public Policy Unit which is responsible for providing advice and guidance on Public Health issues and;
- The Management Executive (ME) which is responsible for the efficiency and performance of the NHSiS. The ME advises Ministers of policy and ensures that policies are implemented. The ME is headed by the Chief Executive of the NHSiS, who is the Accounting Officer to Parliament for health expenditure in Scotland.

The ME is further divided into a number of other areas. These include, for the purpose of this thesis, the Directorate of Purchasing and the Directorate of Trusts. The Directorate of Purchasing does not in fact do any purchasing. It has responsibility for advising government ministers on setting strategy and direction for the NHSiS, and ensuring that strategy is implemented via formal relationships with AHB's. This is achieved by holding the AHB's accountable for their actions and, at the time of the research, structuring the strategic direction for the NHS market.

The Directorate of Trusts had two main objectives with regard to the NHSiS at the time of the research. This was to create the conditions which:

- Ensured that individual Trusts have the opportunity to be successful and;
- The Trust network can play its full part in delivering the objectives of the NHS in Scotland.

The Directorate of Trusts had a number of other roles which are illustrated in table 5.

Table 6. Roles and Responsibilities of Directorate of Trusts 1991-97 (Source: MDG et al, 1993).

Market (provider regulation)	Policy implementation	Provider policy areas
Public interest intervention	Policy not affected through contracts such as market testing of clinical/non-clinical services	Blood products
Contract disputes		Hepatitis compensation
Corporate governance		Ambulance response
Reconfiguration of NHST's in the future		A limited number of prisoners of war from a number of conflicts
Competition and contestability		

The NHSiS has several objectives which at the time of the research was to be achieved via a market mechanism of purchasing and providing. These objectives included:

- Improving health;
- Developing primary care;
- Promoting care in the community;
- Providing effective healthcare that is 'people centred' and;
- Ensuring value for money.

The Common Services Agency

The Common Services Agency (CSA) manages services which are provided most effectively on a national basis. These include the Scottish National Blood Transfusion Service, the Central Legal Office, the Information and Statistics Division, Scottish Healthcare Supplies, the processing of prescription and dental charges, and the study of patterns of communicable

disease. The ultimate responsibility for the management of the Agency lies with a management board appointed by the Secretary of State and chaired by the Chief Executive of the NHSiS (Op Cit.).

The Area Health Boards (AHB's)

AHB's are the planners and purchasers of hospital and community health services for the people who live in their area. There are fifteen Scottish AHB's covering populations ranging from less than 20,000 to over 90,000. Each AHB is headed by a Board appointed by the Secretary of State for Scotland. AHB's are responsible for assessing their populations need for healthcare which is achieved by collecting information about patterns of morbidity, mortality, and the effectiveness of different medical interventions. AHB's also liaise with GP's, Local Authorities, the voluntary sector and other agencies to build up an assessment of their populations state of health.

Having assessed the needs of their resident population, other task of the AHB's at the time of the research included:

- Managing the contracts of family practitioners;
- Paying practitioners in accordance with their contracts;
- Providing information to the public;
- Dealing with complaints from the public and;
- Allocating funds for GP practice developments.

As a result of the 1990 NHS reforms, the role of AHB's in these areas was strengthened and they are now much more actively involved in the strategic planning and development of primary care services in their areas promoting health. In Scotland, the management of primary care services is an important role for the AHB's, unlike England and Wales where, until August 1996 the task primarily fell to Family Health Services Authorities.

The Shields Report

In 1996 the Shields Report (SODoH, 1996) was published by the Scottish Office. This Report examined the roles and responsibilities of the AHB's, but also the accountability relationship between AHB's and GPFH's in the reformed management structure of the NHSiS resulting from the 1990 NHS reforms. Shields was an update of an earlier Scottish Office document (SHHD, 1991) published in 1990. Government policy has since evolved from 1990, and has re-focused on moving care from the secondary care sector to care in the primary care sector. The central components of a primary care led NHS are that decisions about patient care are to be taken as close to the patient as possible. There are a number of issues arising from this. Patient care should be:

- Managed in the most effective and efficient way;
- As close to the patient's wherever possible;
- Use medical technology suited to community-based practice and;
- Take account of the patient's needs and wishes.

The policy reinforces the fact that the GP is the central focus of healthcare because patients expect to have a continuing and supportive relationship with their GP. GP's also act as the gatekeepers to secondary care. However, unless GP's are FundHolders and possess the appropriate resource, they have little incentive to move the balance of a patient's treatment from secondary to primary care. The Shields Report therefore saw an advantage in AHB's involving all GP's in negotiating, even if they are not purchasing, contracts for their patients.

The Shields Report also considered the role of AHB's as market regulators. It confirmed the NHS internal market as not a *commercial market*. It would require good management to achieve the benefits of competition between healthcare providers, while ensuring that there is not over capacity (seen by the ME, as too many hospitals). Shields' argued that if there was a free market, large changes could occur as healthcare facilities were either built by *new players* or were removed by failure of poor providers. Shields' determined that the NHS in Scotland

needed AHB's to control a large degree of change and to ensure that capacity was matched to demand. AHB's were to take a *strategic* role in managing this change. They were seen as having to be proactive, such as providing GP's with information on value for money, and reactive, such as taking action to consolidate services or encouraging new providers to enter the NHS market. GPFH's were seen by the ME as being accountable for their purchasing decisions, so AHB's would have to 'cause change' and achieve coherent strategies through influence and persuasion. AHB's were not to act as market regulators in the commercial sense. If they did so, they would require power from the ME to direct GPFH's purchasing if the AHB judged that the overall market required it. The Framework set out by Shields' ruled this out. However Shields' considered that its framework offered an effective way of ensuring the benefits of GPFH within a *strategic* setting. Shields' viewed AHB's as being simply purchasers, but having several other roles including, leaders, protectors of public health, commissioners, and strategic planners or market managers. The Shields Report expanded and redefined the 4 responsibilities of the AHB's set out in 1991 into 8 new key responsibilities. These were as follows:

- *Needs assessment*: assessing health status and needs to underpin commissioning, and promoting health gain;
- *Strategic Planning*: of services in collaboration with GP's to meet health needs through an integrated service;
- *Leading and co-ordinating*: consulting widely on their plans and forming working relationships with NHS providers, local health councils and partners in Local Government and commercial sectors to develop appropriate healthcare environments and services;
- *Commissioning*: of integrated primary, secondary and tertiary services to meet assessed health needs, allocating resources accordingly, and monitoring the quality of these services;
- *Developing Primary Care*: developing, promoting and strategically directing primary care;

- *Safeguarding the health of the population*: controlling outbreaks of communicable disease, identifying adverse environmental factors and initiating action to control them, and emergency planning;
- *Undertaking statutory duties*: such as the registration of nursing homes and;
- *Accountability*: being financially accountable for their efficient use of healthcare resources and ensuring Codes of Conduct and Accountability for NHS Boards are followed.

The Shields Report emphasised the fact that AHB's had a strategic planning role in so far that developments were consistent with the aim of increasing healthcare provision at primary and community levels. There were also two areas concerning strategic planning that were raised with Shields:

- The concern that GPFH would have an adverse impact on AHB's ability to plan population wide strategies. This was addressed by Shields by developing a GPFH accountability framework and;
- The concern that teaching and research could suffer if GPFH's began to refer their patients to NHST's or private sector providers which offered lower prices than the teaching hospitals. Shields recommended that AHB's would need to inform GPFH's of the implications if they move services to obtain better access or find lower prices as such action could damage the ability of secondary care providers to provide teaching and undertake research.

NHST's

NHST's were first established in Scotland in 1992. The functions of the NHST's are to provide hospital, community services, dental, and ambulance services on behalf of the Secretary of State for Scotland. NHST's are self-governing units with their own Boards of directors and with freedom to organise their affairs subject to the legal framework and guidelines in which they operate, and the contracts they have negotiated with purchasers. At the time of the research there were 47 NHST's in Scotland ranging from hospitals in the acute sector,

community based NHST's, priority service NHST's, some a mixture of community and priority, and the largest NHST in Scotland, the Scottish Ambulance Service. The total number, their mix and income are illustrated in table 7.

Table 7. The NHS in Scotland, National Health Service Trusts (Source: MDG et al, 1993).

Type of NHST	Number	Income £M: Range	Total
Acute	26 (55%)	10 - 156	1614
Priority/Community	12 (25%)	26 - 147	897
Mixed	8 (17%)	17 - 75	366
Scottish Ambulance Service	1 (2%)	-	77
Total	47		2954

Each NHST is accountable to the Secretary of State via the ME, and at the time of the research there were four main accountability mechanisms:

- An annual strategic plan in which the NHST sets out its plans to develop services, its financial projections and its capital building plans;
- Annual report on the previous year's performance;
- Annual accounts and;
- Monthly monitoring reports.

The main financial duties of NHST's were to earn a 6% return on their assets and to live within the external financing limit (the maximum that the NHST's could borrow from the Government) set by the Secretary of State for Scotland in relation to their capital borrowing.

General Practitioner FundHolders (GPFH's)

General Practices that opted to become FundHolders remained responsible to the AHB's for the provision of primary care services. GPFH developed in three distinct ways since the introduction of NHS reforms in Scotland in 1992. GPFH's were allocated a budget to pay for services, which also covered the cost of the drugs they prescribed and the staff they employed in their practices. The resources allocated to GPFH's were deducted from the resource allocation of their AHB's.

Three GPFH options had developed between 1991 and 1997. These were as follows:

- *Standard FundHolding*: this option was the very first model to be introduced, and allowed GP's to purchase a defined range of hospital and community services for their patients. This included out-patient services, X-rays and laboratory services, in-patient and day-case treatment and community nursing services. Standard FundHolding was later expanded to include specialist nursing services, such as diabetic care, and virtually all elective surgery and out-patient services. There were exceptions, however due to cost implications in areas such as organ transplantation and renal dialysis which were funded centrally by the Scottish Office.

- *Primary Care Purchasing Initiative (PCPI):* this was a new option for GP practices who either were not ready to take on standard FundHolding, or did not want to become involved with the hospital side of GPFH. This option included the GP(s) having the resource to provide staff, drugs, diagnostic tests, and most if not all of the community health services in the standard scheme. It excluded all out-patient attendance and all other acute hospital treatments. The Scottish Office, at the time of the research, intended that this scheme could be used as a stepping stone to the standard scheme or the next stage of GPFH, the Total Purchasing scheme.

- *Total Purchasing Pilots*: this third scheme allowed GP's within an AHB area to purchase *all* hospital and community health services for their patients, including Accident and Emergency services. At the time of the research there were six pilot schemes operating in Scotland. These pilot schemes were on trial basis for three years and they were to be evaluated at the end of 1998.

The final Scottish figures up until the end of April 1997 for these distinct types of GPFH are indicated in table 8.

Table 8. GP FundHolding Statistics - 1 October 1997.

	1990	1991	1992	1993	1994	1995	1996	1997
All FundHolding practices	12	18	69	132	162	286	408	501
FundHolding practices as % of all practices	1.1	1.7	6.4	12.4	15.1	26.8	38.6	47.5
Total purchasing	x	x	x	x	x	20	21	33
Standard	12	18	69	132	162	162	170	175
Primary Care Purchasing	x	x	x	x	x	104	217	293
Patients in FundHolding practices as % of all patients	1.9	2.7	10.9	18.7	22.0	33.4	45.2	53.4

Source: Table L 1.8 GP practices engaged in GPFH at 1 October 1997, Scottish Health Statistics, ISD (Data include practices in preparatory or pilot phases). 'X' indicates that the particular form of GPFH was not yet operational.

Section 2: The Operation of the AHB's and NHST's

Introduction

Both AHB's and NHST's had their own management Boards. Although there are differences in the membership of AHB and NHST Management Boards, the role of the Management Board in these organisations are similar. It is the Boards' duty to set the direction for the organisation and to provide leadership for its employees. For the ME, an effective Board is one that has a clear vision and a strategy for implementing this vision (MDG et al, 1993). There must also be arrangements in place for monitoring progress towards this strategy. As far as possible, Boards were to avoid becoming involved in matters of operational management.

At the time of the research, all management Boards in both AHB's and NHST's had the following structure:

- A Non-Executive Chair;
- A group of Non-Executive Directors (up to 6 in number) and;
- A group of Executive Directors (up to 6 in number).

Directors were equal in status and carried corporate responsibility for the work that was done in their respective organisations. They did not however, carry the same legal liabilities as company directors. In relation to their duties, all directors of AHB's and NHST's enjoyed immunity under the law while they were engaged on either AHB or NHST business. The significant change was that the Executive Directors of both AHB and NHST Boards were previously full-time officials of their organisations. They were the managers of either AHB's or hospitals that became NHST's.

Another difference from company Boards, is that AHB's and NHST's functioned in the public sector. This meant that there was often much public and media interest in the decisions that

they made. It also required Boards to be accountable for their actions to the local community, although they were not directly accountable to the community, but to the Secretary of State for Scotland. As a matter of policy, many Boards were seeking to be as open as possible to the public and to foster good relation with the public and the media. Table 9 indicates the composition of AHB and NHST Boards between 1991 and 1997.

Table 9. The Composition of the Management Boards of AHB's and NHST's , 1991-97 (Source: MDG et al, 1993).

	Area Health Boards	NHST Trusts
Chairs	Appointed by the Secretary of State, following selection procedure outlined above	As per AHB's
Non-executives	Normally six appointed by the Secretary of State, on the basis of independent Health Appointments Advisory Committee. Boards with a medical/dental school in their area include a representative from the relative University.	As per AHB's
Executives	Up to six appointed by the Secretary of State including the General Manager, Directors of Finance and Public Health	Up to six including Chief Executive, Medical and Nursing Director, appointed by Chair and non-executives

The Accountability of AHB's

Chapter 1 discussed the development of an accountability review process in England and Wales. There is a similar mechanism in Scotland. The review process is conducted on an annual basis between the Scottish AHB's and the ME. It determines the purchasing intentions of the AHB's for the year ahead, and examines the previous years achievements against the previous Accountability Review. This Review is then translated into a 'Corporate Contract' which formulates the AHB's intentions for the year ahead. The Corporate Contract identifies the objectives against which AHB's intend their achievements to be judged and includes specific measurable targets and milestones which allow both the AHB's and the ME to track

progress. Annual targets in the Corporate Contract relate to each AHB's longer-term strategic aims and also national priorities. The aim of the annual accountability reviews are to establish whether AHB's are achieving the intentions set out in their Corporate Contracts and are implementing national policy.

Planning and Priority Guidance

The ME also issues Planning and Priorities Guidance[5] to all the AHB's, GPFH's, and NHST's in Scotland each year. It is the intention of the ME that this guidance provides the overall context for the planning and delivery of health services for the year ahead. It focuses the NHSiS on what the ME considers to be the most important National priorities. For 1996/97, the guidance continued on the previous years themes of four strategic aims, and three clinical priorities for the NHSiS (SODoH, 1996). These four strategic aims were: improving health; developing primary care; promoting care in the community; and reshaping hospital services. The three clinical priorities were: mental health; coronary heart disease and stroke; and cancer. AHB's, GPFH's and NHST's, all have a role to play in discharging the Planning and Priorities Guidance. Table 10 summarises their respective roles.

Table 10. The Roles and Responsibilities of AHB's, GPFH's and NHST's in relation to the 1996/97 Planning and Priorities Guidance (Source: SODoH, 1996).

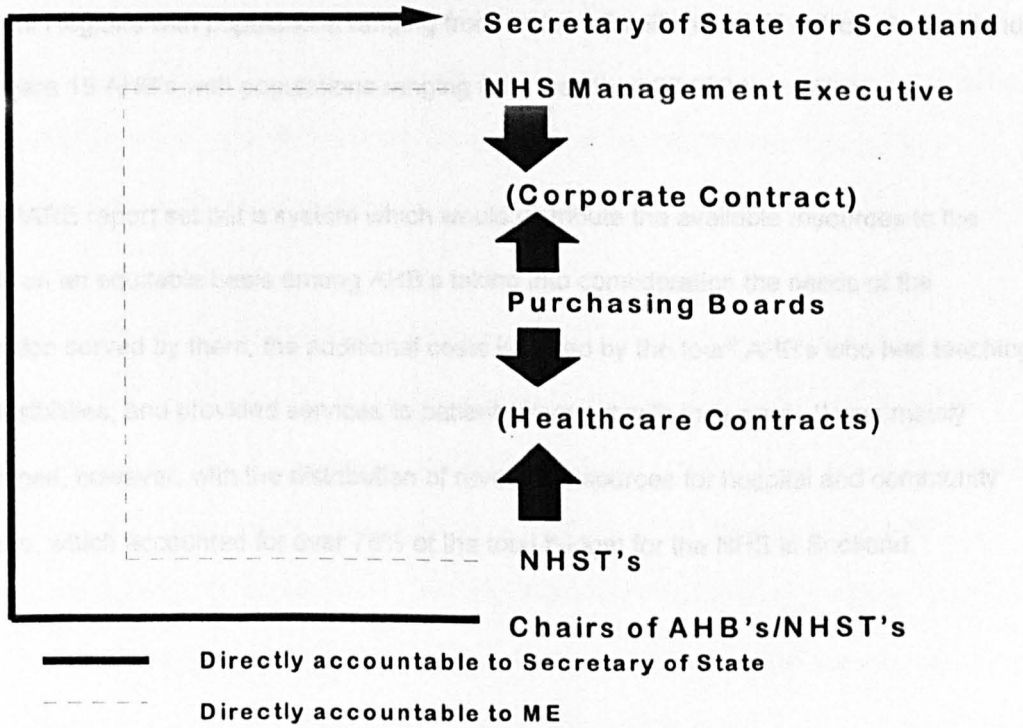
AHB's - must ensure that they reflect the contents of the guidance in the following:	GPFH's - and where appropriate, GP's, should reflect the guidance in the following:	NHST's - should reflect the guidance in the following:
Local Health Strategies	Their purchasing plans	Their business planning
Purchasing Intentions	Their practice plans	Their contracts with AHB's, GPFH's, and other purchasers
Contracts with NHST's and other providers		
Corporate contracts with the ME		
Inter-relationship with primary care		

[5]. Similar to that issued by the Department of Health England (see chapter 1).

Contract Development

Since the introduction of the NHS reforms, considerable progress has been made in the development of contracting (see chapter 1). The ME now *expects* all purchasers (AHB's and GP's) to emphasise the need to involve clinicians[6] in contract development and negotiation, and that contracting should be undertaken in the context of a clear understanding of the likely financial resources available for the contract period ahead, together with the longer term financial strategies of purchasers. Figure 6 illustrates the organisational relationships of the NHSiS up until the end of April 1997.

Figure 6. Organisational Relationships of the NHS in Scotland 1992/97(Source: NHSiSME).



6. This issue will be examined further in chapter 9.

Section 3: The SHARE Funding Formula

Introduction

Following the RAWP funding formula in England, a similar formula was devised for the Scottish NHS. A Working Party on Revenue Resource Allocation was set up by the Scottish Home and Health Department (SHHD) in 1976. This working party subsequently produced the SHARE[7] report (SHHD, 1977). SHARE was based on the English[8] RAWP, and its equivalent in Wales. RAWP was seen as a breakthrough in bringing a theoretical concept of population "needs" into the practical realm of guidelines for an actual distribution of resources (Op-Cit.). However, because the AHB's in Scotland differed substantially in scale, and in the range of services offered, RAWP was not seen by the SHHD as being directly applicable to Scotland. RAWP was designed for the NHS in England for a distribution amongst largely self sufficient Regions with populations ranging from under 1.3 million to 5.75 million. In Scotland there were 15 AHB's with populations ranging from less than 20,000 to 1 million.

The SHARE report set out a system which would distribute the available resources to the NHSiS on an equitable basis among AHB's taking into consideration the needs of the population served by them, the additional costs incurred by the four[9] AHB's who had teaching responsibilities, and provided services to patients from out with their area. It was mainly concerned, however, with the distribution of revenue resources for hospital and community services, which accounted for over 78% of the total budget for the NHS in Scotland.

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7. SHARE, the Scottish Health Authorities Resource Allocation Report.

8. Resource and Allocation Working Party set in England in 1976. RAWP suggested that each of the English Regions should have a target allocation, reached over a period of time, based on a formula based on its population profile and deprivation factor. RAWP proved slow and difficult to implement, and was abandoned after the 1990 NHS Act before equity of resource allocation had been achieved.

9. These AHB's were Greater Glasgow, Grampian, Dundee, and Lothian.

The main elements of the SHARE system was based on the following:

- *Population*: the population of each AHB was given a weighting according to certain measurable characteristics such as morbidity which reflect requirements for healthcare;
- *Movement of patients*: modifications were made to take account of patients resident in one AHB who were treated in the hospitals of another AHB and;
- *Highly specialised services and teaching hospitals*: allowance was made for the four teaching AHB's who had responsibility for providing clinical facilities for the training of doctors, dentists, the highly specialised facilities which required additional training for nurses and other healthcare professionals, and also for the provision of regional or national specialist services.

The result provided an indication of the 'shares' which each AHB should ideally receive if expenditure on hospitals and community services was to be equalised over the population of the whole country. The test of the model was not how closely its results correspond to some kind of ideal provision of health services, but simply how far they achieve an equitable distribution of the available resources.

The result of the 1977 calculations indicated that about 3.5% of the total revenue actually allocated to AHB's would require to be redistributed in order to bring AHB's to "parity" as assessed by the working party formula. It would have been possible to do this comparatively quickly if the disparities between the AHB's were relatively small. However, two AHB's, Ayrshire and Arran and Tayside would have had much farther to go to reach "parity" under the SHARE formula. Ayrshire and Arran would have to have had its resource base increased by 40%, and Tayside would have had to have its resource base reduced by 16%. Due to a slow growth of available resources and the general economic climate of the late 1970's, the redistribution was not made at the one time. Instead it took place over a period of several years.

By redistributing resources over a number years the Scottish Office thought that an equitable distribution would be achieved without money being transferred between AHB's so rapidly that those moving upwards towards parity could not use the extra money to their advantage, and those moving downwards would not have time to plan and carry out the necessary adjustments to the provision of services. Services provided by the CSA and National services which could not be readily incorporated within the model, such as blood transfusion and organ transplantation, were funded directly by the Scottish Office. The system for calculating the equitable share of the AHB's was progressively refined and updated with the figures recalculated each year, and was due to be completed by 1998.

Practical Application

The provision of equitable shares in accordance with the SHARE formula would, in comparison with the actual shares in 1975-76, entail a reduction in the shares of four AHB's. Tayside by 16.17%, Lothian by 4.77%, Greater Glasgow by 2.96%, and Highland by 2.14%. All other AHB's would receive larger shares, the increases ranging from 1.29% to 39.57%. The report also discussed the particular problems which faced Greater Glasgow Health Board. Its allocations were likely to fall markedly during the remainder of the century as a result of a declining population, a decline from the existing high level of cross boundary flows[10] into the area, and the likely development of supra-area services by other AHB's in the West of Scotland. Table 11 indicates the most recent figured produced by the Scottish Office concerning AHB parity. The plus signs indicate that the AHB concerned will be gaining resources, the minus signs indicate the AHB's that will be losing resources. The implications of this loss/gain for the AHB's concerned will be discussed in chapters 7-10.

[10]. Cross boundary flows are patients who are not resident in these AHB's catchment areas and are referred by clinicians in other AHB's for treatment in the teaching hospitals within, for example Glasgow or Edinburgh hospitals.

Table 11. Resource allocations for the Scottish AHB's using the SHARE formula, 1993/94 (Source: MDG et al, 1993).

Area Health Board	93/94 Allocation for spending on resident population £M's	Distance from Weighted Capitation
Argyll and Clyde	200.890	- 0.9
Ayrshire and Arran	159.675	- 5.3
Borders	50.829	- 2.0
Dumfries and Galloway	72.064	- 1.2
Fife	148.179	- 3.1
Forth Valley	119.170	- 1.3
Grampian	230.902	- 2.1
Greater Glasgow	520.467	+ 4.0
Highland	95.192	- 0.5
Lanarkshire	225.656	- 2.1
Lothian	358.175	+ 0.7
Orkney	10.479	+ 0.6
Shetland	11.869	+ 1.4
Tayside	208.799	+ 3.6
Western Isles	18.403	+ 1.7
Total	**2431.469**	0.0

Section 4: The NHSiS and the 1997 White Paper

Introduction

In May 1997 a new Labour Government was elected to office. This new Government was set to change the Conservative's 1990 Reforms of the NHS, and in December 1997 a White Paper was published, *'Designed to Care'* (SODoH, 1997) which set out the Government's plans for the NHSiS. England received its own White Paper which was briefly discussed in chapter 1.

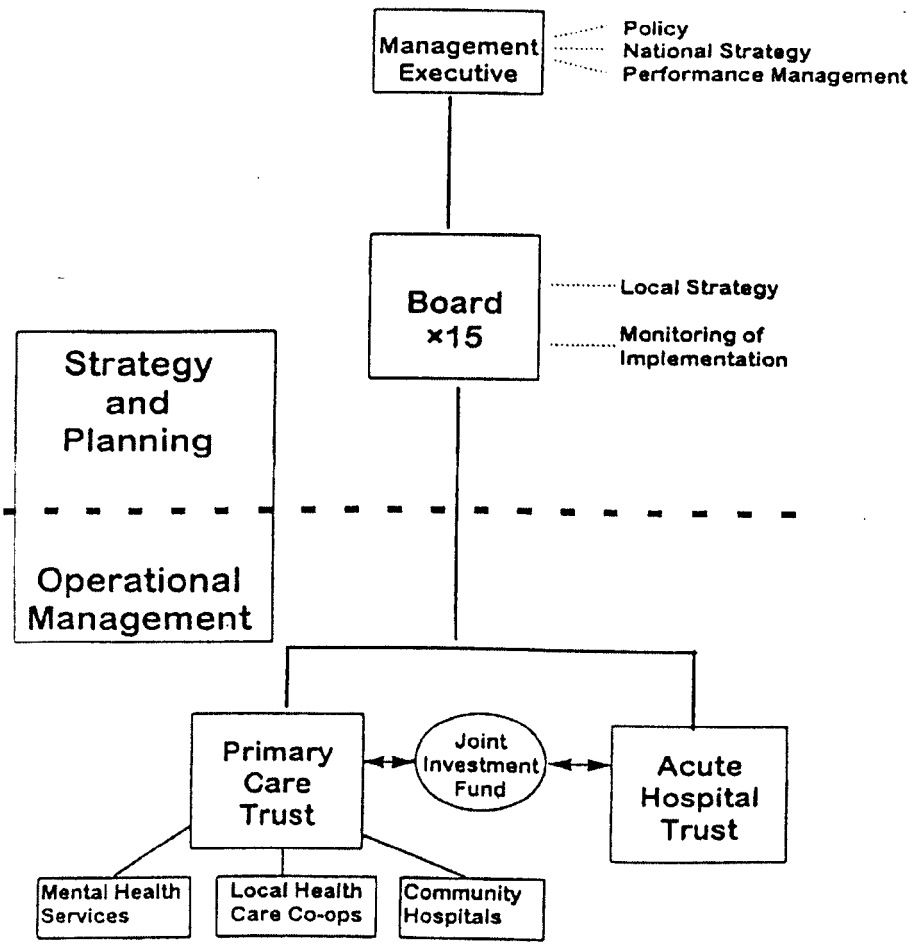
Designed to Care pointed to a range of initiatives which were intended to restore the NHSiS as a public service working co-operatively for patients, rather than operating as a business which was driven by competition. There were a number of important changes, the most important being the reduction in the number of NHST's, and the abolition of the internal market and GPFH's. Strategy and planning is also to change and will now be the sole remit of the AHB's. The NHST's are now to concentrate on operational management. Other significant changes include:

- NHST chairs are to sit ex-officio on AHB's as NED's and as such will be involved in the ME's Accountability Reviews;
- NHST Chief Executives will not only be accountable to their AHB for their use of resources, but will carry responsibility for the quality of care that their NHST provides;
- Equitable distribution of resources, facilitated by the creation of a single, cash limited, funding stream and review of the current SHARE resource distribution formulae. AHB's weighted allocation from the SODoH will now cover both hospital and community health services, prescribing, general medical services and other practitioner related costs and;

- A Joint Investment Fund (JIF) is to be created by the AHB's to facilitate co-ordination between primary and secondary care and foster appropriate changes to the clinical setting in which care is delivered.

The new structure of the NHSiS is illustrated in figure 7.

Figure 7. The New Structure of the NHSiS (Source: SODoH, 1997).



The AHB's are to produce a Health Improvement Plan (HIP) for their area. This plan is to detail developments in healthcare services within the AHB's area which are *designed* to improve the health of the local population in relation to national and local priorities. NHST's are to re-focus their activities on the delivery of patient care and the improved quality of clinical services and will be no longer required to produce individual strategic plans and lodge these plans with the ME.

Instead, the NHST's are now to produce a Trust Implementation Plan (TIP) showing how their AHB HIP is to be put into effect within the individual NHST. The TIP's, like their strategic plan predecessor, are to be submitted to the ME to demonstrate that each NHST's financial targets will be met. TIP's, as a result, must also take into account the financial contributions from other AHB's to cover the costs of treating their patients. This in effect will also help to facilitate the ME's performance management of AHB's (see earlier) in ensuring that the NHST's are being properly held to account for the implementation of the relevant HIP. Although the NHSiS will now change in the next 2-3 years, the research was carried out at the height of the Conservative Government's 1990 NHS Reforms.

It is proposed that the 15 AHB's will remain providing some stability during a period of significant change. The number of acute NHST's are to be reduced and new Primary Care Trusts (PCT's) established. The PCT's will encompass areas currently covered by Community NHST's, but will be much wider in scope. GP's are to form Local Health Care Co-operatives which will function inside the PCT's. It is intended that each AHB will in future only have one acute NHST, and one PCT. There will be different arrangements in the larger conurbation's such as Glasgow and Edinburgh, where more than one acute NHST is the preferred model. These changes are still in their early stages and are currently the subject of a public consultation exercise.

To conclude this section we have discussed the changes to the NHSiS brought about by the 1997 White Paper 'Designed to Care' and some of the new organisational arrangements that are intended to be developed in the next 2- 3 years.

Conclusions

This short chapter has discussed the organisation and structure of the NHSiS, from 1991- 97, and an outline of the proposed changes and re-organisation of the NHSiS post 1997 White Paper. Chapter 3 will now provide a literature review of markets, competition, and healthcare. Meanwhile we note a number of points:

- Since 1974 the NHSiS has had different management and organisational arrangements that that of England;
- Although there are organisational and management differences, the 1990 NHS reforms introduced an internal market, NHST's and GPFH's into the NHSiS which mirrored the changes in England;
- Scotland's AHB funding formula, SHARE, was different from that in England, and while the English RAWP was abolished in 1990, SHARE will reach a conclusion in 1998;
- There were, at the time of the research, 47 NHST's operating in the NHSiS;
- Scotland received a different White Paper, *'Designed to Care'* with the new Labour Government's future plans for the NHS.

Chapter 3: Markets, Competition, and Healthcare

Introduction

The 1990 NHS reforms attempted to create an internal healthcare market in the UK. The central focus of this was the 1990 NHS and Community Care Act which brought into legislation the purchaser/provider split. DHA's became purchasers of healthcare and hospitals became providers of healthcare. Funding was to be allocated to providers via a competitive process mediated by the use of contractual arrangements (see chapter 1).

This aim of this chapter will be to review the contribution of economic analysis to the understanding of the development of the NHS internal market. The chapter will be structured in four sections. Section 1 will provide an analysis of quasi-markets which are derived from orthodox neo-classical micro-economics which has been adapted to aid our understanding of an artificially created regulated or planned market. Section 2 will examine the use of the new institutional economics approach to our understanding of the NHS internal market based upon a transaction cost analysis. Section 3 will discuss the socially embedded approach to economic transactions to assist with an understanding of the NHS internal market. Finally, section 4 will provide some empirical evidence of analysis of the NHS internal market as it operated in different parts of the UK.

Section One: The Development of a Market within the NHS

Introduction

The current reforms of the UK NHS involved importing competition into what had been for almost 40 years a publicly financed and operated healthcare system. Von Otter (1991) has argued that the competitive influence in healthcare provision was aimed at encouraging three main objectives:

- Greater internal efficiency of hospitals as provider organisations;
- Greater responsiveness of the services that these organisations provide to meeting patient preferences and;
- Increased managerial effectiveness.

Between the late 1970's and the present, the introduction of market principles and competition have been the dominant determinant of healthcare provision. Saltman and Von Otter (1995) refer to the new model of healthcare provision as a "planned" market, where the existing planned and centrally controlled healthcare system has market elements intentionally added to, or superimposed upon it. The NHS internal market would fall into this planned market concept.

The rationale for an internal market in healthcare had originally been derived from orthodox neo-classical micro-economic explanations of the operation of markets (Akehurst et al, 1988). A market consists of a network of relationships which are based upon the uncoordinated actions of large numbers of buyers and sellers. Prices are determined by the relationship between supply and demand. If supply and demand for a product or service are equal, the price is said to be in equilibrium.

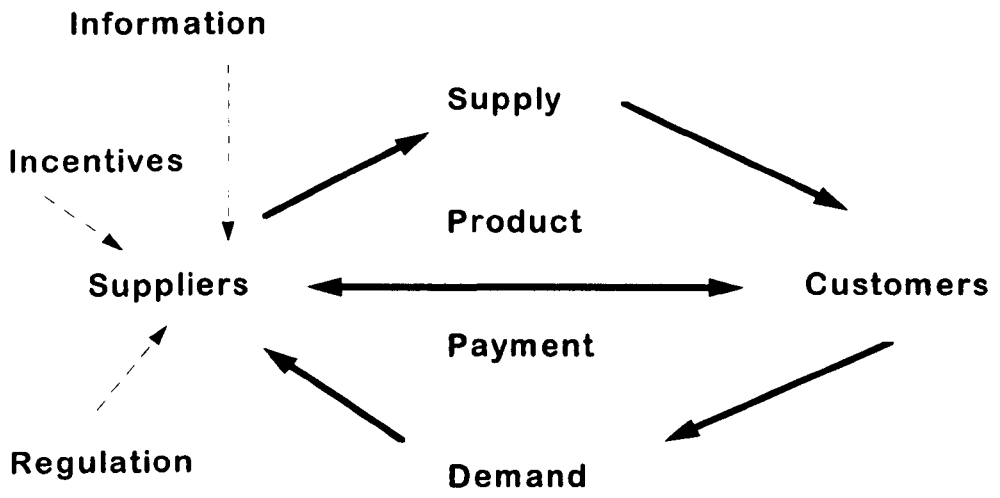
If there is perfect competition no one buyer or seller has any control of price so that s/he can control the market price by their actions. The effect of this is that large numbers of firms adjust their output of goods/services to the known market price in such a way as to maximise profits. When the equilibrium point is reached no one buyer or seller can improve their market position without someone else losing more. The concept of perfect competition thus ensures that resources are allocated efficiently (see figure 8). Competition regulates the processes of production, transfer, and consumption of goods and services. In terms of economic actions, competition has the following features (Borgonovi, 1991):

- Individual firms have to be capable of attracting and retaining sufficient demand to enable them to continue to operate in the market;

- Demand for a firm's product is based on the economic advantage possessed by the firm. This could be in the costs of producing a good which may be cheaper than similar firms producing the same good, but there may be other sources of competitive advantage as well as cost and;

- Each firm will engage in behaviour that seeks to develop and sustain competitive advantage. This could include activities that could drive the firm's competitors out of the market.

Figure 8. The Market Concept.



Market competition therefore serves to regulate the relationships between firms in such a way that it rewards those that are more efficient in the production of goods, or indeed meet the demands of consumers better than any other similar firm.

Johnson (1995) has argued that markets have a number of advantages. Perfect competition in free markets ensures that resources are allocated efficiently, i.e. it produces allocative efficiency. Sellers in the shape of the producers of goods are always attempting to maximise their profits and gain a larger share of the market for these same goods. Producers will try to reduce their costs of production while maintaining or improving the quality of their goods, or engaging in innovation. Any producer who is unable to keep pace with the competition in this respect will be forced out of production. Markets are an appropriate way of sending out information using the price mechanism. If the supply of a particular good exceeds the demand of buyers, then its price will fall. The opposite will happen if the demand for a good is greater than the supply, the price will rise. Changes in price will then act as a signal to buyers and sellers, guiding demand and supply decisions. Producers who are unable to maintain productive efficiency equal to their competitors (making effective use of the resources employed, reflected in X-efficiency) will be driven from the market.

However, markets have a number of disadvantages. Markets are claimed to be efficient in the allocation of resources, but this assumes that there will be competition. The text book ideal is where there is perfect competition, where large numbers of suppliers compete for large numbers of buyers and a number of other technical conditions are satisfied. However, where these conditions are not met market failure can occur. Market failure occurs for three main reasons:

- Imperfections in competition;

- Imperfect information or knowledge and;

- The presence of externalities for which no market exists, or the related problem of public goods, for example police or defence where an effective market is difficult to establish.

To have perfect competition there is a requirement that *all* consumers have a very good knowledge of the products and suppliers that are operating within the market. However, in reality most consumers do not have the information that will enable them to make the best choice. Conventional micro-economic theory also does not take into consideration how decisions are made within organisations. The theory is mainly concerned with questions relating to market efficiency and incentives, rather than how firms organise themselves internally. The firm in many cases is too narrowly viewed as a production unit with innovation based on technological developments. Orthodox neo-classical economic theory also says nothing concerning the strategic development and behaviour of firms, but instead firms make decisions guided by rules which will deliver maximum profits.

Markets and the NHS

The NHS, like other areas of the public sector, has often been criticised for its inefficiency (McLauchlin and Maynard, 1982, Maynard and Williams, 1984, Enthoven, 1985). Critics argued that if a market was introduced these inefficiencies would be reduced and resources would be better allocated. There were four main ways in which the introduction of a market into the NHS was believed to be capable of improving efficiency:

- By reducing X-inefficiency. Internal markets would reduce the amount of 'slack' in the system, the difference between the actual and minimal cost of providing a given volume of service. Removing the X-inefficiency could reduce costs, increase outcomes, or both;

- By improving allocative efficiency through the increased exploitation of spare capacity at marginal costs in some hospitals, particularly the large teaching hospitals, which may have more facilities than can be justified to serve the needs of their resident population;

- Specialisation leading to economies of scale. District Health Authorities (DHA's, the purchasers) could add to their capacity and offer services to their neighbours at lower costs deriving from scale economies and;

- Competition would drive down the wage bill by eliminating surplus labour and enabling pay to be determined on a decentralised rather than a centralised basis.

It was the belief of the proponents of internal markets that there was widespread X-inefficiency within the NHS due to the lack of market competition and discipline. Their expectation was that the perceived threat of competition and the contracting out of clinical services would affect the behaviour of both hospital managers and clinicians in socially desirable directions (Op-Cit).

The Origins of the NHS Internal Market

The NHS internal market has its origins with the writings of Enthoven (1985) who was invited by the Nuffield Institute for Health to examine the operation of the NHS. His report *Reflections on the Management of the National Health Service* is thought to have formed the basis of the NHS reforms of 1990 (Appleby, 1992, Butler, 1992, Klein, 1989). For Enthoven the NHS had a number of problems. It was finding it increasingly difficult to meet the healthcare demands of the public. The NHS was caught in what he called a 'gridlock' of forces that made change difficult to implement. The structure of the NHS also did not contain any mechanism which would provide incentives for either healthcare professionals or managers to develop better quality services at reduced cost. However, he felt that the main problem with the NHS was its insensitivity to the best needs of its patients for appropriate care. Enthoven's answer to these problems and issues was to import some of the rigours and incentives of competitive markets into the NHS. This internal market would extend dramatically the existing government policies already implemented, for example, the contracting out of catering, portering and laundry services within the NHS (see chapter 1). Enthoven considered that the separation of the purchasing and provider roles in the NHS would mean that,

> "[DHA's] *could buy from producers who offered good value. They could use the possibility of buying outside as bargaining leverage to get better performance from their own providers*
> (Enthoven, 1985, p 10).

Competitive markets require the presence of competition. However, with a *contestable* market it is the mere threat of new entrants that acts as the impetus for existing firms to improve their productive processes to ensure that they are as efficient as possible (Baumol, 1982). It was this issue of contestability that Enthoven was alluding to. If existing providers allowed their prices to become too high, or the quality of their products to fall, other providers might decide that they could do better, enter the market, and outperform the existing providers. For Enthoven, the market would work as follows.

Each DHA would receive funding based on a per capita basis, and an allowance for capital. The DHA's would continue to be responsible for their resident population's healthcare needs, but could also provide healthcare for patients outside their area, if compensated by other DHA's, and could purchase from the private sector. DHA's could also refer patients for treatment to other DHA's paid for at negotiated prices. NHS managers were also to be provided with incentives and freedoms to be able to use resources more efficiently. This was to include buying services from more efficient providers. The mere *threat* of going to another provider could stimulate an DHA's own provider units to become more efficient. The internal market would force the development of accurate costing and billing systems and create more efficiency and cost sensitivity because DHA's would be selling and buying services. For Enthoven, these changes in the economic structure of the NHS would be fundamental, but be invisible to patients. This last aspect he thought would be politically attractive to any government.

The Enthoven changes would have to follow certain criteria to be successful:

- Incentives would have to be introduced to encourage NHS managers to make cost savings;
- A culture of buying and selling healthcare services would have to be introduced into the NHS and ;
- Information on hospital costs would have to be substantially improved if efficiency in the use of resources was to be achieved.

Enthoven's conceptualisation of an internal market was that the market would only involve NHS purchasers and providers, and hence be 'internal' to the NHS. With the threat of external provision as a lever of change, it was only intended to deal with the issue of patient flows in and out of the DHA's. Each DHA would still continue to be responsible for providing and paying for healthcare for its own resident population, but not for the patients referred from other DHA's. However, in the 3 years after his publication the idea of a market in healthcare within the NHS developed into was a called a 'provider' market (Culyer and Brasier, 1988) which would allow private sector hospitals to carry out NHS work.

Quasi-Markets

In the early 1990's the terms 'internal' and 'provider' markets evolved further when Bartlett (1991) and Le-Grand and Bartlett (1993) introduced the 'quasi-market' model. Their research was based on the introduction of market mechanisms into all areas of the public sector (see Chapter 1). These changes all had a similar effect on public services and followed the same patterns.

> *"State finance of the service was to be retained; but the system of provision was to change, often radically. All the reforms involved a decentralisation of decision making; most also involved the introduction of competition in provision. The state was to become only a purchaser of services, with state provision being replaced by a system of independent providers competing with one another in internal or 'quasi-markets"*
> (Le-Grand and Bartlett, 1993, p3).

For Le-Grand and Bartlett quasi-markets are 'markets' because they replaced the former monopolistic state provision of provider units with competitive provider units. They are 'quasi' because they have a number of differences from orthodox neo-classical economic markets. These differences include factors in both the demand and supply side of the market. On the demand side the purchasing power of consumers are not expressed in financial terms, but instead take the form of either a 'voucher' or ear-marked budget. The use of vouchers or budgets is restricted to the buying of specific services, or it is centralised with a single

purchaser. Education vouchers for pre-school children is an example of a voucher system, and DHA's/GPFH's with allocated budgets are examples of single purchasers. With quasi-markets it is not the consumer who has the choice in making purchasing decisions. This choice is usually left to a third party on behalf of the consumer, and in the case of healthcare would either be a DHA or GPFH. On the supply side of a quasi-market, there is competition in the same way as with orthodox neo-economic markets between suppliers of services, however unlike orthodox neo-economic markets, within quasi-markets suppliers are not necessarily out to maximise profits (Op.Cit.).

Ferlie et al, (1996) state that the legislative driven attempts by the government to create quasi-markets have been increasingly apparent as a major development in public sector management from the late 1980's onwards. This has been a complex system - wide change which in turn has been central to the introduction of other changes. These quasi-markets mimic market-like mechanisms in which services continue to be free at point of use. The Government's view was that public services were to be more business like, but not a business. The key criteria of the benefits of quasi-markets were, quality, efficiency, choice, responsiveness, and equity. The use of the term "market" in this context may be misleading. For example, to what extent is a quasi-market really like a private sector market at all?. The centre, in the shape of the Government, often retains a battery of regulatory powers which ensures that quasi-markets are very inward facing. Alongside the rhetoric of quasi-markets there were still confusing forays back to the world of strategic planning or direct intervention[11]. Public funding would no longer be allocated through planning or through formula funding, but instead through such devices as competitive bidding, or an earmarked budget which would be given to end-users or to their agents. These agents would then allocate the budget to competing providers. This was intended to sharpen the incentives for performance at the level of the individual provider organisation.

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[11] . Such as the Annual Purchasing and Planning Guidance issued each year to DHA's and AHB's discussed in chapters 1 and 2.

The NHS Market and the NHS Reforms

Within the market, service contracts constituted the essential link between purchaser and provider. They made clear what services were to be provided and the terms on which they were to be supplied. They also had the important function of clarifying risk-sharing arrangements which may become relevant in the face of unplanned events, either on the purchasing side or providing side, (e.g.) providers who are carrying out more work than contracted for could have additional payments triggered by the extra work.

The move to an internal market in healthcare can be seen as a move to replace a management hierarchy by the use of contracting as the prime mechanism of policy implementation. This process is not entirely new. From the early 1980's the Conservative Government had begun to fundamentally change the shape of the public sector. There was a move from bureaucratic hierarchies to markets based on the separation of the purchasing function from that of providing the service. There were a number of reasons for this, Kay and Vickers (1990), Harrison, (1993).

1. A tension had developed between the public and the private sectors. The public now wanted a more responsive public sector to suit their needs. This was in conflict with a commitment by central government to constrain the public sector resource base (a reflection of the need to cut public expenditure and hence reduce public sector borrowing and contribute to the long term control of inflation).

2. The government wanted more devolved managerial responsibility to enable lower level managers to be given greater scope for using their own initiative and innovation to deliver services.

3. In conflict with 2 above, the government was attempting to find a way of exerting more control to improve the performance of the public sector. This was a classic case of financial centralisation conflicting with an intent to devolve managerial responsibility[12].

The purchaser/provider split resolved the conflict between points 2 and 3 above. There would be greater autonomy, but also competition would be introduced into the supply side which it was hoped would pressurise provider units in the public sector to seek ways of improving their efficiency in a manner similar to that which was *believed* to occur in the private sector. Harrison (1993), also argued that the reduction of the management hierarchy and the introduction of competitive markets had increased the choice of providers and allowed performance to be assessed. Purchasers now had a choice on which provider to use, and these same providers would be competing with each other for resources. Performance was assessed through the monitoring of contracts by data supplied to purchasers from providers. The contracts included performance standards which would allow the measurement of agreed targets between purchaser and provider. Harrison (1993) also suggested that moving to contracting allowed the government more control over providers to ensure that they operated in the public interest. He pointed out that such control might be thought of as occurring in a management hierarchy, but the public sector hierarchy had developed over-extended lines of control which led to providers developing a service-led culture, rather than a client-led culture. By separating the responsibility for purchasing from the responsibility for provision, this service led culture was to be broken.

This extensive use of contracting arrangements gives rise to a new set of questions relating to the efficiency and implications of contracting arrangements, focusing on the central issue of the most appropriate economic paradigm for the analysis and understanding of the public healthcare market place. This will be discussed in the next section.

Section Two: Contracts and Transaction Costs

Introduction

This section will discuss the next phase in the quasi-market phenomena. Authors such as Burke and Goddard (1990), Bartlett (1991) and Le-Grand and Bartlett (1993) have attempted to use the transaction costs literature associated with Williamson (1975,1985) to understand the nature and operation of quasi-markets.

Contracts and Transaction costs

By moving from a hierarchy to a market, transaction costs come into play. Transaction costs are additional costs incurred by the use of markets and include costs associated with contract negotiation, litigation, advertising, and the monitoring and evaluation of contract compliance (Robinson and Le-Grand, 1993). These transaction costs have to be understood in relation to the NHS quasi-market.

Williamson (1975, 1985) attempted to determine which factors made contracts expensive to write, implement, and enforce. He concluded that a firm could decide to by-pass the market and instead, rely on a hierarchical form of internal organisation. He saw managerial hierarchies and markets as two distinct methods of economic organisation for dealing explicitly with transactions. For Williamson there were a number of factors which would determine whether a managerial hierarchy or market is more efficient as a means for resource allocations within a firm. These factors included bounded rationality, opportunism, and uncertainty.

Bounded Rationality: people are limited in their ability to process all the information available to them. This leads to uncertainty about the consequences of transactions, or about the

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12. This issue will be returned to in chapter 9.

circumstances within which they might take place, so when making decisions people, while attempting to act in a rational manner, can only do so to a certain extent.

Beyond this their ability to solve complex problems is reduced. This is further compounded when there is an element of uncertainty about the future. If it is expensive to plan for future contingencies in every way, it may become cheaper and more efficient for a firm to use a hierarchy as a form of organisation rather than a market.

Opportunism/uncertainty: with opportunism people can pursue their own interests. They can attempt to gain advantage from only disclosing certain information, providing no information at all, or making false promises. The mere existence of opportunism means that there is always an element of uncertainty introduced into contracting as neither party to the contract can rely on each other to honour non-legally binding contracts. Contracts which deal with complex transactions in an uncertain environment would be very difficult to write, monitor and enforce. They would also have to be specified in the contract. Because of the costs involved this is often precluded in contracts making them incomplete in so far that all future events are not specified. Incomplete contracts can be, however, open to opportunistic behaviour. In such a case one of the parties involved could gain opportunistic advantage from only limiting the information available, or from making over ambitious promises.

In a further debate on the issue of contracts and transaction cost theory, Sako (1992) provides a discussion of two possible trading relationships, an Arm's length Contractual Relationship (ACR), and an Obligational Contractual Relationship (OCR). With an ACR the contract is made explicit and each parties responsibilities are made clear as can be possible.

If in the course of the agreement contingencies arise,

> *"they are settled by resort to some universalist legal or normative rules. All dealings are thus conducted at arm's length, to avoid undue familiarity, with neither party controlled by the other. Consequently, seeking an alternative trading partner is an easy available option when a contract comes to an end"* (Sako, 1992, p 9).

The OCR, which also involves the use of a contract that covers the provision and trading of goods, differs from the ACR in that it is the *relationships* between parties that are important. Significantly, the vital factor with an OCR is the dependence of each of the parties to the contract and the building of trust. Both parties have a degree of flexibility, what Williamson (1985) would term 'opportunism', to deviate to a certain extent from the contractual arrangements. However, the incentive to keep as far as possible to the contract allows each of the parties to appeal to the good nature of the other in times of crisis. These areas will be returned to in chapters 7 and 10. The OCR is therefore,

> *"Embedded in social relations between trading partners who entertain a sense of mutual trust. Because of this underpinning, transactions take place without prior agreement on all the terms and conditions of sale. Even if the tasks and duties of each trading partner are negotiated,* [and] *agreed in a contract, there is an incentive to deviate from them, to do more than is expected by the partner. Such an incentive results from the expectation that the act of goodwill will lead to a similar response from the trading partner, and that in times of unforeseen crisis, one may call on the good nature of a trading partner to allow default in some way from the previously agreed terms of the contract"* (Sako, 1992, p 10).

Le-Grand (1993) states that the transactions which occur within quasi-markets are very complex and multidimensional. They involve the provision of sophisticated services, rather than the simple economic concept of market provision. As a result of these complex, multidimensional and sophisticated services, any market which is devised could involve relatively high transaction costs. Transaction costs can further be divided into *ex-ante* and *ex-post* exchange.

The *ex-ante* transaction costs occur when contracts are drafted during the negotiating stage when agreements are reached.

> *"These tasks can be done with a great deal of care, specifying as many contingencies as possible and detailing all the appropriate reactions in each contingency for all the contracting parties, in which case the associated costs are likely to be high; or they can be done in an incomplete fashion in which case the costs will be low"*
> (Le-Grand, 1993, p 257).

Ex-post transaction costs are the costs involved in monitoring activity levels agreed within the contract. They would also include costs involved with haggling or other disputes arising from the use of contracts.

> *"Ex-post costs are likely to be greater, the less care had been taken in drawing up the terms and conditions of the exchange in the first place. Hence high ex-post transactions costs may be associated with low ex-ante costs and vice-versa"*
> (Le-Grand, 1993, p 257).

Robinson and Le-Grand (1993) argue that there is no doubt that bounded rationality will apply to health services because of the very nature of healthcare, for example, it is very complex, and has much uncertainty attached to it. Opportunism, they continue, may be less clear. This could be due to the ethical and moral issues associated with the provision and delivery of healthcare services, and they assume that self interest and opportunism will not be evident.

Le-Grand and Bartlett (1993) suggest that although not explicitly stating objectives, the reforms were attempting to address the issues of improvements in productive efficiency, service responsiveness, patient choice, and equity. With reference to these issues, Le-Grand and Bartlett determined that there were five criteria that a quasi-market must exhibit if the above objectives were to be met.

These criteria were:

- *Market structure*: the quasi-market on both the supply and demand side should be competitive. There needs to be many purchasers and many providers. The only real exception to this condition concerns a situation where a monopoly exists in one part of the market that it is impossible to break up. If so, it may be necessary to have a monopoly[13] on the other side in order to exercise countervailing power. The quasi-market must also satisfy the requirements of a contestable market, where barriers to entry and exit are not too high.
- *Information*: both providers and purchasers need to have access to accurate and independent information. Providers need to have information mainly about their costs, and purchasers about the quality and costs of the services that they are buying.

- *Transaction costs and uncertainty*: transaction costs, particularly those associated with uncertainty should be kept to a minimum. The transaction costs associated with market exchange should not be greater than the efficiency gains expected or produced by competition.

- *Motivation*: providers need to be motivated, at least in part by financial considerations. Purchasers need to be motivated by their user interests. Le-Grand and Bartlett state that these two motivational factors could raise difficulties in the quasi-market context. On the provider side, there are non-profit providers whose motivation is unclear. Suppliers must be motivated at least in part by financial self interest to respond to price signals in the market. On the purchaser side, there are third parties who act on behalf of service users, for example, DHA's/GPFH's, and whose interests may not always be identical with the service users. Purchasers must be motivated by the needs and wishes of service users taking into

13. This could be only one buyer, a monopsony, which would tie each purchaser and provider into a relationship where neither could benefit from exercising power.

account the agency relationship that exists between the consumers of health care, the patients, and the purchasers.

- *Cream-skimming*: there should be no incentive for providers or purchasers to discriminate between users of services in favour of those who are least expensive. Equity will only be achieved if there are no incentives for cream skimming to occur.

A Critique of the Transaction Cost Approach to Quasi-Markets

The transaction cost approach to quasi-market analysis can be criticised on the grounds that it pays no attention to issues surrounding power, culture and ideology within organisations (Perrow 1981, Bauer and Cohen, 1983, Ferlie, 1992, Ferlie et al, 1996). Granovetter (1985) argues that Williamson overstated the twin roles of governance and hierarchy in regulating transactions, and that trust, which is necessary for economic life, is built up through social networks. This is very similar to Sako's (1992) argument although expressed in a different way. Williamson developed his concepts based on an undersocialisation view of human behaviour. This created the illusion in which behaviour and institutions were not affected by social structure and relations. Production and consumption are allocated by competitive markets in which no producer or consumer influences supply, demand, or prices. Efficiency is over-emphasised at the expense of social and organisational power. Whereas text book economics operates with an atomised undersocialised conception of human action, for Granovetter economic transactions have to be viewed as occurring through the medium of social relationships which are *embedded* between firms.

> *"The embeddedness argument stresses the role of personal relations and structures (or networks) of such relations in generating trust and discouraging malfeasance"*
> (Granovetter, 1985, p 490).

Granovetter then discussed the fact that such networks do not only operate at senior levels within organisations, but indeed occur and form anywhere transactions take place.

In a very interesting debate, examples of which will be illustrated in chapter 7, Granovetter argues that even if firms have a contractual relationship specifying particular guarantees, if there is a dispute very often the firms will resolve the issue without recourse to the contract. This is another factor of embeddedness resulting from social relations. Granovetter quotes Macauley (1963) as indicating that,

> *"Even when the* [organisations] *have a detailed and carefully planned agreement which indicates what is to happen if the seller fails to deliver on time, often they will never refer to the agreement, but will negotiate a solution when the problem arises as if there never had been any original contract"*
> (Macauley, 1963, p 61).

In his further work, Granovetter (1992) reiterates the above, but views economic activity as involving the "mobilisation of resources for collective action" (1992, p6). Markets are constructed by people whose actions are both constrained and also facilitated by the market structure and resources available within their social network in which they are *embedded.*

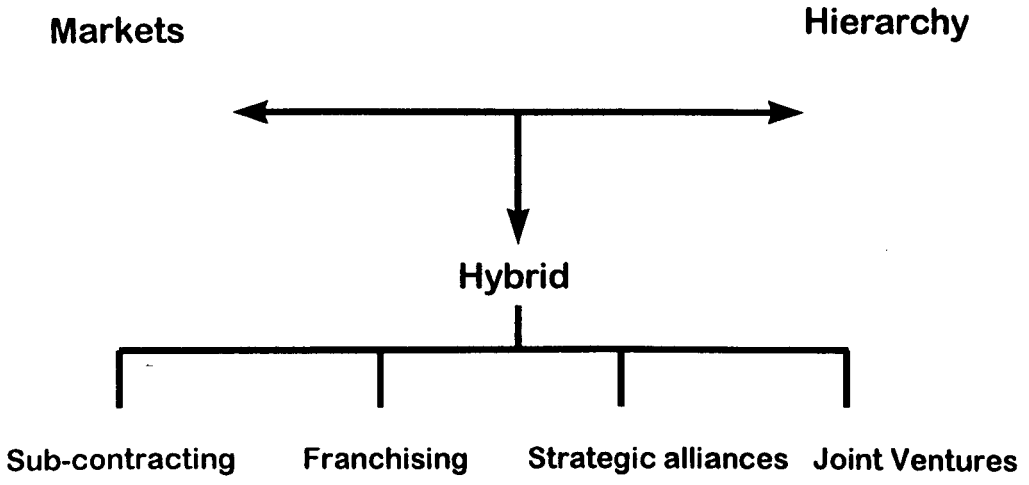
> *"The locus of explanation moves away from the isolated individual to a larger and more social frame of reference"*
> (Granovetter, 1992, p 7).

In response to criticism by academics such as Granovetter that the institutional approach to economics only dealt with two extremes, markets and hierarchies, Williamson (1991) formed a middle ground between his markets and hierarchies dichotomy which he termed a hybrid. This hybrid represented,

> *"various forms of long-term contracting, reciprocal trading, regulation, franchising and the like"*
> (Williamson, 1991, p 282).

Williamson developed a continuum with markets and hierarchies at either end. This dichotomy is illustrated in figure 9.

Figure 9. Williamson's Three Generic Forms of Economic Organisation



In between this dichotomy he conceded that other structures could develop such as firm's sub-contracting work, franchising products to other firms, and forming strategic alliances and joint ventures. His rationale for this middle ground or hybrid was that both markets and hierarchies have deficiencies which would be better solved by the middle ground structures.

> *"the hybrid mode is located between* [the] *market and* [the] *hierarchy with respect to incentives, adaptability and bureaucratic costs. As compared with the market, the hybrid sacrifices incentives in favor of superior coordination among the parts. As compared with the hierarchy, the hybrid sacrifices cooperativeness in favor of greater incentive intensity"*
> (Williamson, 1991, p 283).

This move to viewing markets as comprising social relationships will now be discussed in the next section.

Section Three: Relational Markets and Quasi-Markets

Introduction

The relational model of markets developed out of the concerns of marketeers (Ferlie, 1992). Ferlie argued that the conventional view of an active marketeer, a passive consumer and an atomistic market restricted the understanding of what actually occurred within markets. Economic markets assume that markets consist of individuals or single firms (see section one), but in reality markets tend to be dominated by a small number of large and complex firms who act in different ways.

Relational markets have a number of implications. Corporate buyers could interact with corporate sellers unlike individual consumers. The relationship between companies could also display a complex history of adaptation, commitment, trust and conflict. Buyer-seller relationships are only one example of a set of relationships which could shape a market, as buyer-buyer and seller-seller relations may also be important. The interaction process is not seen solely as revolving around product exchange, but also includes important processes of social exchange, undertaken to reduce uncertainty and to build trust. The result may be a common value system which emphasises source loyalty. There is also a tendency to 'keep things in the family' so that buyers, once locked into a set of relationships, may be relatively weak in seeking new sources of supply (Op.Cit.).

A relational market might therefore display a number of signs and symptoms which could include: a relatively small number of well established buyers and sellers locked into long-run contracts or repeat buying; buying decisions made on the basis of soft data such as trust, as well as hard data such as price, with the result that reputation is a key intangible asset on which providers trade (Ferlie et al, 1996).

Social Embeddedness

Economic transactions have to be viewed as much more *socially embedded* than in the atomistic market and transaction costs framework. The focal unit of analysis is less the transaction and more the social relationship. In relation to quasi-markets the key question concerns the long term effects of the introduction of contracting on patterns of organisational and interorganisational behaviour. The development of a 'relational contract' has its roots in the increased duration and complexity of contracts, particularly with respect to uncertain, complex, and recurrent exchanges. Ferlie et al state that 'spot' contracts are unlikely to offer an adequate means of structuring the transaction, but rather the contract becomes increasingly *embedded* in a social relationship with its own history and norms.

> *"It is the existence of social relations, rather then governance structures or form of contracting, that ensure the interpersonal trust necessary for economic life. The transaction costs approach assumes that the natural state of man is opportunism rather than trust, and finds it difficult to model behaviour on trustworthy institutions, nor does it offer a convincing account of how markets evolve and operate"*
> (Ferlie et al, 1996, p 70).

Institutional Embeddedness

Markets might not only be socially embedded, but institutionally embedded. This will then move away from a micro-level analysis of social networks towards a more macro-level of economic institutions. This view has its roots in social network theory and is quite different from the literature which views institutions as forces in their own right independent of a person's motives and actions (Ferlie, 1992, Ferlie et al, 1996). Firm's are driven to incorporate the practices and procedures defined by existing concepts of work, for example, 'public services should be more business like'. Ferlie et al (1996) state that organisations who set themselves up in this way are more likely to increase their legitimacy, their income, and so their chances of survival.

New organisational forms arise not because of efficiency considerations, but

> *"because of strong fads and fashions in organisational design and strong pressures to conform to centrally mandated templates. The State and the professions are seen as particularly important sources for structuring such organisational fields, especially in public sector settings which relate to powerful professions or which are entirely dependent on flows of state finance"*
> (Ferlie et al, 1996, p 73).

The NHS Quasi-Market and Regulation

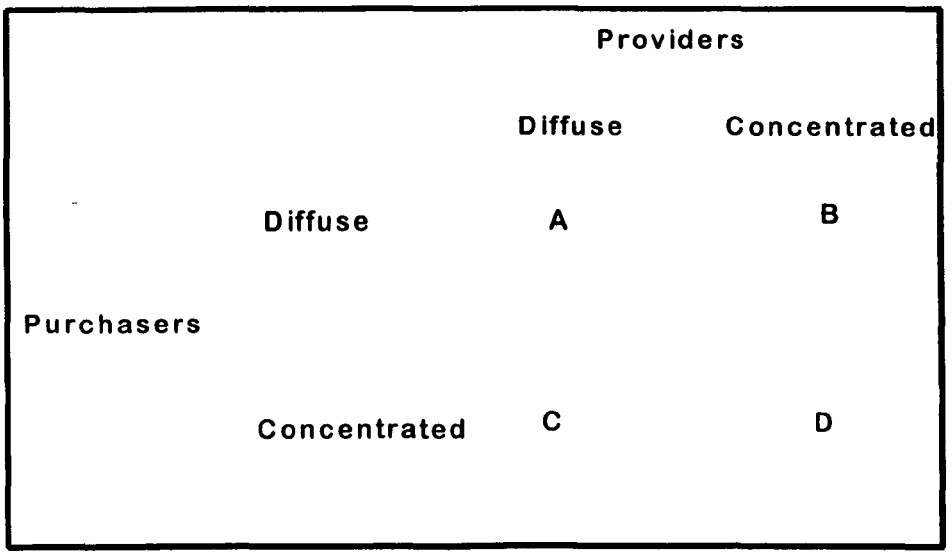
The NHS quasi-market is a managed market. That is, purchasers were consciously and deliberately "creating", or not "creating" the market (Challis et al, 1994). Decisions had to be made whether or not to support traditional providers, or how best to encourage new entrants into the field in shaping the market. Also purchasers were not the only agents who could shape the market. For example, the Conservative Government actively set the scene for healthcare provision in London through the Tomlinson Inquiry (1992).

Regulation could include all attempts to structure the market, for example, determining the quantity and distribution of resources, as well as prices and standards (Propper, 1993, 1995). However, it could also be seen as a means to control standards of quality, either through control of new entrants to the market (registration), or through inspection and monitoring arrangements. The focus would not be on market control, but service control. Service control in the public sector has traditionally been through the direct managerial supervision of provider units within a hierarchical line of accountability. The purchaser/provider split has replaced this accountability. There is now no direct line of accountability between purchasers and providers. The new instrument of control or accountability is the contract.

The forms which regulation take are specific to the nature of the market itself. The literature gives an account of why regulation has been introduced (Kay and Vickers, 1990, Propper, 1993, 1995), but it does not explain which form it will take in specific markets. With reference to the NHS internal market, Challis et al (1994) proposed that the balance between reliance on contracts and on

regulation would depend on the balance of power between purchasers and providers. This would in turn depend on whether purchasers and providers were either diffuse or concentrated in a particular area. Figure 10 illustrates four possible market combinations that Challis et al suggested would emerge from a market.

Figure 10. The Balance of Purchaser and Provider Power (Source: Challis et al, 1994).



At point A, diffuse purchasers are dealing with diffuse providers. This is the concept of a competitive market. At point B diffuse purchasers are dealing with a concentration of providers, which is the case with the public utilities. At point C, concentrated purchasers are dealing with diffuse providers. At point D, concentrated purchasers are dealing with concentrated providers. Challis et al's proposition was that as purchasers and providers moved from point B through to point D, the reliance on regulation would be reduced. At point B, where diffuse purchasers face a concentration of providers, Challis et al state that there has been an assumption that regulation would be needed to prevent abuse of monopoly power and information asymmetries. The transaction costs involved for purchasers in negotiating and drawing up contracts would be very high. At point C, where there is a mix of

concentrated purchasers and diffuse providers, there may well be a mixture of regulation and contracts.

Purchasers would be in a strong position when it came to contract negotiation, but there may be expensive transaction costs due to purchasers negotiating with many providers, and purchasers may have problems in ensuring that quality standards are met. Challis et at argued that in cases such as this, some form of regulation may be needed as a means of reducing transaction costs. At point D, both the purchasers and providers are concentrated. This would indicate that contracts would be better as a control mechanism, rather than regulation. This is because transaction costs are reduced as the number of contracts fall. The NHS internal market, argue Challis et al, would fit into point D in the box. In such circumstances the use of contracts would be the ideal method for controlling standards as there would be no need for a regulatory body. However, at the time of the research, quasi-markets were still relatively new in the NHS, and as such were still evolving. There are specific problems with the internal market which were related to the market itself, and at the time of the research, to the continued development of GP-FundHolding[14].

[14] . At the time of the research, GPFH was continuing to expand, although the new Labour Government elected in 1997 was set to abolish GPFH. This analysis is therefore operating as if GPFH would continue.

The NHS market: in some geographical areas there may be concentrated purchasers and concentrated providers. This will mean that there will be very little competition. On the other hand in large conurbations there may be diverse purchasers and diverse providers, so competition could be greater. DHA's in England have merged, and in some cases formed large purchasing consortia, and healthcare provision was via large provider units. The NHS market was also changing quickly though. If we use Scotland as an example, since April 1996, all hospitals were NHST's or were part of NHST's, and GPFH's were beginning increase in numbers. These two developments may mean that the NHS market could look either like point B, or A in the future. A purchaser who is dealing with only one provider will have lower transaction costs than when contracting with many. Challis et al point out that as the quasi-market develops, so will the need to have some form of regulatory body. However the form this regulation would take was unclear.

GP-FundHolding: If GP FundHolding had developed in the manner the Conservative Government intended, the NHS would fall into point B, with concentrated providers dealing with diffuse purchasers. This would vary with geography, as some areas may have many GPFH's, whilst other may have very few. There may be diffuse providers with a competitive market, but GPFH's could merge to form consortia or Multi-Funds so pooling their purchasing power. If this occurred, and there is evidence to suggest that this was happening (Glennerster et al, 1994), then the situation may well move to point C.

To conclude our consideration of this third strand of the literature emerging relating to the development and operation of a quasi-market in healthcare, we note four central propositions: the market should be seen in relational terms; the quasi-market will continue to be socially and institutionally embedded; market regulation was imposed by the Government via "centrally mandated templates" and; the balance between market regulation and the use of contracts may depend upon the balance of power between purchaser and provider.

Section Four: The NHS Market - Some Empirical Evidence

Introduction

This section will examine some of the emerging literature which has attempted to analyse the evidence on the operation of the NHS quasi-market and shed some light on the theoretical issues discussed in Sections 1-3. This section will examine three case studies in relation to the literature. These case studies offer examples of the NHS quasi-market operating in different parts of the UK. As such they provide an indication of the way the NHS quasi-market may operate in the West of Scotland where the research for the thesis was carried out.

Case Study No 1

Walker and Craig (1994) conducted a study of NHS purchasing in the Tyneside area of North England. The aim of the research was to identify the actions DHA's must take to achieve their full potential as purchasers. Although concentrating on the purchasing role of purchasers, Tyneside was chosen because it fitted the competitive model of economic theory of many competitors and purchasers. There were three teaching hospitals and three general hospitals very close together in the City of Newcastle. There were also further District General Hospitals (DGH's) within a twenty mile radius of Newcastle. Contracts could therefore be placed with any one of a number of providers implying the necessary conditions for competition were present.

Walker and Craig discovered that patterns of service change which could be attributed to the operation of the internal market were very difficult to find. In common with other Cities, a major review of acute services had taken place, and in the case of Newcastle there had been a recommendation to close one of the City's acute hospitals.

The rationale for this closure was due not to market forces, but rather the loss of the purchaser's funding of £11M, over a three year period as a result of a move by the Government to capitation funding[15]. More closures were expected to be recommended, again because of funding problems, rather than competition. The absence of an internal market they found was the result of a number of factors which included; the absence of provider competition; poor information for purchasing decisions and; the absence of contractual obligations.

The absence of provider competition: although there were a large number of providers in the Newcastle area, several factors limited the development of a competitive environment. There was a legacy of 'old-style' strategic planning from the 1980's. Clinical specialties were 'rationalised' onto a single site, the examples of obstetrics and A/E were cited. Other factors such as the need to achieve national targets were found, for example, the reduction in junior hospital doctors hours. These targets would be easier to meet if services were centralised on one site. However, this centralisation of services applied to Newcastle alone, not the DGH's outside the city, so competition from the DGH's may still have been possible. Unfortunately this was undermined by the unwillingness of patients to travel outside their immediate area. There was also the reluctance of GP's, FundHolders and non-FundHolders, to switch their referrals patterns to often new and unknown providers, which would disrupt their long-term relationships with existing providers.

Poor information for purchasing decisions: all markets operate with limited or imperfect information, but the internal market in Newcastle was described by Walker and Craig as suffering from "paralysis as a result". Measurements of quality of patient care within providers was poor, and even when information was available, it could be inaccurate. This had been the cause of a number of disagreements between both purchasers and providers. Cost data was either unavailable, or if available, was very crude and difficult to interpret.

The absence of contractual obligations: the contracts between purchasers and providers were not legally binding, and both relied on trust. However, different perspectives were evident. Providers were congratulating themselves on exceeding contractual targets, viewing this as evidence of good performance and as a result were expecting to be rewarded by their purchasers. The purchasers on the other hand saw their providers seeking payment for work loads that had not been agreed. This had resulted in additional revenue from purchasers being made available to "bail out" providers, which appeared contrary to the intentions of the internal market.

To conclude this case study, Walker and Craig argued that, although there were aspects of the internal market at Newcastle that were local to the area, there were a number of issues which would continue to hamper the development of an internal market within the NHS. The Key issue for them was the annual contracting cycle where purchasers and providers agreed upon the next years activity levels. Reliance on competition was based perhaps more on faith than on reality, with the issue of contestability and the development of long-term relationships being more important than competition.

> *"Theories of firms and markets raise doubts about the ability of a healthcare market to achieve its goals, but these must now be turned into practical contributions to management strategies"* (Walker and Craig, 1994, p11).

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15. Funding based on the population within each DHA.

Case Study No 2

Ranade's (1994) research involved a survey of managers of both DHA's as purchasers and NHST's as acute providers within four DHA's in England between 1990 and 1993. The DHA's comprised: an urban non-teaching (A); a semi-rural non-teaching (B): a rural non-teaching (C); and an urban teaching (D). These DHA's were chosen because they represented different contexts for the implementation of the NHS reforms, and in particular demonstrated three key areas of complexity, competition, and choice.

The variables associated with complexity were teaching and non-teaching status, the number and site of acute hospitals, and the range of specialties available. These factors all affected the range and complexity of relationships, both internally and externally, as well as work loads associated with the NHS reforms. As an example, a third of DHA B's residents were treated across DHA boundaries in over 30 provider units. This increased the complexity and the potential costs of contracting far more than in DHA C, where over 90% of in-patients were treated in the local DGH. Competition for providers and choice for purchasers were assessed by the geographical location of specialties and the number of competing units (see table 12).

Table 12. Key feature of the Case Study DHA's.

Type	District A Urban, Non Teaching	DHA B Semi-rural, Non-teaching	DHA C Rural, Non-teaching	DHA D Urban, teaching
Budget 1990-91 (million)	£81	£56.4	£34	£110
Population	309,000	313, 800	157,000	180,000
Provider Units	Three	Three	Two	Three
Regional Specialties	Ten	None	None	Numerous
% of own business from own DHA	85%	93%	<90%	17%
Budget gainer/loser under capitation funding	Slight -ve	High +ve	Slight -ve	High -ve

Ranade's main research questions addressed the kind of market that was developing in these Districts: what was the nature of the relationships between the purchasers and providers?; were there any market imperfections and; if so how were they being addressed?.

The Districts

DHA A: was highly optimistic concerning opportunities for expansion and increased market share. This was based on its entrepreneurial track record, spare capacity and efficient units. It had already considerable expertise in contracting with other DHA's for earmarked budgets from national waiting list initiatives, and felt it had a head start on its competitors in areas such as clinical management, costing, and the rationalisation of facilities.

DHA B: felt totally unthreatened. It provided a very wide range of clinical services. It did however, have a new community based hospital on the border of its area, and had to fund 50% of the build costs for the hospital. As a result, DHA B had attempted to attract patients from other DHA's and indeed were confident that they could do so. In the main however, the ambitions of the DHA and its NHST managers, were not to increase their share of the market, but rather to make relatively modest service improvements.

DHA C: was pessimistic in relation to the NHS reforms. Its NHST managers did see some opportunity to market their services more effectively, but the DHA managers were bleak about the NHST's prospects. The DHA managers assumed local GP's would refer patients to other DHA's. Significantly, there was only one hospital in the DHA, and it had a monopoly position serving a large rural area.

DHA D: was a DHA which faced intense competition, relatively high unit costs and the likelihood of fewer cost boundary referrals from purchasers who wanted to develop local services in the districts. The DHA's main NHST had a large number of regional and supra-regional specialties serving over 120 DHA's, and had a small resident population which accounted for only 17% of its business. Some of the regional specialties were particularly vulnerable, but the NHST managers were reasonably confident that the hospitals reputation would enable them to compete successfully.

Ranade attempted to answer her research questions using Le-Grand and Bartlett's criteria of market contestability, information availability and quality, transaction costs, and the motivation of both purchasers and providers.

Market contestability: Ranade found that the scope for competition was limited in three of the DHA's, and purchasers preferred to concentrate on improving services for residents within the context of maintaining *local* services. Nevertheless, there was evidence that towards the end of 1992 that purchaser perceptions of choice had begun to widen, particularly on the border of their District areas. Competition was being used at the margins, and providers had begun to experiment with more cost-effective methods of service provision. On the demand side, the DHA was virtually a monopoly purchaser in three DHA's, with fewer than two GPFH by 1992, the fourth DHA had six GPFH's.

Information: It became clear that both purchasers and providers were still experiencing a series of deficiencies in the quality, accuracy and timeliness of information. Providers were still unable to cost and price their clinical activities correctly. Purchaser's knowledge concerning the health needs of their local populations, comparative costs and quality between providers was still too poor to enable them to purchase efficiently. However, in three DHA's activity and financial information was becoming available because of the NHS reforms.

Transaction costs: block contracts were the commonest form of contracts used by purchasers in the research. Quoting Le-Grand and Bartlett (1993), there were lower *ex-ante* transaction costs, but higher *ex-post* costs using block contracts. Some of the DHA's had attempted to reduce the transaction costs, but this had not been successful, particularly in relation to contract monitoring. Some progress had been made in designing cost-sharing agreements with providers to handle future uncertainty over activity levels and agree the risk sharing.

Motivation: providers needed to be sufficiently financially motivated to respond to market incentives for efficiency. Ranade did not imply the need for providers to be profit-maximisers, but it did mean the providers believed that they were responsible for their own financial fate. There was evidence that providers felt insulated from market pressures by their own purchasers, and as a result were less likely to change their behaviour. The reality of the purchaser/provider split and the degree to which DHA's had developed their role as purchasers was also as important as the presence or absence of competition in helping to bring about changes in attitudes of both managers and clinicians in the provider units.

To conclude this case study, Ranade's opinion of the behaviour in the quasi-market in relation to her research area could only be partly explained by economic theory and that other factors were responsible for the way the quasi-market had developed in her Districts. On the purchasing side Ranade found little evidence in all four DHA's that managers were reacting to the stimulus of supply side competition in the way the NHS reforms envisaged, even when choices were available. Instead, competition was seen as being "irrelevant" to their own local situation, or they aspired to protect their own providers, with competition used only at the margins of activity. A relational market was developing perhaps due to problems associated with imperfect information, contractual risk and uncertainty. There were also relationships that had been fostered for many years and which would not be dismantled by the 1990 NHS reforms.

> *"An eclectic mixture of environmental, organisational, cultural and political factors have to be given due importance. In particular a 'relational market' may be a predictable response to problems of monopoly, asymmetry of information, uncertainty and purchaser concern for quality, but it also reflects an 'embeddedness' of the NHS quasi-market in complex networks of existing social relations"*
> (Ranade, 1994, p 260).

Case Study No 3

Ferlie et al (1996) conducted research within one English DHA. The focus of their analysis was based on local interorganisational change as it evolved over time between 1991 and 1993. The research illustrated the difference between economic markets and quasi-markets.

The DHA under study was located in a semi-rural area. It had undergone a number of reorganisations in the early 1980's and 1990's. This had led to a merger with two neighbouring DHA's in early 1993. The DHA had been attempting to rationalise and redevelop its acute sector facilities onto one site, and this process had been continued when its only acute unit became an NHST. This of course meant that the NHST was the only NHST in the District. The senior management of the old DHA had continued on to the newly established Purchasing Authority. The old DHA had been progressively removing contracts from London hospitals in an attempt to develop local services.

The pattern in the old DHA was for every major town, roughly 20 miles apart, to have their own DGH, so there was little natural competition for general services. The acute NHST in the study was part of a local hospital group and was ideally placed to benefit from the movement of contracts from London to the District. The main NHST site was being redeveloped to move services from around the District to the central site. This had been long-term, however, previously it had been tied up with Regional Health Authority (RHA) development money, and there had been difficulties in securing funding. The application for NHST status was an attempt to move away from central capital building programmes such as this, and to have a degree of freedom to develop services, rather than the perceived benefits of a market. The acute NHST senior management, like the new Purchasing Authority were all of long-standing service and had moved from the acute unit to NHST.

The early expectations of the autonomy of the NHST had not been fully realised. The Regional Health Authority was still monitoring the finances of the NHST. The purchaser/provider split and the move to an internal market was again controlled or 'managed' by the Region in so far that the move should be 'steady state' and should spring no surprises. Contracting was to be based on the previous years activity levels. The Purchasing Authority was the main purchaser of the NHST's services in its local market area, and there had been no desire to switch contracts. In effect a local monopoly and monopsony existed, however, the local market was beginning to develop in 1993, mainly due to increasing numbers of GPFH's.

The relationship between the Purchasing Authority and its NHST was described by Ferlie et al as 'negotiative'. The contractual risk was spread between both parties. There were also many areas where the interests of both purchaser and provider coincided, for example, the continued transfer of work from London hospitals. Networks, such as clinical networks, continued to form between purchaser and provider. However, it could also not be seen as fully co-operative. The NHST very quickly built up its own identity based on its autonomy agenda. The historical link between the old DHA and 'its' hospital was eroded as the new Purchasing Authority developed. Continuous negotiations were evident in relation to contracting, and both the Purchasing Authority and NHST went to arbitration with the RHA concerning contract disputes for two consecutive years.

To conclude this case study, Ferlie et al found that the pace of change in this local healthcare market was slow. It remained a very much inward facing and regulated market and as such was institutionally embedded. Few alternative providers had moved into the District, or its surrounding area. Competitive forces remained relatively marginal, and there had been few major changes to services. Contracting, for example, was based on rather crude block contracts, rather than on more sophisticated cost-per-case or cost per-volume contracts. Senior managers had also remained in similar positions in both the old District/new

Purchasing Authority and old acute unit/NHST and the market as a result became socially embedded. The relationships between the purchaser and provider was based on trust, reputation, and co-operation, and as such the market was relational. However, there were the first signs that the pace of market development in the DHA was beginning to accelerate with the relaxation of the 'steady state', the expansion of GPFH's, and the easing of regulations concerning private capital. Ferlie et al also found that there was little evidence of effective price competition, and the quasi-market was heavily influenced by its local context and what Ferlie et al called 'higher tiers' of regulation from the government.

The conclusions to be drawn from this section is that the quasi-market developing within the UK NHS displayed a number of features:

- There was a high degree of regulation from the Government;
- Market information to allow purchasers to make decisions was very unreliable and of poor quality;
- There was very little competition developing between NHST's as providers;
- A relational market was developing rather than a competitive market which may have been as a result of the problems associated with poor information and uncertainty and;
- This market developed as a result of social relationships and "understandings" between purchasers and providers and as such should be viewed as socially embedded.

Conclusions

This chapter has described the origins of the NHS healthcare market from the mid 1980's up until 1996. It was believed that the introduction of a market into the NHS would provide a range of benefits to reduce inefficiency within the NHS. The benefits included improved quality, increased efficiency, better choice, more responsiveness, and equity.

The early debate concerning the application of market principles to the NHS was originally based on standard economic theory. Behaviour in a market was built upon a mixture of information concerning product price, quality, and incentives, rather than then being determined by strategic choice, government and professional regulation. A major weakness of this approach is that it failed to address the question of how decisions were made within organisations. It directs attention to firm efficiency and market structure, rather than internal organisation, nor how markets evolve through time. This was followed by a transaction cost approach to the understanding of the NHS market which asked the question whether it was more efficient for a firm's transactions to be carried out using a market, or be internalised within the firm. This would depend on whether transactions were highly specific, which if they were would tend to advocate internalisation. This approach can be criticised because it views efficiency at the expense of social or organisational power, and assumes that firms operate opportunistically, rather then building trust and long term relationships. The current theoretical analysis relating to the development and operation of the quasi-market has introduced a sociological approach to markets based on the relationships developing between purchasers and providers. This approach views the NHS market as a relational market. There are a few powerful purchasers who form relationships with a few powerful providers. The NHS market therefore could be described as socially and institutionally embedded. The empirical evidence suggested that a market in healthcare within the NHS was beginning to emerge, but that the use of the term may have been misleading. The market does not and may not ever resemble a private sector market, although this probably was not the intention of the government.

Having completed a literature review of markets, competition and healthcare, we provide in the next chapter a selected literature review of strategic management which will form the basis for the analysis of the strategic behaviour of NHST's operating within the West of Scotland NHS in chapter 8 and 9.

Chapter 4: Strategy and Strategic Management

Introduction

This chapter will provide a selected literature review of strategy and strategic management. The chapter is arranged in four sections. Section one outlines the origins of strategy, strategy as a process, and the development of strategic management. Section two examines two competing models of strategic analysis that have been developed in the last twenty years. The first model is the positioning approach associated with the work of Porter (1980, 1985) which analyses a firm's external environment. The second approach has developed from an interest in the role of a firm's resources as the basis for developing strategy (Wernerfelt, 1984, Barney, 1986, Connor, 1991) and analyses an organisation's internal environment. Section three will discuss frameworks upon which firm's can analyse and choose strategic options to either further or maintain their existing products. Section 4 will discuss strategy, organisational culture and the effect of the control a firm's senior managers have upon their operating divisions as strategic business units (SBU's).

Section One: The Development of Strategic Management

Introduction

Strategy has its origins with the ancient Greeks and Romans, and indeed the Greeks provided the term itself. It has connotations with the military and only began to develop within commercial organisations in the 1930's and 1940's (Bracker, 1980). It has now developed into an academic discipline and area of study for both practising managers and academics alike (Hart, 1992).

The Concept of Strategy

There are a number of approaches to the concept of strategy. Some are based upon the realisation of plans and objectives, some upon a series of patterns, and yet others based upon economic approaches to strategy. A selected review of the main literature is given below, and it can be seen that in many cases although there are distinct differences, there are also many similarities.

Ansoff (1965) argued that strategy provided the rules by which the present and future performance of an organisation can be measured. Rumelt (1974) viewed strategy as a series of objectives, policies and plans that when combined gave a firm or organisation its purpose, and indicated how it would survive and succeed in its particular industry. The particular plans, policies and objectives of an organisation express its strategy for interacting with an ever-changing complex environment. Andrews (1980) viewed strategy as the patterns of decisions within a firm, which determined objectives, goals, purposes, and produced a plan to enable the firm to reach its objectives. Andrews also discussed focusing a firm's resources into distinctive competencies, which then could be converted into competitive advantage.

Mintzberg and Quinn (1988) continued on this theme, but introduced what for them were five important areas associated with strategy. These areas were plan, ploy, pattern, position, and perspective. Johnson and Scholes (1993) have argued that organisational strategy is based upon setting the direction and scope of an organisation over a period of time, while matching its resource base to its environment and markets and meeting stakeholder expectations. Economic approaches to strategy are based on the notion of rent seeking. For Bowman (1974), strategy was the continuing search for rent. Rent itself can have many meanings. Tollison (1982) defined rent as the return in excess of a resource owner's opportunity cost or above normal returns[16]. Economic rent can also be used to describe what strategy aims to do and can perhaps be best understood as the extra price that a firm can charge because of some *special* attribute that it has in relation to other firms. As a result, this special attribute gives the firm a sustainable competitive advantage over its rivals.

Strategy as a Process

Having examined a selected review of the literature, which described the origins of strategy, the next step is to consider the 'how' of strategy, the strategy process. The question then becomes in what way does strategy develop within organisations? De-Witt and Meyer (1998) have described this process as,

> *"The manner in which strategies come about. How is strategy made, analysed, dreamt up, formulated, implemented, changed, and controlled. Who is involved and when do the necessary activities take place".*
> (de-Witt and Meyer, 1998, p3).

There has, over the years, developed a debate or what can be better described as a dispute in relation to strategy as a process, with particular reference to the way strategy develops within a firm. This discourse falls into two camps, the design school and the crafting/incrementalist school.

More recent authors have also begun to consider strategy in social terms building upon an organisations past, culture, use of power, and the political nature of organisational life. These approaches will now be considered.

The Design School

The design school approach to the strategy process argues that strategy develops using a small number of concepts that *design* strategy and has been associated with the Harvard Business School in the early 1960's. This process viewed strategy as one of *design* so achieving a fit between a firm's external threats and opportunities, and the internal distinctive competencies of the firm (Chandler, 1962, Ansoff, 1965, Andrews, 1980). The process involves clear thought by a firm's senior managers, especially its Chief Executive. The strategies produced should be unique and explicit to the firm. This typically followed a three stage process of strategic analysis followed by choice, and then implementation.

The Crafting/Incremental Approach

However, Mintzberg (with Waters 1985, 1987) argues that strategy formation is more likely to result from the complex political processes of negotiation, bargaining and certainly compromise that occurs within organisations, rather than being in the domain of a single person or group of senior managers. Instead of being deliberate, strategy *emerges* from organisations rather than being formulated from deliberate strategies (Op Cit.). Such deviations occur for a number of reasons. The organisation's Chief Executive and senior managers will never have the necessary information to develop a fully intended strategy, nor do they have full control of their organisations, and no matter the organisation, strategy formation is never simply the preserve of the Chief Executive and senior managers, but is a reflection of all levels within the firm.

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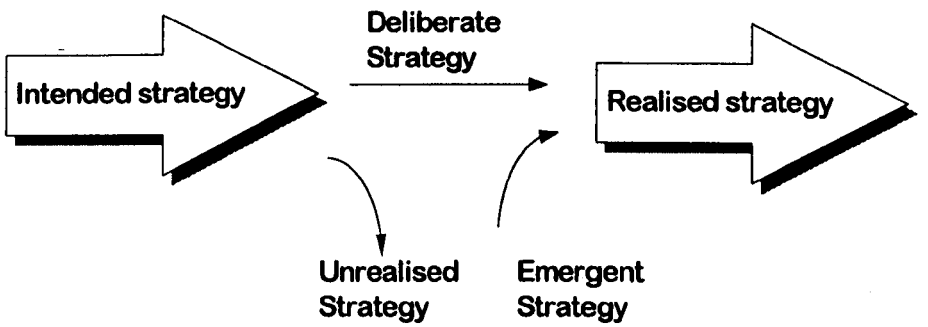
16. Rents can also be described as earning in excess of what a firm needs to break-even.

For Mintzberg, the problem of separating the formulation of strategy from its implementation prevents organisational learning. Formulation and implementation have to go hand in hand, with the organisation's strategy constantly being revised and updated with experience. Strategy thus, according to Mintzberg, is *crafted*, rather then pre-planned. Crafting strategy involves the skills, dedication, experience, and commitment of everyone within an organisation. As a result, the formulation and implementation of strategy merge into a *learning* process through which strategies emerge. Figure 11 illustrates this process.

Figure 11. Mintzberg's Emergent Strategy (Source Mintzberg and Walters: 1985).



All strategies take place within a *context*, and as such are subject to its influence to a lesser or greater extent. For Mintzberg, the route (deliberate) between an intended (explicit and implicit intentions) and realised (actual) strategy is portrayed as the 'normal' route which may be disrupted by either internal or external environmental influences. Some strategies are not realised, while other strategies emerge from the learning process.

Strategy as a Series of Increments

Quinn (1980) also criticised the design school model of strategy formation and development. Quinn developed the concept of logical incrementalism, which viewed strategy as having two elements, goal orientation and process orientation. Strategy develops in increments or phases (the goals) building on previous increments. Analysis and action (the process) are a series of successive steps, but ideas often develop in the behaviour of the organisation.

Quinn recognised that firms are political bodies and consist of people pursuing their own objectives and who experience their own learning processes. However, Quinn argued that politics and power within organisations can be both productive and destructive. Constructive dialogue and common objectives can turn into a destructive process because of hidden personal agendas and mental models. Quinn continued to state that it is not sufficiently recognised within strategic management that strategy implementation problems occur because organisational policy is seldom neutral, and always contains elements of power, politics, and constant negotiation.

Strategy as a Social Process

Building on the work of both Mintzberg and Quinn, a number of authors have began to argue that strategy processes has emphasised an 'either/or' dichotomy suggesting that strategic decisions fall into the rational or incremental school (Lindblom, 1959), or the formulation and implementation school (Andrews, 1971, Porter, 1980). This, it is argued, is a mistaken split.

Johnson (1988, 1990, with Hodgkinson, 1994) considered that strategy as a process should be seen as the 'product' of the political, social, cognitive and cultural fabric of an organisation, rather than as the result of rational analysis, choice, and implementation. Schendel (1992) concluded that the distinction between the content of strategy (formulation), and the process of strategy (implementation) was fuelled by a conceptualising of strategy as a process involving organisation and decision making which as a result separated the process side of strategy from the content side. Developments in the content side of strategy, Schendel continued, in particular resource-based approaches (see later) have highlighted this weakness. Schendel argued that managers within firms have an ability to use resources to gain competitive advantage over rivals, this ability also being a 'unique' resource. This has led to a recognition that strategy content and process designed by a firms managers needed an approach which did not separate content from process.

Strategy process research has thus been limited by the omission of the actions of managers and others as *people*, and the *relationships* between them.

Pettigrew (1977, 1992) also argued that strategy development within organisations should be seen in terms of a process. Therefore in relation to strategy process research, the what (content) and the how (process) are best regarded as inseparate. Pettigrew (1992) agreed with Mintzberg that the *context* an organisation finds itself operating within has a strong bearing on its strategic development. Organisational context has two aspects associated with it, inner and outer. The outer context refers to the economic, social, political, competitive, and sectoral environments in which the organisation is located. The inner context refers to organisational structure, culture (see later), politics, and power distribution within the organisation. The context thus shapes particular features of strategic processes and strategic content. Strategy as a process is therefore *embedded* in the particular context of an organisations and as a result can only be studied as such. Pettigrew also argued that strategy processes have to be seen not only in relation to context, but also though the *actions of people*. Strategic management should be seen as consisting of a multilevel series of activities and processes.

> *"Context is not just a stimulus environment but a nested arrangement of structures and processes where the subjective interpretations of actors perceiving, learning, and remembering help shape process. Strategy processes are both constrained by features of context such as tradition, and also shape contexts by preserving or altering technological strategies or corporate culture"*
> (Pettigrew, 1992, p10).

Pettigrew concluded by indicating that the performance of an organisation should be linked to a higher level of analysis including sector specific changes, the national political context, and lower levels of analysis such as the culture, history and politics of an organisation. Different strategic processes will also be evident depending on the level of analysis, intra-firm, inter-firm, or sector. De-Witt and Meyer (1998) take this debate a step further and indicate that

context in effect determines both strategy processes and content and embeddes these two areas in an organisations environment.

Eden (1992) continued on Pettigrew's theme suggesting that the strategy development process within firms will be more effective if seen as a predominately social, rather than as a planned analytical process. Organisational decision making occurs within a framework that Eden called a 'negotiated order', and this included strategic development and action. The strategy process therefore is a framework the meaning of which is negotiated, given a particular form, and is open to revision via problem solving within organisations. This will include issues associated with negotiation, bargaining, actions, and capabilities.

Schoemaker (1993) added to the notion of context and highlighted the unpredictable nature of strategic processes. Organisational environments in particular are so complex that,

> *"Each decision context becomes its own reality with limited consistency across situations and goals"*
> (Schoemaker, 1993, p 110).

In this way the particular context an organisation finds itself in becomes the driving force for strategic decisions, rather than any formal planning. Organisations are also unpredictable because of their complexity. Strategic decisions as a result are pushed and pulled between context and top down planning, with the balance shifting due to circumstance, time, control, and goal alignment. The contextualist view therefore promotes a planning model that is more experiential, learning based, and is process orientated. It therefore focuses upon managing contexts and creating conditions from which strategic decisions are arrived at *without* direct planning.

Hart and Banbury (1994) continued on the theme that strategic decisions tended to be distinguished between the formulation and implementation schools. Returning to the resource-based approach to strategy, these authors suggested it may be more appropriate to consider an organisation as possessing different combinations of strategic resources which

then form capabilities (see later). There are many different process 'skills' needed to develop strategy making 'capability'. A firm which can develop such capabilities may therefore outperform less process-orientated rival firms.

Hart and Banbury considered that strategic decision making consists of a process which involves the *whole* organisation and advocate taking a 'systems' view of strategy making which focuses on the interrelationships between the organisation's senior managers and its employees. By focusing on these interrelationships, Hart and Banbury identified five processes or 'modes' of strategy decision making. These were command, symbolic, rational, translative, and generative. Each process or mode reflected the pattern of interaction between the roles of managers and employees and also represented a key resource or skill available to the organisation.

These processes or modes in effect reflected the nature of the strategic management process within the organisations. They concluded that the more firms were able to develop competencies in 'multiple modes' of the strategic management process, the higher their performance. Multiple modes consisted of incremental, directive, participative, controlling, and empowering relationships. The strategy processes were complex and reached deep into the organisations involving many people. The implication for managers is that to be successful, strategy processes must provide a strong sense of strategic direction and everyone within the organisation must contribute in some way to the strategic management process.

This sub-section has highlighted a number of issues associated with the development of strategy within organisations. What can be drawn from the discussion is that strategy development is often not based upon rational planning and analysis to meet organisational objectives, but is the result of political compromises between competing groups, culture differences, other social factors such as the use of power, and environmental regulatory constraints and is embedded within particular contexts that organisations find themselves in.

Understanding strategic management is therefore about understanding that organisations have diverse frames of reference, and that these frames of reference have to be reconciled both within and between organisations to enable strategy to be developed and implemented.

The Development of Strategic Management

The introduction of strategic planning emerged in the 1950's and 1960's (Grinyer, 1971). Many companies had expanded and needed some method of ensuring that they met their objectives (Op Cit.). The main focus and problems for these companies was the control process and co-ordinating decisions to be made among their various divisions. This was first achieved using a financial budgeting process which was based on an annual activity. This was superseded in the 1960's by an emphasis on longer-term planning which would give consistency with the control and co-ordination process. Ansoff (1965) has stated that the planning process was suited to the post WW II period of rapid growth and stability that allowed companies to expand and develop. Bazzaz and Grinyer (1981) in their study of corporate planning suggested that planning in the UK developed later than it did in North America. Long-term planning consisting of five to eight year strategic plans were developed which allowed companies to improve their efficiency through economies of scale and scope, engage in mass marketing schemes, and to invest in technology for the future. The main method for companies to grow was through diversification. During the 1970's portfolio planning developed as the model to complement strategic planning that large diversified firms could use for determining strategies and allocating resources to their divisions (Ansoff, 1977).

With strategic planning there was a need to determine an organisation's long-range objectives, provide appropriate procedures for developing and evaluating alternative strategies, and finally evaluate the results of the strategic plans. This was achieved by attempting to ensure the commitment of managers who would have to implement the plans. This was usually shown diagrammatically and there are a number of variants. Armstrong (1982) has indicated that strategic planning tended to follow a number of stages.

This included the specifying of objectives, the generation of strategies, the evaluation of strategies, and finally a method to monitor the results of strategies. These stages could all be linked via a joining loop which provided a means to alter one of the stages if necessary.

Planning Under Attack

However, by the mid to late 1970's formal strategic planning was beginning to come under pressure from a variety of sources. The economic crisis of 1974, which led to much instability in the economies of Western Europe and North America, led to strategic planning showing its weakness for operating in mainly stable environments where the future could be predicted with some accuracy. Competition was also beginning to come from the international arena which again threatened the stability and long term survival of many companies. Many companies were forced to abandon their five to eight year strategic plans for more flexible approaches to strategic management (Mintzberg, 1994). Strategic planning tended also to be undertaken by an organisation's strategic planning department who had sole responsibility for the development of strategy. Line managers would simply implement these plans. This led to the disillusionment with the strategic planning model, and strategy formation then became devolved to the managers who in the past were mainly responsible for the implementation of strategic plans. However, strategic planning continues to be used by many organisations including those in the public sector (Bunning, 1992).

Scenario Planning

From strategic planning developed scenario planning. First developed by Kahn and Wiener (1967), this tool has been continually refined over the years (Wack, 1985). Whereas formal strategic planning tended to focus upon a distinct approach or view of the world, scenario planning on the other hand offered managers the chance to examine a number of options that might unfold in the future and thus avoid some of the pitfalls associated with formal strategic planning (Op Cit.). Chandler and Locke (1982) give a very precise description of scenario planning techniques open to managers and state that scenario planning in effect attempts to

stimulate external pressures that a firm may face. It gives managers a test-bed for their ideas within a 'safe' environment.

Van der Heijden (1996) has indicated that scenario planning distinguished itself from strategic planning through its explicit approach towards ambiguity and uncertainty in relation to strategy development. Scenarios were used to test strategy proposals in an attempt to improve upon them and stretched the organisational vision beyond areas that were traditionally seen by managers as relevant. In effect scenario planning examined an organisation's strategy from a number of multiple futures, which were used to create an adaptive organisation which recognised change and uncertainty. This was then used this to advantage to see things that might have invisible using traditional strategic planning. The move now was away from the ability of firms to diversify and plan in terms of new products and markets, to one where competitiveness was more important. Strategic management now was in favour, rather than strategic planning.

The Move to Strategic Management

Strategy began to be described in terms of the fit between an organisations resources and its external environment (Porter, 1980). In this way an organisation could develop a competitive advantage over its rivals. Strategy could now be *managed*, and in a number of ways. Strategic Planning tended to be very prescriptive and inflexible. More flexibility was seen as being needed in a firm's environment. From the mid 1970's onwards, there was increased awareness of the analysis of a firm's external competitive environment. This was associated with the work of Porter who developed a framework for analysing industry structure and a firms profitability. In tandem with the environmental and competitive advantage models, the 1980's also saw the re-emergence of analyses which focused on a firm's internal environment. A firms competitive advantage was now seen not so much as depending on the external world and postioning within a market place, but on the exploitation of resources that a firm possessed which were unique to that firm (Wernerfelt, 1984, 1986, Barney, 1986). Strategic planning had evolved into strategic management.

Section Two: Strategic Management Frameworks

Introduction

This section will examine the two main models of strategic management that have developed in the period 1980 - 1994. The first model takes a market or product based approach to strategy. This model essentially analyses a firm's industry structure to assess its profit or rent earning potential based on entry and exit barriers. The second model views strategy from the perspective of a firm's resources and capabilities which give it a competitive advantage over its rivals. These two approaches constitute part of what has become known as the content side of strategy, and is the product of the process of strategy (de-Witt and Meyer, 1998). The content side of strategy is concerned with the 'what' of strategy. What strategies that an organisation eventually pursues, and is usually the result of some form of analysis and option appraisal exercise. Content will also be discussed in section three with specific attention to strategic options

The Market, Environmental or Positional Model of strategy

The emphasis on the external environment began in the late 1970's and early 1980's.
In this period, most developments in strategic management focused upon the industry environment of the firm and its competitive positioning in relation to rival firms. Porter (1980) has been the main architect of this approach to strategy. It has its roots in industrial economics and focuses on the industry a firm operates within. This approach encourages managers to develop their firm's resources and then match these resources with market or industry opportunities. Central to the concept is the structural forces which operate within a firm's environment, and how these forces influence the performance of the firm. All firms operate within a particular industry and are in competition with each other. An industry comprises groups of firms that produce similar products or services for the same market.

This competition is dependent upon five forces. These five forces consist of:

- Buyers and suppliers who all have differing degrees of buying and supplying power;
- Potential entrants who seek to increase their market share of the particular industry;
- Substitute products/services which can perform the same function as the products/services of the industry and;
- Existing industry competitors.

The objective of a firm is to manoeuvre itself into a *position* that will enable it to defend itself against these five forces. Porter relates competitive strategy to his industry structure analysis. By identifying the forces, which have an effect on a particular industry, firms will then be able to determine their strengths and weaknesses. Porter argued as a result of this analysis, that the firm could then take defensive or offensive action that would enable it to combat the five forces. The firm could then *position* itself to ensure that its own capabilities give it the best defence against the competitive forces. Having described the forces that will shape an industry, Porter then identified generic competitive strategies a firm could use to combat these five forces, while at the same time outperforming rival firms. These generic strategies will be discussed in more detail in section three.

The Resource-based Approach and Strategy

The resource-based approach to strategy is an emerging framework that has developed in recent years to complement the positional approach to strategy and includes an appraisal of an firm's competencies and resources (Mahoney and Pandian, 1992). The resource-based approach to strategy in this sub-section will be examined from three points of view. The first will be what has become known as the classical resource approach to business strategy. The second and third approaches are additional contributions to the classical approach by Prahalad and Hamel (1990), and Kay (1993) respectively. These two latter contributions can also offer a framework which can be used to identify specific resources and capabilities and will be returned to in chapters 8 and 9.

The origins of the resource-based approach to strategy lies with the work of Penrose (1959). Penrose saw a firm containing two key elements, administration and a collection of what she called 'productive resources' or firm capabilities. The firm then organised these resources together with resources from its outside environment to produce goods and services at a profit. Penrose contrasted 'entrepreneurial services', which she said could be provided by any employee of the firm, and 'managerial services' which she considered as the implementation of ideas generated from the entrepreneurial services. Services, entrepreneurial or managerial, are the contribution which resources make to the operation of the firm. Capabilities are created over time and can be dependent on the history of the use of resources in what Penrose suggested was a complex and path dependent process. Path dependent capabilities, which are capabilities that a firm accumulates over time due to history and opportunities, provide the foundations for the firm's strategic architecture[17]. Firm innovation is also very closely related to the nature of existing resources. It is therefore the resources of the firm which will limit the choice of markets that it will enter.

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17. Strategic architecture in this sense are ways in which a firm deploys its resources and capabilities.

To return to the concept of strategy discussed in section one, Penrose argued that if a firm expands into activities which can give it a competitive advantage over firms in the same industry, it will have an advantage which will most likely lead to the potential to generate economic rent. This idea of a firm consisting of a bundle of resources which could be used to gain competitive advantage was not taken up again for several years, although both Andrews (1980), Porter (1980,1985), Mintzberg and Quinn (1988) all have discussed the use of a firm's resources to confer some form of competitive advantage.

A historical review of strategy research indicates that viewing a firm from a resource-based approach has been central to the field (Connor, 1991). Rumelt (1984) argued that,

> *"The strategy concept is that a firm's competitive position is defined by a bundle of unique resources and relationships and that the task of management is to adjust and renew these resources and relationships as time, competition, and change erode their value"*
> (Rumelt 1984, p 557).

It was during the 1980's and early 1990's that the resource-based approach developed further and indeed complemented the existing positional approach. Influential contributions have come from a number of scholars including, Wernerfelt (1984), Barney (1986, 1991), Dierickx and Cool (1989), Amit and Schoemaker (1991), and Peteraf (1993).

An interesting aspect to the resource-based approach to strategy is that it attempts to combine the often dichotomous schools of strategy making, the rational vs. incremental or formulation vs. implementation schools (see section 1). This is also related to strategy as a process. Strategic processes have already been discussed in section 1, so will not merit further attention here. However, the resource-based approach does indicate that a competitive advantage based upon a single resource or skill is easier to identify than a competitive advantage that involves multiple resources grouped into competencies. Strategic processes based upon the development of a complex pattern of co-ordination between many actors and diverse resources may be more difficult to understand and imitate that strategic processes that depend on the exploitation of a single resource (Grant, 1991).

Developing this argument further, Dierickx and Cool (1989) have argued that the imitability of an organisations capability is related to the *process* through which the resource is acquired. Firms that are able to accumulate resources and capabilities which are complex in relation to their strategy may also be more successful at sustaining competitive advantage than firms whose resources and capabilities are less well developed (Barney, 1991).

What are Resources?

Barney (1991) described resources as all the assets, capabilities, information and knowledge that are controlled by a firm which then able it to implement strategies that improve its efficiency and effectiveness. Grant (1991) made the distinction between resources and capabilities. Resources are inputs into the production process and include capital equipment, skills of employees, patents, brand names, finance, and so on. However, on their own, few resources are productive. Productive activity requires the co-operation and co-ordination of teams of resources which then form a capability. A capability is the capacity for a group or team of resources to perform some task or activity. While resources are the source of a firm's capabilities, for Grant, capabilities are the main source of its competitive advantage. Hall (1992) discussed resources which are tangible and intangible. Tangible resources include intellectual property rights of patents, copyright, contracts, and reputation. Intangible resources are both assets and skills. Skills include employee know-how, and organisational culture.

Wernerfelt (1984), was one of the very first authors to develop the resource-based approach to strategy. Wernerfelt attempted to examine a firm from the perspective of its resources rather than via products with reference to strategic options. He used Porter's "five forces" model for analysis. Although this model was designed for analysing products, markets and industries, he was interested in the circumstances that a resource would lead to rent generation and concluded that examining firms in terms of their resources would lead to

different insights than the traditional product/market perspective. These were similar to Porter's entry barriers, but Barney called them resource barriers.

Barney (1991) identified four areas that he considered that managers needed to address in relation to a firm's resources that underlie sustainable competitive advantage.

- **The question of value**: resources can only be a source of competitive advantage when they are valuable thus allowing a firm to develop and/or implement strategies that improve its efficiency and effectiveness. Providing an organisation's resources are imperfectly mobile, unimitable and non-substitutable, other firms will not be able to copy its strategy;
- **The question of rareness**: Barney discusses the question of how rare a valuable resource must be in order to have the potential to generate a rent. Barney argues that if a firm's valuable resources are unique among a set of competing firms, the resource will generate a rent;
- **The question of imitability**: valuable and rare organisational resources can only be sources of competitive advantage if firm's that do not have these resources cannot obtain or imitate them and;
- **The question of organisation**: a firm has to be organised to exploit its resources and capabilities. This organisation can include a firms' structures, management control procedures, and systems.

Core Competency

Prahalad and Hamel (1990) popularised the idea of firm resources but introduced the notion of "core competencies". For Prahalad and Hamel,

> *"Core competencies are the collective learning in the organisation, especially how to co-ordinate diverse production skills and integrate multiple streams of technologies. They are the glue that binds existing businesses. They are also the engines for new business development"*
> (Prahalad and Hamel, 1990, p 82).

A core competence is a bundle of skills and technologies that enables an organisation to provide a particular benefit to customers, not just the actual product or service.
Core competencies are not product specific, nor are they a single discrete skill or technology. They are the sum of learning across individual skills sets and individual organisational units Prahalad and Hamel have argued that in the future many firms will be increasingly dependent on expert or knowledge workers for competitive advantage. Strategy in this respect involves building on internal core competencies, not just simply positioning the organisation in response to market signals. Key competencies are not traded on the market, but have to be built up within the organisation. What is important is the build up of core competencies based on both tangible and intangible assets such as learning levels, the attitude to experimentation, the ability to manage change, and levels of knowledge. By acquiring such competencies organisations will increase their profitability.

Core competencies are multidisciplinary crossings of all an organisations business units, and at all levels within the organisation from top to bottom. Core competencies are also the skills of employees within a company's SBU's. These skills have to be focused on the organisation as a whole, and not simply kept within a particular business unit. Peoples efforts must be recognised within the organisation, not simply within particular departments. Core competencies are present within organisations and do not disappear over time or lose their value in the way fixed assets do. In fact core competencies can be enhanced over time as they are used. Organisations can also assist themselves in developing core competencies by joint ventures with other companies. In this way core competencies can be developed quickly and at considerably less cost than if developed alone.

Core competencies are present within every organisation. For Prahalad and Hamel, core competencies can be identified using three tests.

- A core competence provides potential access to a wide variety of markets;
- A core competence should make a significant contribution to what the final end user or customer wishes to get from a product or service and;
- A core competence should be difficult for competitors to imitate.

Distinctive Capability

Kay (1993) described the concept of an organisation's 'distinctive capability' and added value as a means to gauge corporate success. A distinctive capability is "some feature of its relationships which other firms lack and cannot reproduce" (p 64). An organisation's distinctive capability has three primary areas associated with it, architecture, reputation, and innovation. Added value is simply the difference between the value of a firm's outputs and the costs of the firm's inputs.

Architecture: This is a network of relational contracts within or around the firm. Firms may establish these relationships with; employees (internal architecture), suppliers or customers (external architecture), or among a group of firms engaged in related activities (networks). The value of architecture rests on the capacity of organisations to create organisational knowledge and routines which can respond flexibly to changing circumstances.
Reputation: Kay indicates that reputation is the most important commercial mechanism for conveying information to customers. Reputation, though, is not equally important in all markets. Customers find out about product characteristics and qualities in many ways. Reputation is the market's mechanism of dealing with areas of product quality which customers cannot easily monitor for themselves.

Innovation: Kay argues that what appear to be the rewards of innovation are often really the product of a firm's architecture. Some firms have established an architecture which stimulates the continuous process of innovation. Other firm's have created an architecture which enables them to implement innovation particularly effectively. The process of innovation often involves complex interactions between firms. However, managing innovation is both costly and risky. New products may fail because there is no demand, or insufficient demand. Firm specific innovation normally rests on the local application of generally available knowledge or technology.

The issue of appropriability[18] is fundamental. The central characteristic of a distinctive capability is that it cannot be easily be replicated. A fundamental weakness of innovation as a source of competitive advantage is that it can be easily replicated. The result is that the innovator may be exposed to the costs of innovation and the risks of development and introduction, only to see competitors share or dominate the fruits of success.

The most effective way of turning innovation to competitive advantage is generally to deploy it in conjunction with another distinctive capability. Kay gave the examples of Innovation and reputation and innovation and architecture as potent combinations. It is firms with another distinctive capability which are generally best placed to derive competitive advantage from innovation.

Strategic Assets

Kay also discusses the fact the some competitive advantages are based not on the distinctive capabilities of firms, but on their dominance or market position. These are the strategic assets of the firms concerned. There are three main types of strategic assets:

- Some companies may benefit from natural monopoly. They are established in a market that will accommodate no more than one firm;

- In other markets incumbent firms have already incurred many of the costs of supply, but entrants have not. In these, the cost structure of firms may give them a competitive advantage and;
- Firms can benefit from market restrictions which are the product of licensing and regulation.

Kay discusses that firm's which benefit from strategic assets are generally engaged in activities where government regulation is an important influence on business behaviour. Sometimes government can create or reinforce strategic assets. The establishment and exploitation of strategic assets can also be restricted by regulatory and anti monopoly policies. Distinctive capabilities enable firms to produce at lower cost than their competitors, or to enhance the value of their products in ways which put them ahead of their rivals. Distinctive capabilities are therefore the product of the organisation or the firm itself, its architecture, its reputation, or its success in innovation.

[18] Appropriability for Kay is the ability of an organisation to realise the benefits of its distinctive capabilities itself, rather than its competitors, suppliers, or customers.

Section Three: Strategic management: Options and Styles

Introduction

Section 1 indicated that the strategy process within a firm include the three stages of analysis, choice and implementation. This section will provide an overview of some of the strategic management choices that are available to managers when they have conducted the analysis stage of the strategy process. This area also comes under the heading of strategic content and was described in more detail in section two.

Strategic Options

There are a number of strategic options that are available for managers to use within their organisations. Section 2 discussed that Porter (1980) identified three generic strategic options that a firm could pursue. These options were:

- **Cost leadership**: which emphasises producing a standardised product at the lowest unit cost in the industry for buyers who are price sensitive;
- **Differentiation**: where a firm produces products which are considered 'unique' industry-wide and are offered to buyers who are less price sensitive and;
- **Focus**: firms offer products, which fulfil the needs of particular buyers within a segment, group, or market of a specific industry.

Ansoff (1977) provided a framework which has become known as the Ansoff Box or matrix. This box allows opportunities to be highlighted and analysed which can then lead to the development of strategic options. These strategic options include; withdrawal; consolidation; market penetration; product development; market development; and diversification. All of these options depend on the particular circumstances that an organisation may find itself in,

and more importantly the environment, both internal and external that the organisation operates within. These options will now be briefly discussed.

Withdrawal: firm's may use this strategy if the market that they are operating within is in decline and they wish to exit to reduce their losses, or if their profits are falling;

Consolidation: this is essentially a change in the way that an organisation operates, while its markets, services and products remain the same;

Market Penetration: firm's attempt to increase their market share through improving the quality of their products, improving their productivity, or increasing their marketing activity;

Market Development: while maintaining their existing product range, firms' can aim to develop new markets for their existing products and capitalise on their production expertise. This can be achieved by extending into new geographical areas or devising new uses for their products;

Product Development: firm's can decide to develop new products using their existing skills and knowledge while at the same time exploiting their marketing strengths;

Diversification: diversification occurs when a firm moves away from its existing products or market areas. It can either be related where the organisation's existing products and services remain the same, or unrelated where an organisation develops a product or service which have no direct relationship to the industry or market in which it is operating;

Internal Development (organic growth): some organisations can expand their existing production and distribution facilities or decide to develop new products internally as a means to gain the skills and knowledge which will enable them to compete successfully in their market(s);

Mergers and Acquisitions: mergers tend to be undertaken by firms which want to come together for mutually beneficial reasons such as reducing costs through economies of scale in management overheads. A greater mass of services can also create a stable and secure source of supply and demand within individual organisational departments which insulates them against competitive forces.

Joint Development and Strategic Alliances: an alternative approach to mergers that a firm can take is to develop joint ventures and strategic alliances with other organisations. Craven et al (1993) focused upon the four areas of environmental turbulence, diversity, skill and resource gaps in relation to strategic alliances and joint ventures. They identified that strategic alliances between firms are likely to occur in situations where there are high levels of environmental diversity, turbulence, and where there are skills and resource shortages between firms. Joint ventures were seen to be driven more by environmental turbulence and diversity when firm's did not have major gaps in particular skills or resources to deliver services in the market place.

There are a number of benefits of joint ventures and strategic alliances (Waters et al, 1994). Where there is a high degree of competition and fast moving environments there is often little scope to create new services from scratch because of the high set up costs involved. Joint ventures and strategic alliances therefore have the benefit of allowing organisations the flexibility to move in and out of particular markets or services within the same area, and also to add value to existing areas of operation through closer links with other organisations. Organisations can also benefit because and still have ownership and control of themselves, and in some cases joint ventures and strategic alliances can provide useful experiments to future merger.

Section Four: Strategy, Culture and Control

Introduction

Each of the approaches discussed in section 3 outlining strategic options has focused on the primary directions that a firm could pursue in their search for competitive advantage over rivals. Approaches to strategy can also be characterised by the particular *style* of management adopted by a firm's managers as they adapt to their environments. From this perspective, a firm's managers can be viewed as having distinctive management styles which can be differentiated according to the degree of control given to their operating divisions. One such typology has been developed by Goold and Campbell (1987) which in their later work developed into the corporate parenting typology (Goold et al, 1994). However, before discussing corporate parenting, organisational culture and strategy will be discussed.

Organisational Culture and Strategy

Organisational culture is an elusive concept which is perhaps better experienced when people are part of an organisation, rather than observed from outside the organisation. Culture is made more meaningful by experience. Culture influences every aspect of the work environment, how people feel about what they do, how they carryout their jobs, and why some things are important or unimportant. Organisational culture is the pattern of beliefs, assumptions and values shared by an organisation's members.

Organisational culture has three important characteristics (Duncan et al, 1995):

- It is learned, often by experience. People who work in an organisation over time accept its expectations and the way the organisation organises its activities;
- It is shared. Shared understandings and meaning are important because they help an organisation's members in understanding the way work is to be carried out and;
- It is both objective and subjective. Objective culture is the rituals and ceremonies that are carried out by the employees of an organisation. Subjective characteristics are the beliefs and values of an organisation's employees.

Culture is also important in determining the capabilities of an organisation, can be supportive of efforts to improve performance, or indeed can resist changes to the accepted way of doing things. Kanter (1989) has emphasised the need for a synergy between organisational strategy and culture if organisations are to compete successfully. In this way strategy will be influenced by organisational culture. Johnston (1987, 1988) discussed a number of cultural factors that have an influence on an organisation's strategic development. These factors can either be external such as the prevailing political climate in the public sector, or internal such as the values and beliefs within the organisation. This culture Johnson referred to the organisational *paradigm*, and he introduced the concept of a cultural web which supported the paradigm. The cultural web consisted of six elements:

- *Stories*: which helped to legitimise certain types of behaviour;
- *Routines and rituals*: the methods by which organisational strategies were carried out;
- *Symbols*: important when undergoing strategic change;
- *Organisational structure*: enabled successful implementation of strategy;
- *Control systems*: which rewarded/punished certain types of behaviour and;
- *Power structures*: key factors in culture and could have a strong influence on strategy.

The Corporate Parenting Typology

Goold and Campbell (1987), and with Alexander (1994) determined that different management styles were appropriate to different types of businesses and different types of corporate management. They gave particular attention to two distinct corporate management functions, the involvement of corporate head office in business strategy formation, and the type of control exercised by the head office. Goold et al called these two functions *corporate parenting*, and the corporate parent was the 'corporate' hierarchy of managers, functions and services outside an organisation's SBU's. The types of control identified by Goold et al were strategic control, strategic planning and financial control. Goold et al then introduced the concept of the corporate parents[19] *adding value* to their organisations. Value is created if an organisation's purposes and priorities are furthered, or if business opportunities were provided to SBU's. Value was also created if the corporate parents influenced the businesses they own, what Goold et al called *parenting advantage*. Value can also be destroyed, for example, deciding on inappropriate strategies, or too much control being exercised over SBU's.

How Parents Created Value

Goold et al argued that parents created value in four main ways; by stand-alone influence; by linkage; through functional and service influence; and via corporate development activities.

- *Stand-alone-influence*: this was concerned with the parents influence on the strategies and performance of each SBU. The range of issues depended on the degree of what Goold et al call the *decentralisation contract*[20] between the parent and their SBU's;
- *By linkage*: parents could enhance value through linkages with their SBU's. This was achieved through the corporate decision making processes and firm structures, policies, guidelines, and through personal pressure;

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19 . Now abbreviated to parents.

- *Through functional and service influence*: the main responsibility for exercising parental influence lay with the organisation's Chief Executive and other senior managers. However, the parent also contains a range of corporate staff functions and services and;
- *Through corporate developmental activities*: these created value by altering the portfolio of the SBU's or could re-define new SBU's by merger.

The Strategic Management Parenting Styles

- *Strategic Planning*: parents were closely involved with their SBU's in the formulation of their business plans. Parents provided a clear overall sense of direction within which their SBU's developed their strategies and took the lead on selected corporate development initiatives. Goold et al modified this style of parenting to that of a *controller*. In the controlling role, the parent had little involvement with the each SBU, except to set targets and monitor their achievements.
- *Strategic Control*: planning was decentralised to the parent's SBU's, but the parents retained a role in measuring and assessing their SBU plans. SBU's were expected to take responsibility for developing strategies, plans, and proposals in a 'bottom-up' manner. Goold et al modified this parenting style to that of a *coach*. In the role of the coach, the parents encouraged each SBU to develop to their full potential through drawing upon capabilities within their SBU's.
- *Financial Control*: parents were strongly committed to the decentralisation of planning to their SBU's. They structured their SBU's as stand-alone units with as much autonomy as possible, and with full responsibility for formulating their own strategies and business plans. The parents primary roles were to insist that all decisions were 'owned' by the SBU's, and that proposals met agreed financial criteria. Goold et al modified this style of parenting into an *orchestrating* role. Parents in the role of orchestrator co-ordinate their SBU's and ensure that resources are shared with all their SBU's.

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20. The decentralisation contract between the parent and SBU defines the issues on which the parent provides control and influence, and those that it devolves to the SBU.

Conclusions

This chapter has reviewed some of the literature surrounding the origins and conceptualisation of strategy. This can essentially be divided into two main areas, strategic processes (how strategy is arrived at), and the content of strategy (what strategies an organisation pursues). Section one indicated that strategic processes inform the different ways strategy is developed and the potential influences upon strategic decisions within organisations. Section two and three indicated the types of strategic decisions that an organisation can take which are often the *products* of its strategy processes. Strategy has also a context which determines both the process and content of an organisation's strategy and indeed locates an organisation in a specific environment.

The thesis will examine the extent to which NHS managers were beginning to act strategically within the NHS internal market that was developing in the West of Scotland. In chapters eight to eleven, reference will be made to these managers and their NHST's exhibiting strategic behaviour. For the purpose of the thesis a definition of strategic behaviour will now be offered which seeks to articulate this chapter to the actions of the managers and their NHST's that will be reported and discussed in chapters 8-11. *Strategic behaviour, in the present context, is thus the range of strategic decisions than an NHST and its managers are pursuing within particular resources constraints: these decisions are arrived at by the interactions and influences of individuals and groups through a process, and which takes place within a context specific to the particular NHST.* This definition has a number of characteristics associated with it. It is likely that NHST's facing similar decisions will respond differently. Strategic decisions will also be complex and could be based upon an often uncertain and changing environment. This broad definition, and its associated characteristics, will be used when considering the different approaches to strategic management used by the NHST case studies (see later). Revisiting chapters one to three, it is clear that the NHS is subject to political influence and direction deriving from a number of powerful stakeholder groups, and operates in an ever changing and uncertain environment. The NHS market is also likely to be

relational and as such developing and enacting strategies may be based upon developing a myriad and network of inter and intra organisational relationships and arrangements.

These factors collectively could imply that the strategic processes and eventual content of NHST strategies will be influenced by these new relationships. These issues will be explored in chapters eight to ten.

Following from the discussion of corporate parenting, the NHST's used in the research (see chapter 6) act as parents with regard to their clinical specialties. These clinical specialties are arranged in groups within hospitals called Clinical Directorates. Chapter 5 will now examine the origins, development, and management arrangements of Clinical Directorates in the UK NHS.

Meanwhile we note a number of summary points:

- Strategy has connotations with the military and only began to develop within commercial organisations in the 1930's and 1940's;
- Strategic planning emerged in the 1950's and 1960's as a means to assist firms in dealing with increased size and complexity. Strategic planning evolved into strategic management because of a number of failings of strategic planning;
- There has been an ongoing debate within the literature concerning strategy making as a process. This has led to a dichotomy between the formulation side of strategy, and the implementation;
- Strategy development is never a simple process, is often dependent upon the relationships between an organisation's stakeholders, and revolve around factors associated with history, culture, politics, and the use of power;
- There are two main strategic management frameworks, the market/positional approach and the resource-based approach;

- There are a number of strategic options that a firm can pursue to improve or maintain its competitive advantage over rival firms and;
- In the later chapters on competition and strategic behaviour, we will have occasion to refer to the relevance of these various debates as they have influenced NHST decision-taking.

Chapter 5: Clinical Directorates in the UK NHS

Introduction

Chapter 1 indicated that the 1990 NHS Reforms provided the opportunity for managers of NHST's to begin to develop strategic behaviour. Chapter 4 provided an overview of strategy, strategic management, and types of strategic behaviour. This behaviour can develop at two levels within NHST's. The first level is with the senior managers of the individual NHST's, and the second level is with the clinical specialties within the NHST's arranged as Clinical Directorates. This chapter will examine the development of Clinical Directorates within the UK NHS. Clinical Directorates are grouping of clinical specialties such as surgery, medicine, and support specialties such as laboratory and imaging. Their origins and development requires a better understanding hence the rationale for this chapter.

The chapter consists of four sections. Section one provides a historical review of the origins of clinical management and management decentralisation within hospitals. Section two discusses the introduction of Clinical Directorates into the NHS. Section three examines in more detail the Clinical Directorate as a model of clinical management. Finally section four concludes with a critique of the Clinical Directorate model.

Section 1: The Origins of the Clinical Directorate

Introduction

The origins of the Clinical Directorate model of clinical management lies with the Johns Hopkins (JH) hospital based at Baltimore in the USA. Since 1974, the JH hospital had been operating a clinical management system (Disken et al, 1990). The JH hospital during 1974-75 was faced with severe financial problems, due in part to the escalating costs of healthcare in the USA (Hirst et al, 1995). The JH in response to this financial problem, and to increase the accountability of doctors, introduced a decentralised management system (Heyssel et al, 1984). This system required extensive financial and management information than had previously been the case, and for the first time involved doctors in management decisions. Prior to this the doctors at JH had very little involvement in budget preparation and had limited accountability for the financial performance of the hospital. The organisation of the hospital was changed to a system of clinical management. Each of the clinical specialties had an appointed head, a doctor, known as a Functional Unit Director (FUD). This is illustrated in figure 12.

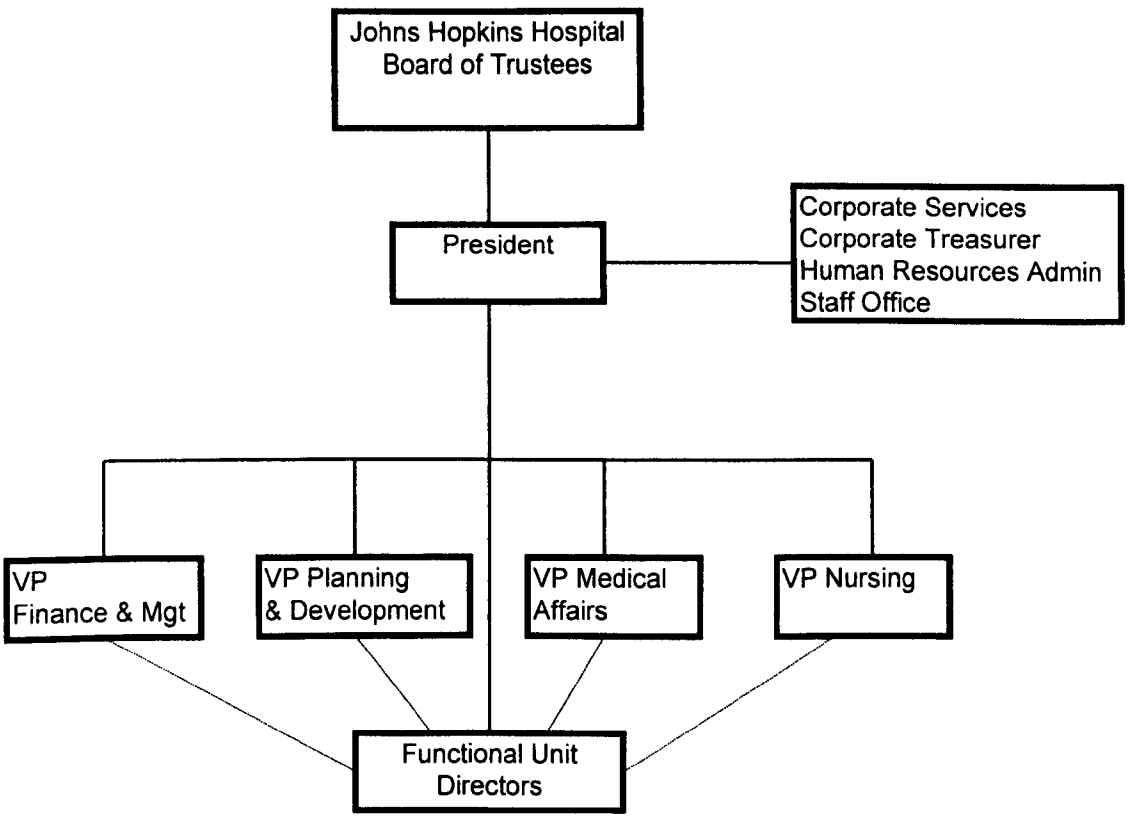
The JH hospital changed organisational *form* and became in effect a holding company for a series of smaller units or "specialty" hospitals, the Functional Units. Decisions were now made at the level of the FUD, rather than with the hospitals central administration. There were regular meetings between the central administration of the hospital, and the FUD's which enabled a broader understanding of hospital wide policy, as well as providing a forum for discussion with the doctors and managers of the hospital. Each of the Functional Units was led by a doctor, who in turn was supported by an administrator and nurse manager. All three formed a management team, and were accountable for all direct costs associated with the operation of the Functional Unit. Each Functional Unit operated within the general policies of the hospital in relation to strategic objectives and goals (Op Cit.).

Heyssel et al (1984) identified two important factors that allowed the system to be successful:

- *Financial Devolution* - before 1972, 80% of the hospital's costs were allocated to its departments by its central administration. By 1983 the pattern had changed, and the Functional Units directly controlled over 50% of their own budget.

- *Management* - the key factor essential to the successful implementation of the system was the willingness of the hospital's administration to delegate decision making to the FUD's who had the support in turn of their own administrator and nurse manager. Another major component of management success was the introduction of a hospital wide financial and management information system designed to support the decentralisation of decision making.

Figure 12. The Johns Hopkins Model of Decentralised Management (Source: Heyssel, 1984).



Good communication between the hospital's senior managers, and the Functional Units was also important to the systems success. The JH now had a highly structured planning, budgeting and monitoring process. The Function Units prepared a business plan for the following year and bids for development resources to improve or expand existing services. The Functional Units also had to prepare a five year business plan. There were regular accountability reviews to measure how well each Functional Unit was performing according to its yearly business plan, together with corporate meetings with all the FUD's to discuss JH wide issues/policies.

The transfer of responsibility accompanied by the authority to make decisions was paramount to the success of the system. The JH hospital management were willing to allow the Functional Units to have responsibility and authority, while acknowledging the fact that the FUD's were doctors first, and managers second. The idea was to allow the FUD's to develop and improve their management skills, since many of them were already managing specific areas of their work. This led to a redefining of the role of the JH hospital management. It now focused more on strategy, policy development, and monitoring the performance of the Functional Units, rather than on the operational management of the hospital departments through direct line reporting (Heyssel et al, 1984). The FUD's at JH still had a substantial clinical role, and the managerial aspect was undertaken on a part-time basis, supported by an accountant or business manager who provided the day to day operational management of the unit. The original concept was that each clinical specialty would be managed as a separate clinical unit. However, this ran into problems because it became apparent that it was inefficient to have numerous FUD's and the hospital divided into tiny units and large numbers of autonomous budget holding doctors and some of the smaller functional units were merged (Hirst, 1995).

Section 2: The Introduction of Clinical Directorates into the NHS

Introduction

Within the NHS, the traditional model of hospital management was for consultants to relate on an individual basis to hospital general managers via their hospital medical representative groups who provided a collective view of priorities which were then passed onto general managers (Buxton et al, 1989). In larger hospitals Medical Executive Committees (MEC's) could elect a smaller executive group having some collective responsibility for medical performance and activity. A Unit Management Board (UMB) existed to bring together service providers from the MEC, nursing and paramedical groups, together with managers, from finance, personnel and so on, to discuss the management of the hospital. These group's often did not work well with one another (Rea, 1995). Both doctors and managers worked in isolation from each other and followed different objectives, and the doctors were not directly involved with the allocation and control of resources. Decision making could also be time consuming as decisions had to go through several committees who were some distance from the actual patient.

The introduction of Clinical Directorates into the UK NHS has been associated with Guy's hospital in London. Guy's and other hospitals will be discussed later. However, it was the RMI discussed in chapter 1 and the 1990 NHS reforms which saw the widespread adoption of a model of management *decentralisation* within hospitals in the NHS, particularly in the acute sector. This typically involved the development of sub-unit[21] organisations which divided a unit into a number of multidisciplinary groupings according to the their work outputs (Packwood et al, 1991). These groups replaced the traditional models of unit organisation

[21] . In this instance unit is taken to imply an NHS hospital.

discussed above based upon single disciplinary hierarchies which often were a reflection of professional interests.

To re-cap on chapter 1, the RMI was an attempt by the Department of Health[22] (DoH) to make health service provision more cost-effective by enabling service providers, mainly hospital consultants, to relate their activities to costs. As a result, the RMI pilot sites began to develop clinical management structures as a way of organising themselves to meet the RMI objectives. These objectives were:

- To improve the quality of care given to patients;
- To allow the involvement in management by service providers, particularly clinicians;
- To provide improved information and;
- To allow for stronger control of resources.

The NHS Review carried out in 1988 argued that both patient and staff satisfaction could only be improved by re-organising the NHS so that it would become more competitive and cost effective. By 1989 an RMI unit had been setup within the Department of Health to help focus RM development in all NHS acute hospitals (Buxton et al, 1989). Buxton et al continued to state that RM at this time took on a new impetus which included for the first time the involvement of clinicians, nurses and managers in both *strategic* and operational decisions within hospitals. This specific inclusion of strategic matters was an important feature in the later development of RM and reflected the increasing recognition by clinical staff more experienced in management that they needed to be involved, not only at the operational levels of management, but at the strategic level.

This argument was continued in the White Paper *'Working for Patients'* (HMSO, 1989). The purchaser-provider split and the introduction of the quasi-market and competition were two methods that were seen as improving the NHS. Working for Patients also introduced methods

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22 . Prior to 1990 the Department of Health and Social Security (DHSS).

to improve the management of the NHS. Management was strengthened in its relationship with health care professionals by an emphasis on managing clinical activity. Health care professionals were also encouraged, particularly clinicians, and in some cases forced to manage their activity through clinical audit. Packwood et al (1991) have indicated that some form of sub-unit organisation predated the RMI, but no particular organisational structure was defined as a prerequisite form beyond that which could easily involve service providers in the management process. Further, it was never intended or expected by the DHSS that implementation of the RM process would require, or result in, a standard pattern of hospital organisation. Local structures would be free to evolve to meet the requirements of the RM process as it unfolded (Op.Cit.).

At least two of the RMI pilot sites (see chapter 1) had set up sub-organisational structures before the RMI began in 1986, so sub-unit organisation did not arise solely because of RM. This has been illustrated by Scrivens (1988) who conducted a survey of NHS District General Managers in England, with particular reference to Clinical Directorates. Two of the quotes were as follows,

> *"The main organisational mechanism for corporate management at clinical level will be the Clinical Directorates, i.e. firms or specialties will be combined into Directorates headed by team leaders responsible to the UGM for the management within the clinical area".*

> *"The concept of posts of directors of clinical services is two fold: to involve medical staff in the management process, and to devolve responsibility for the planning and management of core services to those who deliver them".*

The Guy's Model

The Clinical Directorate system in the UK originated at Guy's hospital in London in 1985. Guy's had close links with the JH hospital. In 1984 Guy's ran into major financial problems which resulted in the closure of wards and services being cut back (Smith and Chantler, 1987). The doctors at Guy's, as a result, lost confidence with the hospital managers, and suggested that a new method of management be established with the doctors taking the key role. In 1984 a group of managers and doctors visited the JH hospital to study the application

of decentralised management principles where day to day management decisions were taken by a clinical head of service in each of the major specialities. On return it was decided to develop a model of clinical management based on the JH hospital. Guy's reorganised itself into 14 Clinical Directorates each headed by a Clinical Director, a senior consultant, supported by a business manager and nurse manager.

> *"A major debate ensued among clinicians, which sought to reconcile clinical freedom with management authority and accountability. In the end, the consultants agreed to accept a system that sought to equate power with responsibility. In return for the freedom to manage their own affairs, they had to accept responsibility for the financial consequences"*
> (Smith and Chantler, 1987, p 14).

Each of the Clinical Directors was responsible and accountable for consultants and other medical staff in their Directorate. The Directorates had to prepare sound business plans outlining objectives for the next 2-3 years and had responsibility for their own nursing, administrative and support staff. The business manager was personally accountable for ensuring that the Directorate achieved the corporate objectives set out in its business plan. The business managers were drawn from staff who were pursuing a general management career. As the Clinical Directorate model took off at Guy's more strategy and planning roles developed for business managers (Op Cit.).

The Leicester Model

In 1985 Leicester Royal Infirmary (LRI) was facing a number of problems associated with a large teaching hospital (Barker, 1990), and as a result carried out an internal organisational analysis which focused on two perceived main weaknesses:

- A fragmented and impersonal organisation had developed which focused on professional rivalries and hierarchies, rather than on any corporate goals of the organisation and;

- There were almost no opportunities for the involvement or ownership in the management process for clinical staff, and related to this no mechanisms existed for planning or controlling performance while matching this to resource use.

LRI introduced a new management programme in 1986 in an attempt to address the above shortcomings. This was to be achieved by drawing together responsibility for the planning and control of performance to key staff members so ensuring that the hospitals resources were used to deliver the best possible standards of healthcare provision. Clinical Directorates were established at LRI which at the time,

> *"represented a radical step forward in NHS management culture with direct medical participation in the planning and management of resources, accountability for the delivery of agreed outputs, and regular monitoring of performance"*
> (Barker, 1990, p1428).

Ten Clinical Directorates were set up led by a Clinical Director, a consultant, appointed by the General Manager of the Hospital. Responsibility was delegated to the Clinical Director to exercise corporate responsibility and accountability for their specialism(s). This included controlling budgets and staff, and future planning of their clinical services through LRI's planning and review process. There was a certain flexibility to manage services and budgets according to local circumstances and priorities providing that service commitments were achieved and financial limits were adhered to.

The Clinical Director was part-time to enable him/her to continue with their clinical practice, and was supported by an associate manager who was full-time. The Clinical Directorate also had a senior nurse who was responsible to the associate manager for managing the Directorate's nursing resource. The Clinical Director through the associate manager had responsibility for the employment, training, management and discipline of all staff involved with delivering the service. Clinical Directorates were established at LRI to develop teamwork within each specialty and,

> *"In a large institution with the tendency to an impersonal atmosphere, the creation of a series of 'mini hospitals' was intended to engender pride and personalised service within each locality. But to achieve the benefits of localism, without the risk of fragmentation into parochialism, the clinical units are united by a strong bond of hospital wide corporate identity through the management board"*
> (Barker, 1990, p 1428).

The Management Board was LRI's governing body and included the hospital General Manager, the 10 Clinical Directors and their Associate General Managers. All the members contributed to LRI's Board discussions and had shared ownership of all decisions. The Board oversaw LRI's corporate plans and performance. It determined LRI's hospital wide policy issues and collectively supported the General Manager for the hospital's overall performance. Barker concluded that,

> *"Delegating real authority to those responsible for clinical/resource management, and matching this with accountability, creates an environment of teamwork based on real involvement, commitment and ownership. There is a strong identification by all involved with the work of the specialty which fosters communications, high morale, pride in achievement, and quality of patient care"*
> (Barker, 1990, p 1429).

Further Development of Clinical Management in the UK

In 1992 a joint steering group was set by the British Association of Medical Managers (BAAM), the British Medical Association (BMA), the Institute of Health Services Management (IHSM), and the Royal College of Nursing (RCN). These organisations collaborated in a year long project examining the development of clinical management within the NHS. The project involved a combination of a literature review, 13 site visits in England, and 37 questionnaires sent to hospitals in England, Scotland, Wales, and Northern Ireland. This group (now known as BAMM et al) was established to conduct joint policy work in relation to clinical management. BAMM et al published a consensus statement in 1993 on the principles for effective clinical management which was defined as,

> *"the explicit identification of the range of financial and other resources available to provide patient care and the assurance that these resources are utilised to greatest effect for the benefit of the individual patient and for groups of patients"*
> (Joint Consensus Statement, BAAM et al, 1993, p 1).

In their joint consensus statement, BAMM et al made two important conclusions in relation to clinical management and related matters in the NHS. These conclusions are discussed below and will be returned to in chapter 9.

- There should be a commitment to decentralised clinical management which moves responsibility and authority for decision making for using clinical resources as close to the patient as possible. This should be developed as the preferred model in the UK and;

- There would not be 'one right structure' for decentralised clinical management. Use should be made of flexible solutions which meet the needs of individual provider organisations and their patients.

Strategy Development

The joint statement made explicit recommendations regarding *strategy* development. The NHST Chief Executive and the Clinical Management Team (CMT)[23] should form the meeting point between the NHST Board and the clinical specialties for the integration of strategy and operations. The BAMM et al study revealed that when clinical management teams. particularly the team leaders, were not fully included in the strategic planning process of their organisations there was a 'disconnection' between the NHST's strategic agenda and that of the clinical specialty resulting in confusion over objectives, or the return of old hierarchies which undermined the entire system of decentralised management. In such cases, BAMM et al found that the development of a meaningful corporate strategy which provided a unifying framework for individual clinical specialty strategic planning became impossible.

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23 . The CMT's consisted of all the hospitals senior managers, Executive Directors if an NHST, and all the hospitals Clinical Directors.

Contracting

For effective contracting, BAMM et al concluded that there should be meaningful involvement of a NHST clinical specialties in determining the overall NHST strategic plan. If done effectively, this process would provide the framework within which all the NHST's clinical specialties could move in the same direction through their individual specialty strategic plans. Every clinical specialty strategic plan should be consistent with their overall NHST strategy.

Time

A critical issue was the amount of time the Clinical Director could actually spend managing their Directorate, and the degree of management skill they could bring to the role of Clinical Director. In their study, BAMM et al found that training was not that well developed and often Clinical Directors did not know what was expected of them with regard to management. In the absence of support from the NHST senior managers, they had little basis on which to plan their own development.

Section 3: Clinical Directorate Models, Typologies, Roles, and Groups

Introduction

By far the commonest clinical management model/structure chosen by acute hospitals, has been based on the Clinical Directorate model. Clinical Directorates aim to involve doctors in management, and give a patient centred approach to management with a business overview (Rea, 1993). In 1990 the British Medical Association's (BMA) Central Consultants and Specialists Committee (CCSC) endorsed the Clinical Directorate as the optimum structure for hospital decentralisation. The BMA also recommended,

> *"Clinical Directorate structures as the most appropriate way of involving clinicians in management, provided that these structures follow the principles identified in the CCSC's guidance. Clinical Directorates must have the support of the hospitals consultant body. There must be extensive consultation with consultants and other medical staff since Directorate structures will bring about important changes in the organisation of consultants work. This could include consultants being managerially accountable to a Clinical Director and the linking of certain specialties within a single Directorate"*
> (BMA, CCSC guidelines, 1990 p2).

Disken et al (1990) have indicated the reasons for moving to a model of clinical management in the NHS:

- A need to decentralise and delegate decision making in the NHS nearer the patient;
- A need to break down the barriers that had developed over the years between professional hierarchies and groups;
- A need to improve the quality of clinical services to patients;
- A need to bring hospital consultants "on board" hospital management as a group;
- To allow a more explicit evaluation of clinical work and outcomes and;
- To address the problems of financial pressure on the NHS.

The standard model of clinical management chosen by hospitals, both pre and post NHS reforms, has been the *Clinical Directorate.* There are a number of key components (Hirst, 1995, White, 1993, Rea, 1995):

- Hospitals are divided into small autonomous units, each of which has a single recognised manager who is a doctor;
- The doctor-manager is called a Clinical Director, who is responsible for an allocated budget, and for achieving activity and quality targets;
- A nurse director and an administrator/business manager reports to the Clinical Director on day to day operational issues;
- Each unit operates within the general policy framework of the hospital;
- They are responsible for meeting contract obligations and;
- Increasingly they are responsible for the direct negotiation of contracts with purchasers.

The final model chosen by an NHST is a reflection of its individual circumstances. This will include what the NHST senior management and hospital clinicians view as the most appropriate method of involving its clinicians in the management process and what the NHST sees as the role of the Clinical Directorate. BAMM et al's (1993) study found that the impetus to adopt a particular model of clinical management tended to come from one person, typically the unit Chief Executive or a senior consultant.

Often the setting up of decentralised management structures within hospitals were seen as a necessary condition for a hospital in applying for Trust status, and to enable contracting to develop within the post 1990 NHS. Indeed the BAMM et al study revealed that around 70% of units surveyed had introduced, or would be introducing, clinical management as part of their NHST application. Clinical management was expected to facilitate approval for Trust status. Financial crisis was also mentioned by BAMM et al as a factor which had led to the

introduction of clinical management as was a crisis of confidence between a hospital's managers and clinicians.

Clinical Directorate Typologies

Peel (1992) has described at least seven variants of the Clinical Directorate model. These varients are shown in figure 13, and are explained in the following paragraphs. These variants are by no means exhaustive, but merely indicate some of the Directorate structures that have developed.

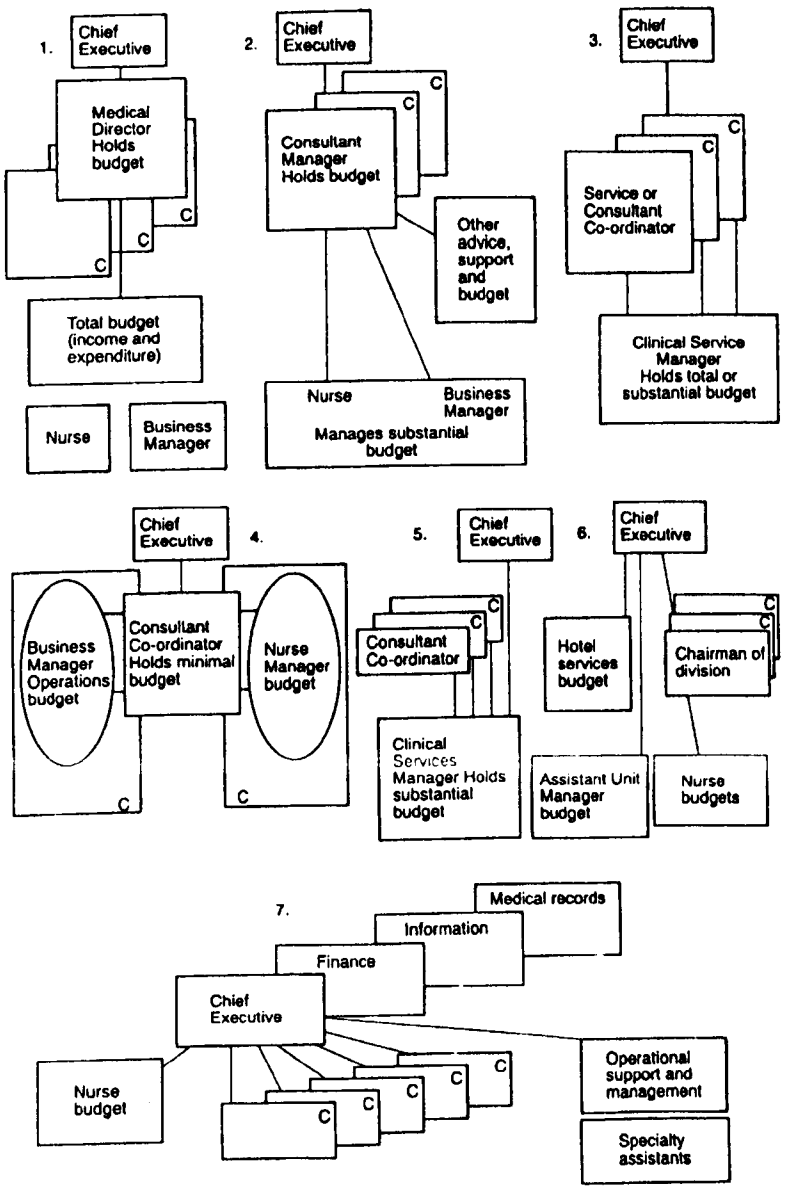
The Seven organisational types of Clinical Directorates

1. *The Medical Director Model*: the Clinical Director, is directly line accountable for the clinical and managerial performance of the Directorate. The Clinical Director has to manage the Directorate from developing its business plan to the delivery of services to patients, with support from the Directorate business and nurse/service manager.

2. *The Consultant Manager Model*: the Clinical Director is "first among equals" with the Directorates other consultants. The Clinical Director reports to the NHST's Chief Executive in a representative capacity, not as a manager of the other consultants within the Directorate. In this respect, this model is similar to the old MEC chair-person role (see earlier). The Clinical Director will be very involved with Directorate management issues, such as developing business plans and negotiating contracts with purchasers, and will use its business and nurse/service managers as an executive arm.

3. *The Consultant Co-ordinator Model*: the main power base with this model rests with the Directorate nurse/service manager, who often has, but not necessarily a clinical background, for example, nursing or paramedical. The Clinical Director with this model has a supervisory role, rather than being the identifiable leader of the Directorate.

Figure 13. Seven Organisational Types of Clinical Directorates (Source: Peel, 1992).



4. *The Clinical Triumvirate Model*: the managerial responsibility is shared by the clinical management team of the directorate, which usually consists of the Clinical Director, the business manager, and nurse/service manager. It was the most common model found by Peel.

5. *The Clinical Service Manager Model*: there is no role for the Clinical Director with this model, the Directorate clinical service manager (CSM) has direct line accountability to the NHST Chief Executive. The CSM has direct responsibility for both clinical and non-clinical budgets.

6. *Divisional Directorate Model*: this particular model is often taken as the first step towards a full Clinical Directorate model. Groups of clinical services are allocated budgets which are then under the control of a medical chair of a Division, who may have administrative support.

7. *Direct Access Directorate Model*: this is similar to pre 1990 NHS reform doctor-manager relationship. Managing day-to-day operational services is replaced with an agreement over the work of individual consultants, for example, case mix and workload. The model can be used to dilute any existing tension, or possible sources of conflict in doctor-management relationships within NHST's. Individual consultants report directly to the NHST Chief Executive.

BAMM et al (1993) indicated that a number of other structural models of clinical management had developed. Prominent was the two or three person 'pendant' team which replaced the traditional 'triumvirate'. These pendant models appeared to develop out of a need for some NHST's to formalise a clearer distinction between the roles of the business manager and nurse manager. The three person pendant structure involved a nurse manager or senior nurse who was responsible to the business manager, who in turn was responsible to the clinical director. The two person pendant structure consisted of a clinical director and a combined business/nurse manager post usually filled by a nurse, but could also be another health care professional.

Service and Support Clinical Directorates

Clinical Directorates can be categorised into two distinct types, *Service Directorates* and *Support Directorates* (Rea, 1993). Service Directorates are Directorates who provide a direct service to purchasers such as surgery or medicine, and are also known as "bed-holding" Directorates because they treat in-patients within the NHST. Support Directorates can provide a direct service to purchasers through external contracts, for example, GPFH's, but on the whole, as their name implies, provide a support function to the service Directorates. Support Directorates include specialties such as pathology, theatres, and Imaging and are also known as "non-bed holding" Directorates as patients do not normally stay in these Directorates for treatment.

The Clinical Directorate Management Team

At the heart of clinical management is the Clinical Management Team (CMT)[24]. These teams lead clinical groups which form,

> *"The engines which do the work of the provider organisation. What this means is a potential revolution in the way patient services are organised and delivered. If CMT's really are the engines of the organisation, it means that the necessary resources have to be devolved to them. It means devolving budgets, responsibility for staff and support functions like finance and information to them"*
> (Harwood, 1993, p 27).

The main thrust of clinical management is via the clinical management team. which have been described as the "engine of the healthcare provider organisation" (Edmonstone and Havergal (1994,p 5). The teams typically consist of a Clinical Director, business manager, and nurse/service manager. There may also be support from the NHST with regard to Directorate accounting, HR matters, and professional matters in relation to nursing/clinical issues through the Director of Nursing and Medical Director.

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24 . This CMT is different from the BAMM discussion of a CMT. The BAMM CMT comprised the senior managers and clinicians of an NHST.

The Clinical Directorate Management Team Roles

The Clinical Director: Clinical Directors are appointed by the NHST's Chief Executive on recommendation by the remainder of the Directorates consultants. The period of appointment is usually for 3-4 years and can be renewed if so desired by both parties. Clinical Directors are medically qualified, and should act as the strategic team leader for the Directorate. The role requires a doctor with visionary and dynamic qualities who can lead the other Directorate staff.

Servers (1993) has said that,

> *"The fundamental role of the Clinical Director is to direct the strategy of the clinical service for which the Directorate is responsible"* (Servers, 1993, p 88).

The Clinical Director is in essence a part-time manager, as s/he is still a practising clinician, what Willcocks (1994) has termed the general manager of the Directorate. Clinical Directors are normally paid for one, two sessions at the most, as Clinical Director. A session is equivalent to four hours. The role has two other aspects to it, one of managing the interface between the Directorate and patient, and one of influencing other consultants within the Directorate (Sims, 1994). Mole and Dawson (1993) also argue that Clinical Directors will need skills in financial management, Human Resource management and strategic planning to be able to carry out the role effectively. This will involve consultation and negotiation which could be in a direct contrast to the experience of many Clinical Directors who in the past operated within a largely hierarchical approach to management and decision making.

Recent research carried out in Scotland specifically examined the roles and responsibilities of Clinical Directors (Marnoch et al, 1996). A number of relevant findings emerged which will be returned to in chapter 9. These included:

- Very few Clinical Directors were involved at a strategic level within their NHST's;

- Clinical Directors were of the opinion that they had considerable influence over NHST managers at al levels;
- Clinical Directors, generally, were not involved with contract negotiation and did not have a high opinion of the negotiation process and;
- The Clinical Director management role was tightly squeezed into a heavy clinical load, and took up to two thirds of their management time. However, the Clinical Directors emphasised the need for maintaining clinical contact.

The Business Manager (BM): Often a career NHS manager, s/he has to implement the strategy devised by the Clinical Director for the Directorate. Over the years since Guy's first set up Clinical Directorates, the role of the business manager has developed from a largely analytical support function into a clinical general management role, including responsibility for Directorate contracting, finance, and marketing (BAMM et al, 1993). Clinical Directors require strong support from BM's, and BM appointments can be shared between two or more Clinical Directorates. However, in this case there is the danger that the BM's spread their support too thinly.

The Nurse/Service Manager: Is a clinical manager, nurse or other professional who gives a clinical perspective to the operational side of management. S/he can also be involved with the planning, co-ordination, and implementation of a service which is centred on the Directorate's patients (Hopkins, 1993). The nurse manager provides the professional and managerial leadership within the Directorate. S/he will advise the Clinical Director on the best use of nursing or paramedical staff to provide an efficient and cost effective service, while ensuring that high standards of patient care are provided.

Clinical Directorates and NHST's

There are a number of ways that the Clinical Directorates can influence the work of their NHST's. This can be achieved via a number of distinct groups or through particular

individuals. These groups can have a number of titles depending on the particular organisation. However, typically they are called the Trust Management Group (TMG), Corporate Management Team (CMT), or Trust Operational Management (TOM) Group. These groups will be returned to in chapters 8 and 9 and have the responsibility of determining the NHST strategic decision making. All Directorates are represented on these groups by their respective Clinical Directors, and therefore can have an impact on NHST wide policy/strategic issues through this medium. The Executive Directors of NHST's are all members of both the NHST Board, and together with the Clinical Directors, form the TMG's/CMT's/TOM's. Executive Directors will bring their own particular technical experience to both fora, for example, finance, nursing, and personnel, while the Clinical Directors bring their own technical experience in the shape of which ever specialty they are involved with. The TMG/CMT/TOM can provide the Directorates with opportunities, through their Clinical Directors, to influence their NHST policy and strategy direction, while bringing to the attention of the TMG's/CMT's/TOM's opportunities or threats to the organisation as a whole.

Clinical Directorate Groupings

Clinical Directorates cover a self contained number of clinical specialties, and the size and number of these Directorates will vary depending on the size of the NHST. There could be as few as six Clinical Directorates in a small District General Hospital (DGH), and as many as 16 in a large City teaching hospital. Each Directorate can also contain as few as three consultants and as many as fifteen. Tables I4 - 15 indicate some possible specialty groupings. Too few Directorates would not justify the management time and effort, and too many Directorates could end up being unwieldy as specialties could differentiate into sub-specialties with different clinical activities and management difficulties associated with them (Capewell, 1992).

Table 13. Possible Clinical Directorate Speciality Groupings. The Leicester Model (Source: Capewell, 1992).

Surgery and Specialties	Pharmacy and therapy services
ENT and Ophthamology	Commercial Services
Medicine and Specialties	General Services
ITU and CCU	
A/E and Orthopaedics	Nursing
Paediatric Medicine and Surgery	Estates
Obstetrics and Gynaecology and Community Midwifery	Finance
Anaesthesia and Theatres	Information
Clinical Laboratories	Personnel
Radiology and Medical Physics	

Table 14. Possible Clinical Directorate Speciality Groupings. IHSM Model (Source: Capewell, 1992).

Medicine
Surgery
Obstetrics and Gynaecology
Paediatrics (possibly including Obstetrics and Gynaecology
Orthopaedics and Trauma
Anaesthesia (possibly including ITU and Theatres

Table 15. Possible Clinical Directorate Speciality Groupings in Larger Hospitals (Source: Capewell, 1992).

General Medicine	Oral Surgery
Renal Medicine	Urology
Geriatrics	Neuro-surgery
Infectious Diseases	Cardiac Surgery
Cardiology	Orthopaedics
Neurology	Paediatrics
Dermatology	A/E
Obstetrics	Anaesthetics
Gynaecology	ITU
General Surgery	Theatres
ENT	

Section 4: A Critique of Clinical Directorates

A number of problems associated with Clinical Directorates have been identified in the literature. Packwood et al (1990) have indicated that the move towards decentralisation and sub-unit organisation have not been without criticism. This had been generally associated with the problems of grafting managerial authority and responsibility onto clinicians whose working practices have been based upon clinical freedom. Packwood et al concluded that the responsibility of sub-units tended to be clearer from the outside than from within them. The main danger was that the sub-units developed a strong identity and become too parochial thus failing to take a wider corporate view and concentrate on their own interests.

Johnson (1990) argues that considerable pressure was put on all consultants to imitate the Guys model of Clinical Directorates. In many cases the imitations were a poor copy of the Guys model. Boards of Directors evolved into what he called 'lead clinicians' who were then responsible to management for carrying out Health Authority policy. This was a far cry from the original Guys version of a group of clinicians accepting corporate responsibility for the running of the hospital. Lay managers saw the Clinical Directorate system as a means to gain control over consultant decision making, and this is not what the Guys model espoused.

Fitzgerald (1991a) found it surprising that Clinical Directorates had been so readily accepted into the UK NHS, since there was no empirical evidence of their effectiveness or efficacy. She concluded that it was perhaps the publicity received by Guy's Hospital, which itself was based on the JH model, which provided the assumption that Clinical Directorates was the most suitable for the NHS. Fitzgerald (1991b), has also questioned whether the Clinical Directorate is the preferred clinical management model for organising services in acute hospitals.

> *"Current specialty boundaries may reflect history, but may be less appropriate to the needs of the future. Emergent services, such as day hospitals, could be said to constitute a significant approach to care and therefore need to be managed separately"*
> (Fitzgerald, 1991b, p 26).

More recent research by Fitzgerald (1997) compared clinical management models in acute hospitals in both the UK and Canada. In the UK the Clinical Directorate structure was based upon a hierarchical structure with the Clinical Director at its apex. She confirmed the part-time management basis of Clinical Directors, and a triad or triumvirate structure of a Service/Nurse Manager and Business Manager who reported to the Clinical Director. Clinical management in Canada on the other hand operated using a different model. Here a diad structure existed of the Clinical Director and Associate Manager managing the specialty and sharing power. The major difference between the Canadian model and the UK model of clinical management was that Clinical Directors in Canada allocated a larger proportion of their time to their management role, and in places was as much as 50% of their time. Another major difference is that the Canadian healthcare system is funded on a fee-for-service basis. Clinical Directors in Canada were often paid by the other specialty consultants for their management time, so may be more motivated to be managers than their UK counterparts. Fitzgerald concluded that this raised a number of key questions for UK Clinical Directors. What is the appropriate allocation of hours that should be given to management?, and should there be full-time Clinical Directors?.

A number of authors have also commented on the lack of involvement by Clinical Directorates in the strategy process within their NHST's. Chaston's (1994) research focused upon the involvement of Directorates in areas such as objective setting, policy, decision making, and resource allocation within a number of NHST's. He concluded, that although the performance of NHST's was critically dependent upon the degree to which NHST management allows authority over the nature and content of the strategy process, there was still a tendency by NHST senior managers to retain absolute control over key strategic objectives, financial budgets, and service portfolios. Corbridge (1995) has commented that in order to operate effectively, an NHST needs to manage successfully the strategic and operational aspects of its delivery systems. However, in many cases some NHST Chief Executives were failing to let go of some of their strategic planning to newly empowered Clinical Directors, and involving

themselves in the day to day operational management and were not concentrating on NHST strategic matters.

Conclusions

This chapter has examined the development of clinical management, predominately discharged through the Clinical Directorate system. The origins and history of Clinical Directorates in the UK NHS has been discussed, together with empirical evidence indicating this model be developed as the sole medium for clinical management within the NHS. The various models, typologies, groupings, and management arrangements have also been discussed, together with a short critique of Clinical Directorates.

Chapter 5 now concludes the literature review chapters. Chapter 6 will form the link between the literature review and the empirical chapters and discusses the research methodology used to collect the data for the thesis. Meanwhile we note a number of points:

- Clinical Directorates are groupings of medical specialties arranged for management purposes. They have their own management teams consisting of a Clinical Director, Business Manager, and Nurse/PAM manager;
- The Clinical Directorate model adopted in the UK was based upon the Johns Hopkins model of hospital decentralised management;
- Guys' hospital in London was the first NHS hospital to adopt the Clinical Directorate as a decentralised management structure;
- The RMI accelerated the development of decentralised management structures within NHS hospitals and began to involve health care professionals in strategic as well as operational issues;
- There are a variety of Clinical Directorate models in operation, the choice of model is dependent upon the individual circumstances of NHST's and;
- Clinical Directorate management teams should be involved with the management agendas of their NHST's such as strategy and contract negotiations with purchasers.

Chapter 6: Research Methodology

Introduction

This short chapter will link chapter 1- 5 of the thesis to the empirical chapters, 7- 9, chapter 10, the discussion of the research findings, and chapter 11, the thesis conclusions. It will also define the main research questions and the research methodology that was used to attempt to answer these questions.

Overview

The thesis examined the extent to which NHS managers were beginning to act strategically in the period 1994-1997 within the NHS quasi-market in the West of Scotland. Chapter 1 gave an account of NHS organisation and management culminating in the 1990 reforms of the NHS which attempted to create a quasi-market within the NHS by setting up purchaser/provider relationships and creating NHST's and GPFH's. This quasi-market was intended to put competitive pressure on healthcare providers and hence improve efficiency. Chapter 2 indicated that although the 1990 NHS Act applied to the whole of the UK, the NHS in Scotland was organised differently to the rest of the UK. It described the structure of the NHS in Scotland, and the relationships between the Scottish ME, the AHB's, GPFH's, and NHST's. This is significant because the empirical research which follows this chapter was carried out in the West of Scotland. Chapter 3 discussed markets and competition, and related this to the NHS and the nature of the particular market that was finally introduced into the NHS. The chapter concluded with three cases studies which examined the development of the internal or quasi-market in these areas. From these case studies conclusions were drawn against which findings from the study in the West of Scotland will be placed concerning the development of a quasi-market in health care in Scotland. This will be discussed in chapter seven.

Chapter four introduced the concept of strategy in management and the development of business and corporate strategy from its early planning days to its evolution into strategic management. Strategic development was then discussed as were the stages in the strategy process that firm's could undertake. These ranged from analysing and developing strategic plans, considering and choosing strategic options, to implementing strategic options. A comparison was made of two complementary models of strategic analysis, the positioning approach (which examined a firm's external environment), and the resource based approach (which examined a firm's internal environment). The chapter also examined strategic options that could be pursued by a firm, the importance of culture to strategy development, and methods by which a firm's senior managers could allow their operating divisions to develop. These models will be used in the chapters eight and nine as a means to analyse the process of strategy formation, development and implementation that occurred within NHST's in the West of Scotland.

Chapter five examined the origins and development of Clinical Directorates within the UK NHS. These, in relation to the NHST's, can be regarded as the operating divisions or strategic business units of a larger organisation. The Clinical Directorates provide the services of the NHST's and consist of clinical specialties which offer particular services upon which NHST's can build their strategies upon. The Clinical Directorates were described in chapter five as being in an ideal position to make a significant contribution to the strategic development of their NHST's. This will be explored further in chapter nine.

Thesis Methodology

The aims of the research were to use some of the theories and tools of strategic management that have been developed in relation to the private sector, to investigate the extent to which NHS managers, clinical and non-clinical, were responding strategically within the NHS quasi-market and not just seeking efficiency improvements. Of particular interest was the extent of strategic behaviour at different levels within particular NHST's. This could be seen at the level of the NHST senior management, and at the level of the clinical specialties arranged as Clinical Directorates within the NHST's.

Special Considerations

NHS organisation in Scotland differs from that in England and Wales, the former being much smaller and more compact. Whereas Scotland has 15 AHB's, England and Wales had, at the time of the research over 130 District Health Authorities (Ham, 1997). The present research was carried out in the West of Scotland, which it was thought would provide a microcosm of the Scottish structure. The West of Scotland also has the largest grouping of NHST's in Scotland as a whole, ranging from major City acute NHST's, to small DGH's, Community, and specialist NHST's. It should enable a clearer picture to be obtained of the development of strategy within the NHST's and the nature of competition within the NHS in the West of Scotland. In the final analysis this should enable some broad conclusions to be drawn with respect to differences between England and Scotland.

Theoretical Approaches

The NHST's may be viewed as operating in a context of managed competition (see chapter three) which will influence the strategic responses and initiatives of the NHST's. How they respond to this is likely to be affected by their perception of the intensity and sources of competitive pressure, as well as their relationships to the AHB's as purchasers.

Empirical Issues

Two principal issues relate to the location of strategic decision taking within the NHST's, and the shape and context of strategic decisions in differing competitive environments. Strategic plans and their implementation may be decided by the NHST senior managers and the clinical specialties arranged as Clinical Directorates, but also may well be decided by the NHST senior managers alone, akin to that of a multidivisional organisation structure with a central board and a number of business units. Different levels of competitive structures may lead to differences in strategic thinking, for example, in the degree of innovation and the formation of alliances. It therefore was an important part of the research to map out the ways strategic thinking evolved as well as where the decision nexus lay and what informed it.

The Main Research Questions

A number of research questions emerged from the literature review chapters. These were as follows.

- What was the nature of the market and level of competition developing in the West of Scotland NHS between 1994-1997?;
- What evidence was there of strategic behaviour developing within NHST organisations?;
- What was the nature of the strategic management process developing within the NHST's?;
- Where was the locus of strategic decision making located within the NHST's?;
- What was the involvement of the Clinical Directorates in the strategic decision making process within the NHST's? and;
- What was the nature of the relationships between NHST senior managers and the Clinical Directorates within the NHST's?.

There was relatively little known concerning the main research issues, particularly the interactions of the NHST's, their Clinical Directorates, the AHB's, and indeed the Scottish Office as the agent of Government in Scotland. Therefore, a qualitative research methodology consisting of five case studies using interviews was undertaken. This approach was used rather than a quantitative research methodology for a number of reasons. Given the nature of the research objectives, there was a paramount need to understand how the NHST's at senior management level, and at Clinical Directorate level, were approaching the challenge of strategic development. This, almost of necessity, required a 'close' involvement with management thinking. The approach then developed into using NHST's as case studies (see later). The nature of the problems, strategic development and the relationships between the actors involved, would not have been understood by more objective distant approaches associated with quantitative research methodologies where the emphasis is on collecting data using designed instruments such as questionnaires and classifying responses into categories and forming knowledge from responses (Hari Das, 1983).

Interviews were undertaken, both structured and semi-structured, with key personnel involved in the determination of strategy and decision making within the sample NHST's. Some of the interviews were structured, particularly where access was granted to certain people, who due to pressures of work were only prepared to allocate a fixed time period to the researcher. In these cases, a structured list of questions was asked with little or no time to investigate or probe answers. Semi-structured interviews were carried out in the majority of cases and gave the opportunity for time to be spent on issues brought up during the course of the interviews, while keeping to an agenda of answering the main research questions. Interviews were carried out with NHST Chief Executives, Directors of Contracts and Planning, Clinical Directors, Business Managers, and Service/Nurse Managers . A first round of interviews was conducted between the spring of 1995 and the spring of 1996.

The interviews were repeated 8 - 12 months later to ascertain if there had been any changes or developments since the first round interviews. These second round interviews were either carried out face to face or via the telephone. From the first round interviews three main areas were seen to be developing as important issues in relation to strategic development within the NHST's. The second round interviews focused on these three main areas. These areas were:

- The nature of the market and the level of competition;
- Strategic behaviour in response to the market and level of competition and;
- The relationships between the NHST senior management and their Clinical Directorates.

Interviews were also carried out at AHB level and were concerned with their development as purchasers within the quasi-market, and whether they had used their power as purchasers to develop a market or force changes in the way the NHST's delivered their clinical services. Interviews at the Scottish Office were carried out to inform our understanding of the overlying political environment in which both the NHST's and the AHB's were operating. Tables 12 - 15 at the end of the chapter provide a breakdown of the interviewees from both the first and second round interviews.

The unit of analysis for the empirical work was the NHST. As indicated earlier, five NHST's, as providers, were selected as case studies. The NHST's were all based in the West of Scotland, four within a major City, and the fifth located outside the City. They were chosen because of their location, size, and range of clinical specialisms. All the NHST's were from the acute care sector.

In this thesis the NHST's were named A - E, and the AHB's West AHB and East AHB to protect confidentiality. The NHST's were as follows:

NHST A: a major City acute University teaching hospital achieving NHST status in 1994. It provided local, Regional and Tertiary service operated from four sites in the East of the City. In 1995/96 the NHST had a total budget of £115M. Of this 56% of services were bought by West AHB, 26% of services by other Scottish AHB's and English DHA's, and 18% by other sources including NHST's, GPFH's, the NHS ME, and non NHS work;

NHST B: a major acute hospital achieving NHST status in 1993 and was located in the South of the City. It included a Regional specialty in Neurosciences and other specialisms such as a physically disabled rehabilitation unit, a spinal injuries unit, and podiatry and limb prosthetics. In 1996 its total income was approximately £72M. Of this Scottish AHB's accounted for 80%, the Scottish ME 17%, GPFH's 2%, and other sources 1%;

NHST C: a major City acute University teaching hospital with Regional and Tertiary patient referrals located in the West of the City. In 1995/96, the total income of the NHST was approximately £92M. Of this income, Scottish AHB's accounted for 89.5%, GPFH's 1.3%, other Scottish NHST's 2.5%, and the Scottish ME 6.7%;

NHST D: a major specialist Paediatric and Maternity hospital gaining NHST status in 1993 and located in the West of the City. It comprised a hospital for children and a maternity hospital, and provides community child health services including Regional and Tertiary referrals. Total income for 1995/96 was approximately £46M, of which 92% came from Scottish AHB's and English DHA's, 4% from the Scottish ME, 1% from GPFH's, 1% from other Scottish NHST's, and 2% from other sources including oversees referrals;

NHST E: achieved NHST status in 1993 and was one of Scotland's largest District General Hospitals (DGH's) located outside the City to its South-West. It provided services on one site including medical, surgical, obstetrics and gynaecology, and some specialist services such as ophthamology and urology. Its total budget allocation was £50.6M for 1995/96. Around 90% of its income came from East AHB, other Scottish AHB's formed 6%, and other sources 4%.

East AHB: located in the West of Scotland, its catchment area ranged from major conurbations, to the very rural, and included some 26 island communities. It had a total population of 433,000 in 1994. Its block allocation for 1995/96 from the Scottish Office was £245M. Of this 33% was spent on acute care, 33% on community care, 23% on maternity care, 4% on child care services, and the remaining 7% in other areas. The Board was losing resources under the SHARE funding formula.

West AHB: located in the West of Scotland, and providing health services for the entire population, and some surrounding areas, of a major City. Its total income for 1994/95 from the Scottish Office was approximately £777M, of which 69% was spent on hospital and community health services. West AHB was the largest health authority in the UK until some of the English DHA's began to merge in 1994/95. It supported 8 NHST's including acute, community, priority, and dental. Four of these NHST's were used as case studies. The Board as with East AHB, was losing resources under the SHARE funding formula.

The Case Study Approach

A case study approach was used in this research, which can be described as an in-depth analysis of a single case that is representative *in some way* of a research topic (Strauss and Corbin, 1990, Mason, 1996). Methods used in case-studies have ranged from highly experimental, quantitative studies to highly qualitative descriptive studies. Yin (1984) has argued that case studies have the advantage when 'how' or 'why' questions are being asked concerning a contemporary set of events which the researcher has very little or no control over.

> *"The case study allows an investigation to retain the holistic and meaningful characteristics of real-life events, such as individual life cycles, questionnaires and management processes"*
> (Yin, 1984, p 14).

Further, Yin has postulated that case studies have a distinctive place in social science research and have a number of applications which include:

- Explaining the causal links in real-life events that are too complex for questionnaires, surveys, or experiments to explain;
- Describing the real-life context in which organisations, and the people within them, operate and;
- Exploring situations where events have no clear or single set of outcomes (Op Cit.).

Hakim (1987) has placed case study types on a broad continuum between descriptive reports and rigorous hypothesis testing.

> "Case studies are a useful design for research on organisations and institutions in both the private and public sectors, and encompass studies of firms, workplaces, schools, trade unions, bureaucracies, studies of 'best practice', policy implementation and evaluation, industrial relations, management and organisation issues, organisational cultures, processes of change and adaptation, extending to comparative studies of nations, governments and multinationals"
> (Hakim 1987, p 25).

Craig-Smith (1991) has noted that providing the *context* of a case-study is incorporated, the analysis can be considered valid. Thus the case-study can provide the basis for an in-depth analysis providing that conclusions are restricted to the context in which the case study has been selected. The case study approach therefore has been increasingly seen as the appropriate strategy to adopt when conducting research within an organisational setting.

The Format of the Research

The data *types* used in the research fell into four general periods and could be placed into the following categories: historical data, secondary data, primary data and 'ad-hoc' data. Historical data, in the form of documented histories, written reports and published accounts were used as the means by which background information about the organisations could be gained. This

historical data was supplemented by data obtained in the second period in the form of secondary data. The bulk of the data for this study fell into the third, primary, research period (see figure 14). The final period of data collection was 'ad-hoc' data. This took the form of regular updates of events through continued contact with key people after the primary-data research period was completed, allowing further analysis of any temporal consequences of observed events in the primary-data period. Background information also needed to be gained about the *wider environment* in which the case-studies existed. The nature of the NHS quasi-market and wider political environment that the NHST's operated in were therefore examined (see chapters 1 - 3), as were their individual histories. These are defined in more detail in chapters 7-9. Figure 14 illustrates the above process, and figure 15 provides the time period in which the research was conducted. Chapters 7 - 9 will now provide the empirical data.

Figure 14. Theory, Concepts, and Data in the Research Process.

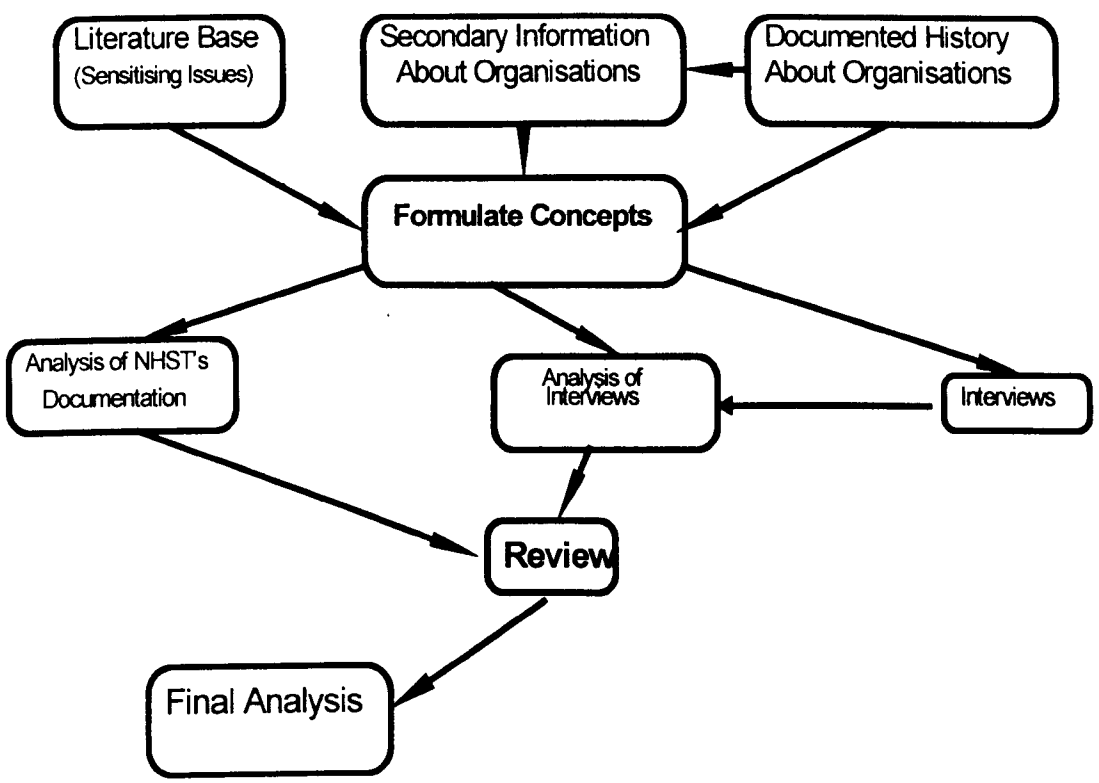


Figure 15. Break down of the Research Periods.

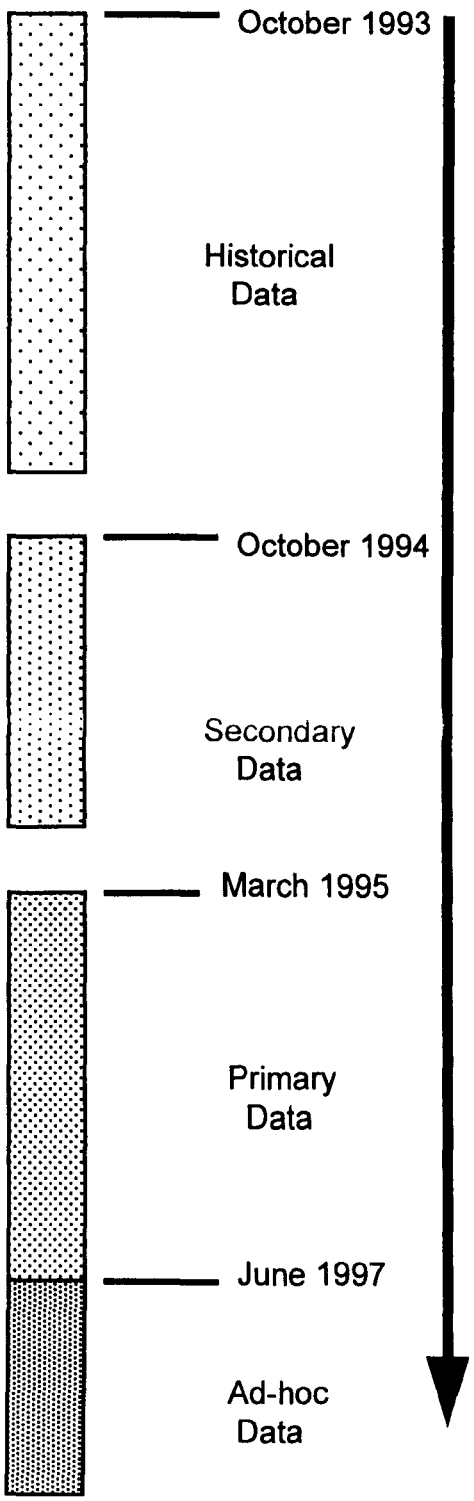


Table 16. First Round Interviews (numbers interviewed in brackets if more than one).

	NHST				
Person Interviewed	NHST A	NHST B	NHST C	NHST D	NHST E
Chief Executive	✓	✓	✓	✓	✓
Director of Contracts and Planning		✓		✓	
Medical Director			✓		✓
Clinical Directors	✓ (2)	✓ (2)	✓ (3)	✓ (2)	✓ (3)
Business Manager	✓ (3)	✓ (2)	✓ (3)	✓ (2)	
Business Support Manager					✓
Service Managers					✓ (4)

Table 17. First Round Interviews (numbers interviewed in brackets if more than one).

	Organisation		
Person Interviewed	Scottish Office	West Area Health Board	East Area Health Board
General Manager		✓	
Director of Contracts and Planning		✓	✓
Director of Strategic Development			✓
Director of Commissioning			✓
Speciality Commissioners		✓(Gynaecology)	
Health Economists		✓ (2)	
Director of NHST's Scottish Office (SO)	✓		

Table 18. Second Round Interviews (numbers interviewed in brackets if more than one).

	NHST				
Person Interviewed	**NHST A**	**NHST B**	**NHST C**	**NHST D**	**NHST E**
Chief Executive	✓	✓		✓	✓
Medical Director					✓
Clinical Directors			✓ (2)	✓ (2)	✓ (2)
Business Managers	✓ (2)	✓ (2)	✓ (2)	✓(2)	

Table 19. Second Round Interviews (numbers interviewed in brackets if more than one).

	Organisation		
Person Interviewed	**Scottish Office**	**West Area Health Board**	**East Area Health Board**
General Manager		✓	
Director of Contracts and Planning		✓	
Director of Strategic Development			✓

Chapter 7: The Development of the NHS 'Quasi' Market in the West of Scotland

Introduction

The NHS quasi-market was introduced in the hope that competition between purchasers and providers would increase efficiency, quality, offer better choice, and lower costs. To return briefly to the conceptualisation of the 'new' NHS quasi-market, there was a purchaser/provider split, resources were allocated to purchasers in the shape of Area Health Boards (AHB's), and General Practitioner FundHolders (GPFH's), and hospitals became providers of healthcare services as NHST's.

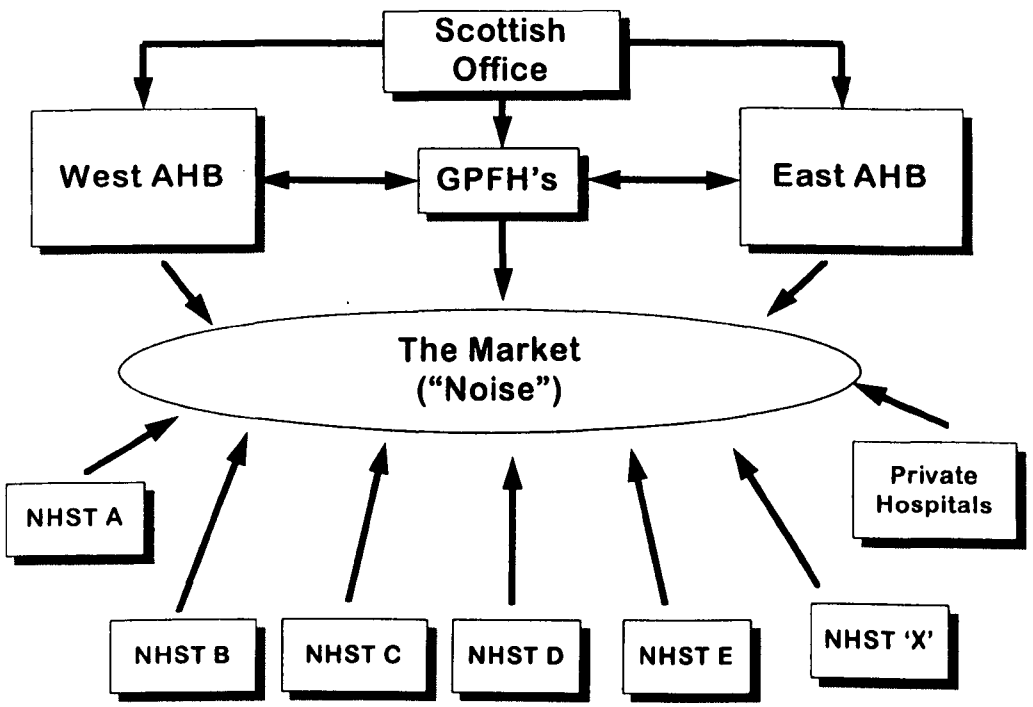
Chapter three examined the logic surrounding the development of an NHS internal or 'quasi' market. It considered the main approaches used to analyse this market. These were orthodox neo-classical economic theory, the new institutional or transaction cost framework, and the social embeddedness approach. Chapter three also concluded with a discussion of empirical studies of the NHS market carried out in England.

This chapter will describe and analyse the development of the NHS quasi-market in the West of Scotland. It will focus on the relationship of the market to the framework discussed in chapter three, and it will add to the empirical literature developed elsewhere. The chapter will be in three sections. Section 1 will discuss the views of the Scottish Office Management Executive in relation to the development of an internal market in Scotland. Section 2 will examine the empirical evidence relating to the two AHB's as purchasers in the West of Scotland. Section 3 will examine the empirical evidence in relation to the five NHST's as providers in the West of Scotland. Competitive strategic development can be dependent on the level of competition occurring between organisations within particular markets. This chapter as a result will inform the types of strategic behaviour that may develop in the case

study NHST's as a result of market development and the level of competition in the West of Scotland.

The West of Scotland provides perhaps the best image of competition and possible market for healthcare in the Scottish NHS as a whole. There are four AHB's in the area, an increasing number of GPFH's, a small but never the less vibrant private healthcare sector, and a significantly large number of NHST's[25]. Finally the Scottish Office purchases tertiary services such as oncology and organ transplantation. The actors within the NHS in the West of Scotland consisted of: the Scottish Office Management Executive (ME); the AHB's; the GPFH's: the NHST's; and the Private Sector. These actors are illustrated in figure 16, and will now be discussed in turn. The researcher has used the term 'noise' to refer to the inter-relationships between the actors within the market which will become apparent during the chapter.

Figure 16. The NHS 'quasi' market in the West of Scotland.



25. There are in the region of 14-15 NHST's, the largest number in any one area in Scotland.

Section 1: The Scottish Office

Introduction

The view of the Director of Purchasing at the Scottish Office was that there was not a single market as such within the Scottish NHS. The geography of Scotland would render this concept meaningless. There might not be the opportunity for competition in certain areas of the Country, (e.g.) the North of Scotland and the Islands. There was in reality, a 'series of situations' or a series of markets. There was a healthcare care system with some competition. The NHS was a public service, with competition occurring over certain issues, but not full blown competition as with commercial markets. There was also the perception by the Director of Purchasing that the market was not yet mature, as it only was in the last 3-4 years that full purchaser/provider separation had occurred. The structural elements of the market were in place, but it would take time for both purchasers and providers to develop their new roles.

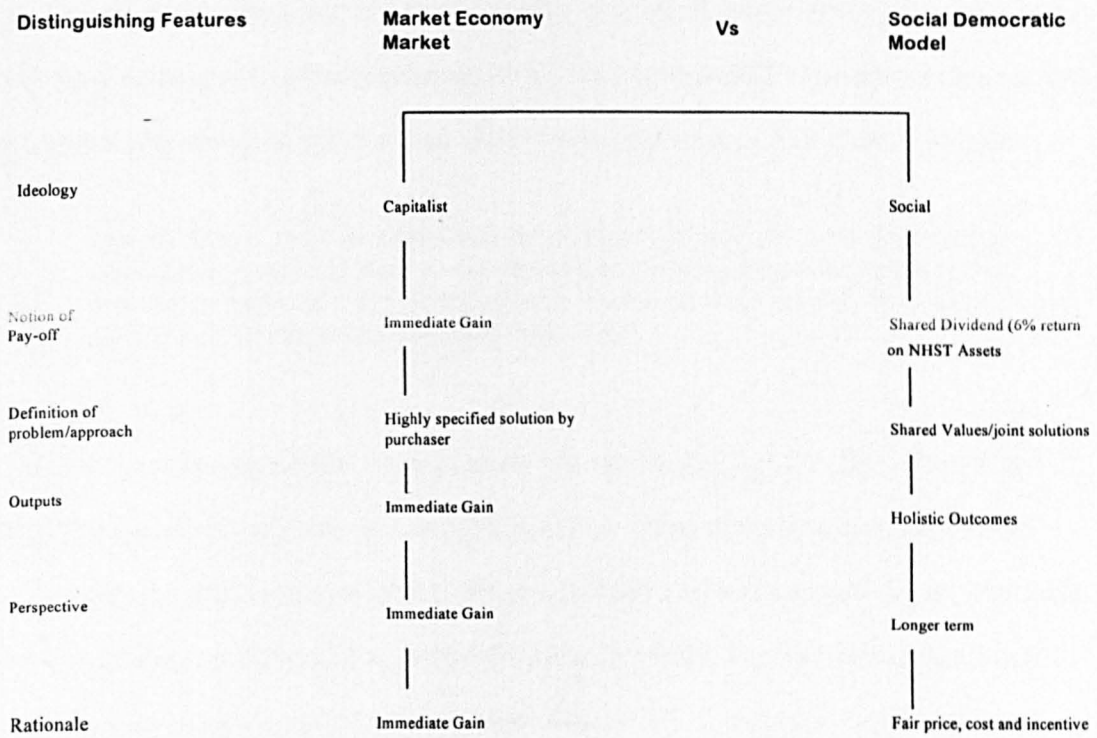
The Director of Purchasing then talked about the use of specific 'levers' which could be operated in the market. One such lever was the mere threat of competition, contestability. He held the view that the Scottish AHB's did not want direct competition between their providers, but rather the mere threat of competition as a method of seeking service improvements. This mirrored Enthoven's (1985) conceptualisation of the development of competition within the NHS. The most important factor was the relationship between the centre and the periphery which would determine the nature of any competition and market that eventually developed.

> *"There is a limit to the nature of markets, and where they exist they are established through custom and practice which are politically feasible, remembering that the NHS is a political system as well as a healthcare system"*
> (Director of Purchasing, Scottish Office NHS Management Executive).

The Director of Trusts at the Scottish Office discussed what he called an unfettered market and an Social Democratic market. The NHS internal market should be developed along the Social Democratic market model, rather than based on an economic market model. The two market models are shown in figure 17 with an additional column to aid explanation.

> *"We are all here for the patients. It should not be about short term 'rip-offs'. This might be all right for small chunks of business, and there should not be market regulation per-se, but contractual procedures via strategic contracting"*
> (Director of Trusts Scottish Office Management Executive).

Figure 17. Purchasing Mechanisms for the Internal Market in Scotland (Source: Director of Trust's, SODoH, 1996).



There were a number of distinguishing features of both types of markets, according to the Director of Trusts. There are, for example, different ideologies involved. A market model is more capitalist, whereas the social democratic model is based upon the social basis of society.

The pay-off in a market model is for immediate gain, whereas in the social democratic model, the pay-off is based on a shared dividend (the 6% return on all assets, see chapter 2, that NHST's had to make each year to the ME which is then put back into the NHS). The market economy is also often associated with the short term, whereas a healthcare market should be based upon the long term and on outcomes of care, rather than individualised items of service.

Section 2: The Purchasers

East AHB

Introduction

East AHB had been financially squeezed by SHARE, and as a result had less resources to buy healthcare services. East AHB supported 7 NHST's, including community and acute, spread over a wide geographical area. According to the Director of Strategic Development at East AHB, some NHST's were accepting that the resources available from the AHB were all that they would be getting with some development money. However, some considered that they were working with no financial constraints. None of the NHST's had been accepting that the market was changing and that they would have to cut back on their costs. However,

> "[NHST E] *is coming to realise that the money they have got is the money they have got and they will have to live with this and start looking at services, rather than at the opposite end of it saying here are the services where's the money?"*
> (Director of Strategic Development, East AHB).

The Director of Strategic Planning used as an example, NHST C in the City. There was a £500,000 gap on a continuing contract with NHST C. Some of this was due to in year pressures, new drugs and treatments. The issue became how to resolve this gap. Although there had been negotiations between the AHB and the NHST, the AHB had wanted the NHST to try to make efficiency savings, but the view of the NHST was that the AHB should stop buying services.

> *"I had offers on the table February/March to all the Trusts which were based on the previous for that years position plus adjustments, and although they were gaps they were small. By the last week in March I had taken them all off the table. On that basis they* [the NHST's] *then turn and say what are you going to stop buying. We take the line of OK, that's the money you tell us what are the best services that you can take cash out of with the least effect on the population. By and large they* [the NHST's] *then come back and say you are the buyer you tell us!"*
> (Director of Strategic Development, East AHB).

The Director of Strategic Development felt that many NHST's had not "wakened up properly to what a Trust is all about". For the Director of Strategic Development,

> *"A Trust has got to market its services to GP's basically. That's where patients come from, that's where the money comes from ultimately, and yes they've got to push new services. Different parts of different Trusts have been quite successful in how they've marketed. They've gone out and spoken to GP's, they've won business, they've impressed. There's still some of them who have just got their head in the sand, we'll do what we want to and sod the GP's!.*
> (Director of Strategic Development, East AHB).

The Board had tried to use its power as a purchaser, and by and large NHST's had ignored the 'signals'. As an example of a 'signal', East AHB threatened to 'dock' financially NHST C for breaches of waiting time guarantees and other contractual issues. The figure quoted was £8000. However, East AHB never actually took the money from the NHST because it wanted the money as a *bargaining tool*. For example, there was the case of a patient who needed to travel with a piece of ventilation equipment which was old and needed replaced. The NHST asked if the Board would pay for a replacement ventilator. The Board said no, but if the NHST found the machine, the Board would forget about the breaches of contract. So the patient went away satisfied, the NHST lost no money, and neither did the Board. So there was a tendency to *trade* between East AHB and the NHST's it bought services from. This indicated that a relationship was beginning to develop between East AHB and NHST C which was not solely mediated by contracts. This supported Granovetter's (1985, 1992) claim that economic transactions have to be viewed as occurring through the medium of social relationships which are embedded between organisations. With regard to Sako's (1992) obligational contractual relationships discussed in chapter 3, there was a 'crisis' of a sort, and rather than resorting to the use of the contract, favours were carried out by both parties, the AHB, and the NHST.

Market Testing

East AHB was one of the first AHB's in Scotland to tender a major clinical service, in this case the orthopaedic service for North of the river Clyde. At the time of the research this service was being provided by NHST C based on historical lines. When East AHB was formed in 1974, it did not have the necessary infrastructure to provide orthopaedic services, and patients were sent to hospitals in the City, one of which was NHST C. The Orthopaedic services for the area were provided on a very minimal basis by general surgeons at Lomond Healthcare[26] (LHC) NHST. However, for the major Orthopaedic procedures, patients would need to be transferred to other hospitals, for example NHST C in the city. The service that NHST C provided was fragmented. Its provision depended on the availability of trained staff, and some elements of the service were provided at both at LHC and at NHST C. Both East AHB and its GP's were unhappy with the service. When NHST C lost one of its consultants, the service to the North of the river virtually stopped. In consultation with the local GP's the Board decided to put the service out to tender in a market testing exercise. LHC would still provide a local service for some procedures, but the Board also wanted an out-patient presence at LHC for more specialist orthopaedic cases. Tenders were received from NHST C, NHST B, and NHST E. NHST E was awarded the contract. This represented an example of a purchaser market testing a service which was in the spirit of *Working for Patients* with NHST's competing with each other. However, the NHST's who were unsuccessful were extremely unhappy and suspicious that the awarding of the contract to NHST E was a political move designed to keep the service within East AHB and provided by one of the AHB's own NHST's.

The tendering exercise for orthopaedics was not straightforward though. The Board, although it awarded the contract to NHST E pump-primed the initiative by around £8M of its own money

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26 . Lomond Healthcare was one of East AHB's own provider NHST's.

which was the shortfall of where the Board was and where it wanted to be. This was a huge investment.

In the first year of the contract there were a number of 'hiccups'. NHST E unfortunately incurred financial problems and had problems with operating theatre time. Normally, one operating theatre was staffed at all times for emergency work with a second having staff who were 'on-call'. Because of the orthopaedic contract, two theatres were having to be staffed due to the increased workload, and this had resource implications that were not properly considered in the tendering exercise. Most of the heavy orthopaedic work was done at NHST E, and this had led to waiting list increases. The service though was very good, according to the Director of Strategic Development, with excellent waiting times in comparison to nearby NHST's. However, the waiting list had increased at the time of the research from 6 to 12 months for all orthopaedic patients, including patients who lived in the area where the orthopaedic contract covered. There were reasons for this increase in waiting times. East AHB were not offering the patients of GP's, some of whom were GPFH's, a *differential* service. East AHB wanted *all* its patients to have equality of access. The problem, the Director of Strategic Development continued, was what the GPFH's would do if the waiting time for say a hip operation at NHST E was 6-12 months and another NHST said it could do the work with a waiting time of 3 months?. How would the GPFH's react to their patients?. At the time of the research the GPFH's were keeping with the NHST E contract, but if the waiting times increased any further they could reassess the situation and switch to another NHST. If this occurred it would have disastrous resource implications, both for East AHB and NHST E[27].

East AHB almost went to another market testing exercise for priority services provision and went as far as beginning to draw-up service specifications. However, the NHST who were providing the service 'got wind of this' and dropped their prices by 25%. The possibility of

[27] NHST E after the contract was awarded recruited more orthopaedic surgeons and nurses to cope with the work load.

market testing was used as a threat to this NHST which worked, and the Director of Strategic Development was of the opinion that real cost savings would only be gained from the market testing of services. This was a good example of the issue of contestability, articulated by Enthoven (1985) and discussed by the Scottish Office, actually being used. However, the change in UK Government in the May of 1997 prevented the market testing exercise going ahead as its ideology was not based on competitive forces, but collaboration in health care.

West AHB

Introduction

West AHB was one of the largest health authorities in the United Kingdom, and supported eight NHST's, both Community, Acute, and Dental. It was also one of the biggest losers along with East AHB concerning funding from the Scottish Office under the SHARE[28] formula. In moving to SHARE parity it was to lose some £57M worth of income out of a total budget of £530M[29] by the year 2000.

The Acting General Manager of West AHB stated that there had been some developments in a local market in healthcare in the West of Scotland, but that it had been relatively modest. It had diverted some orthopaedic work from NHST A to NHST B because the waiting times for orthopaedics were "excessively long" at NHST A. The AHB had also contracted with a number of private hospitals in the last 2-3 years exclusively as a result of funding made available by the Scottish Office to tackle waiting lists, particularly in plastic, cardiac and cataract surgery. However, this was because its own providers did not have the capacity at that time to do the work in the time scale demanded by the Board.

West AHB had also invited tenders for some clinical activity. This was not part of an overall competitive exercise as such, but for local competition for specific services. In this case it was cataract surgery. It was pointed out by the Board that this *was* specific. West AHB wanted to reduce the waiting time for cataract patients to a maximum of 12 months for all acute in-patients and day-case patients. One of its NHST's, not used in the research, was already doing this type of work for the Board. This NHST would have been asked to treat an additional 150 cataract patients in the last four months of 1995. However, the NHST could do a maximum of 100, not 150 in the time span requested.

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28 . See chapter 2.

West AHB decided to tender the remaining 50 cataract procedures, and invited bids from the other NHST's in its catchment area and from local private hospitals. The tender was finally awarded to the NHST C. If the NHST that was already providing most of this service could have carried out *all* the work, then West AHB would not have tendered the outstanding 50 cases.

West AHB had not attempted to shift what it purchased, except as part of a *strategic decision.* For example, West AHB Board decided that from the summer of 1996, it would only buy in-patient dermatology from two NHST's, NHST B and NHST C. The Board would no longer buy in-patient dermatology services from a third NHST which also provided the service. This business moved from this third NHST to NHST C. This move was economically and technologically driven, and also due to the medical Royal Colleges. It would be cheaper to provide the service on two sites rather than three due to falling patient numbers, better technology at the other two sites, and the Royal Colleges stipulated that a certain minimum number of cases should be treated by clinicians in training to maintain accreditation for training purposes. So the changes so far had been relatively modest.

If West AHB had attempted to increase the risk and uncertainty by engaging in a much more aggressive style of purchasing and moving of business, in combination with the impact of moving to SHARE parity, the Acting Board General Manager said that the whole process would have become unmanageable. One or more of West AHB's NHST's could have run into severe financial difficulty and there would have been what he called "material turbulence", and much political unhappiness about this. West AHB, under such tight financial circumstances, had tried to manage and minimise the extent to which change had unfolded. For example, West AHB was attempting to move year on year, to price equalisation for services provided by al its NHST's through a cost benchmarking exercise using data that it had gathered from the acute sector, rather than using direct competition between its NHST's. The Board in this

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29 . Source, West AHB.

way was attempting to get average prices for clinical procedures from all its NHST's. In the financial year 1995/96 the Board managed to extract a higher level of cost improvement savings from its NHST's than it had done in the past because of the benchmarking exercise. Some NHST's would be able to cope with this, others would have to examine their cost bases and ways of reducing costs. The Acting General Manager of West AHB continued on this theme and said that it was not a simple case of offering prices to individual NHST's. West AHB knew which of its NHST's were more expensive in relation to prices offered to the AHB, than the other City NHST's. The more expensive NHST's, the Acting General Manager continued, were offered "a little bit more uplift" than other City NHST's to give them time to address their cost bases. West AHB ranked its NHST's in a scale of 1 - 5, and used this scale "to make offers", of funding to individual NHST's. Although the City NHST's were forced to examine their efficiency, this was not as the direct result of competition between NHST's.

In 1995/96 some 203,000 in-patients and day case patients went through West AHB's acute hospitals. The AHB took the view that attempting to agree contracts with the six acute NHST's for this number of patients at individual procedure level was not practical at that point in time because of the difficulties of monitoring the process. Transaction costs would also be a problem. The Acting General Manager of West AHB gave an example of a City NHST quoting the cost of a clinical procedure ranging from £250 in 1994, £130 in 1995, and £180 in 1996. As a purchaser, information on which to base contracting decisions could not be made when prices fluctuated so much. However, by averaging the prices offered to NHST's, this uncertainty could be removed.

The Acting General Manager of West AHB in a follow up interview eight months later indicated that there had been several changes, although much continuity could also be observed in relation to a market and competition for healthcare in the West of Scotland. One of the key points was that of what the GP's wanted, as it was GP's who refer patients to hospital, *not* AHB's.

West AHB's priorities had continued to be one of driving out the excess cost through the cost benchmarking exercises. The Board had continued to use this mechanism as a means of leveraging out the excess cost in the system to force the NHST's to examine their efficiency and enable the AHB to continue to purchase clinical services with the reduced level of funding allocation that was available to it under SHARE. This remained the more likely approach than more wholesale movement of activity between NHST's. It would also leave West AHB with resources that were put into a development fund that NHST's could bid for to support existing services, or develop new services. West AHB was not convinced that the wider use of tendering for clinical services had a role to play in the City, and never had the view that there would be a true market in the NHS. There were too many restrictions, not least the financial impediments and the political constraints and sensitivity that would revolve around making some of changes that might have the potential to flow if a market was set up.

> *"Letting the market rip, politically, is not practical. This is an alternative to the approach used by* [East AHB] *who packaged a whole service, orthopaedics, and put it out to tender to a number of Trusts.* [West AHB] *would not want to use such an approach because of the potential for volatility that might unfold from tendering for clinical services. The volatility could be difficult to manage in a situation where much volatility already exists"*
> (West AHB Acting General Manager).

When pressed further on East AHB's market testing exercise, the Acting General Manager of West AHB had definite views on the matter which questioned the rationale behind East AHB's decision.

> *"They* [East AHB] *got into real difficulty. Whatever story they will wrap around that, for some significant time I think they were doubting the wisdom of what they had done. I think it will be interesting to see what unfolds from that"*
> (Acting General Manager, West AHB).

General Practitioner FundHolders (GPFH's)

Introduction

Although not directly included in the research, GPFH's were another group of purchasers who could use their purchasing power to bring an element of competition into the NHS in the West of Scotland. In this way there could be a true market structure of many purchasers and many providers. However, GPFH had been slow to take off in Scotland (see table 7 in chapter 2). In the West of Scotland GPFH's were situated in specific 'clusters' in particular areas.

The Director of Purchasing at the Scottish Office said that the government's target for population covered by GPFH's in Scotland was 40%, and in fact the coverage at the time of the research was 45%, and would reach 50% by April 1997[30]. He continued to state that, although there is not yet a critical mass of GPFH's, it was only now that NHST's were recognising that purchasing power was switching from AHB's to GPFH's.

Of the two AHB's used for the research, West AHB by far had the larger number of GPFH's. With East AHB, GPFH's had not taken off in a big way, and at the time the research was conducted there were only five GPFH's in East AHB's catchement area. East AHB at first had been somewhat apprehensive about GPFH's as it felt that they could take away a sizeable proportion of its budget, and as a result problems with their contracting could occur. The Director of Commissioning at East AHB had visited all prospective GPFH's and talked to them about the advantages and disadvantages of GPFH with the hope that some of them would pull out of the scheme. However, none of them had pulled out of the scheme, and East AHB's concerns were never realised.

30 . Table 7 in chapter 2 illustrates the final breakdown of GPFH figures for Scotland.

West AHB purchased £530M worth of healthcare services through contracts, mainly with NHST's but with other healthcare organisations in 1996. GPFH's in aggregate in the City were responsible for less than 10% of this figure. Some GPFH's had used the private healthcare sector as a means of driving out savings from NHST's. West AHB gave the example of a GPFH in the West of the city. This GPFH transferred his GI[31] endoscopy referrals from NHST C, to one of the City's private hospitals because the price quoted from the private hospital was 40% cheaper than that quoted by NHST C. NHST C then dropped its price for this procedure for the next year, and the GPFH moved his business back to the Trust. Although this is anecdotal, this would represent evidence of a purchaser using its purchasing power to force a provider to reduce its costs and improve its efficiency.

West AHB was convinced that cross-subsidisation was occurring at this NHST, but it was very difficult to see where some of these cross-subsidisations[32] were going on in the system. This was an example of what West AHB called the many "games" that were played around this area, and "what you get is punch and counter punch".

> *"At one level, it is not really credible that this Trust has dropped its prices for this service by this amount. Our ability, and the GPFH's ability, to try and see where they* [the NHST's] *have buried the cost in another bit of their profile really is quite difficult"*
> (Acting General Manager West AHB).

The problem that this loss of GP fund presents to an NHST, the Acting General Manager continued, would be that it would leave a 'hole' in its contract income stream, and this hole could not just be bridged by avoiding the costs that it previously was incurring.

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31 . GI, gastro-intestinal.

32 . Cross-subsidisation was not allowed under the 1990 NHS Act which created NHST's.

The NHST would save on some of the marginal costs, but would not save anything on staff costs out of this kind of arrangement.

> *If they* [the NHST's] *come back to the Board, currently as the main purchaser and say, well you know, I'm helluva sorry, but with this FundHolder that has moved that business away, we've lost £40,000 of income. We can only reduce our expenditure by £15,000, so there is a £25,000 burden on the rest of the system as a consequence, we* [West AHB] *are not very thrilled, and get stuffed! is likely to be the answer, and go away and find some other way of dealing with it"*
> (Acting General Manager West AHB).

The Acting General Manager of West AHB recognised that this was a real complication, and he suspected that there will be other such moves and 'games' in the future, because when GPFH's and other AHB's take away business in these circumstances,

> *"They* [the AHB's and GPFH's] *will want to walk away with total cost, but the Trust will be in real difficulty in trying to shake total cost out of the system. GPFH's have been much more aggressive around price negotiations, and have used this as their main lever for trying to drive down the costs of hospital services"*
> (Acting General Manager, West AHB).

West AHB was aware that some GPFH's had gone to NHST's and guaranteed to send a minimum of 90% of their referrals, but were wanting a discount, for example 5%.

> *"So the Trust's weigh this up and say on balance this is probably the better risk for us to take, so they take a 5% hit and go away and see how they can cover this, and play it back into* [West AHB] *in a way that they think the Board will not be able to find"*
> (Acting General Manager, West AHB).

So there was evidence, although anecdotal, to suggest that the NHST's who contracted with GPFH's and AHB's were behaving opportunistically by attempting to recoup any cash shortfall from AHB's (Williamson, 1975,1985).

NHST's and GPFH's

The Chief Executive of NHST B saw GPFH 's as the only true "causing consequence" purchaser. The GPFH's were the only true purchaser where the consequences of failure to win or maintain GPFH business would be significant.

> *"If I win FundHolder business that I previously did not have, that's real new money to me, its real new patients, I recover money that gives me an opportunity. If I lose FundHolder income that is real money that does not come in, and if it is underpinning my expenditure, that gives me real cost pressures. But FundHolders in* [the City] *are still very much at the margin. Our total FundHolding income this year is about £2.2M out of £91M"*
> (Chief Executive NHST B).

The Chief Executive of NHST A thought that GPFH would have an effect on funding to the Trust because as a matter of course NHST A expected to lose 10% of its GPFH's funding This was due to a number of reasons; poor fund setting[33], although the variation is becoming less on this aspect; failure of the Trust to get invoicing out to the GP's so they refuse to pay; or because GP's 'play the system'.

> *"Playing the system can either be legitimate in that the GP's are finding a better service, however they define this, or they are playing the system in a way which is less acceptable"*
> (Chief Executive NHST A).

The Chief Executive of NHST B perhaps summed up the existence of GPFH's and what it could mean for NHST's,

> *"They are very much the proverbial irritant. They are big enough to be trouble if you lose the money, and they are not big enough to make you build bigger services to win the business"*
> (Chief Executive NHST B).

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33 . The money allocated to the GP's fund.

Section 2: The Providers

NHST A

Introduction

With respect to the development of a market for healthcare developing in the City and the West of Scotland, the Chief Executive of NHST A commented that there had not been much in the way of tendering of specialist services by AHB's as a means of comparing the prices of acute providers. Tendering had occurred in the North of Scotland, where an AHB thought that NHST A might be interested in some services, and there was the much celebrated East AHB orthopaedic services tender. However, these examples were not directly impacting on NHST A's catchment area. Information was, he continued, an important ingredient within any market, but was a problem in the NHS market in the West of Scotland.

> *"For a market to work, there needs to be perfect information, which is always going to be elusive, available to any prospective purchaser. Perfect information is always going to be a problem whenever you start talking about pricing. There will always be an initial debate surrounding this issue, and making this information available will begin to happen"*
> (Chief Executive NHST A).

For the Chief Executive of NHS A, competition where it existed, was for scarce resources. GP's were becoming far more important points of change in the market place. When he first arrived at NHST A and actively went out to see local GP's, there was a real sense of surprise that anyone from the hospital would want to go out and meet with them. It was now becoming much more routine, and the GP's expected it.

The BM for the Directorates of Accident and Emergency (A/E), Burns and Plastics, and Obstetrics and Gynaecology said that there was a definite perception of competition with these specialties. With Obstetrics it was becoming very competitive, especially with the proposed closure of one of the City's smaller maternity hospitals[34]. There was no competition with gynaecology, it was a core service and as such every City hospital which provided the service would have to maintain it. The maternity unit on the NHST E site had also being given the go-ahead to redevelop[35]. The BM said that West AHB had done a survey of all the GP's on the Southside of the City. It found that GP's would refer 53% of their patients to City hospitals, while the remainder they would send to NHST E outside the City, so NHST E could become a competitor for maternity services in the South-side of the City.

The Directorate had an infertility sub-specialty contained within it. This came under the general heading of the Assisted Conception Unit (ACS). With ACS there were a number of different types of treatments available[36]. In 1996 the Directorate promoted IVF, but cut back on some of the other ACS procedures. There also would be a new treatment for male infertility becoming available in 1996/97, ICSI[37], and the Directorate would certainly be promoting it to attract business. With IVF, AHB's in the past did not consider it a priority up until 1995. However, one AHB started buying it, and many more AHB's had become interested and made purchases of the procedure. The service had been developed over many years, but had not been well marketed. Other NHST's, such as NHST C which also provided an infertility service, and the private sector were now seen as direct competitors for this service. This Directorate was actively marketing its ACS service in light of the perceived developing market.

Eight months later after the initial interview, and as a result of increased marketing of the ACS programme, there had been an increase in the number of contracts for 1996/97. Competition

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34. Under West AHB's maternity services review.
35. As a result of East AHB's maternity services review.
36. Such as IVF, GIFT, ZIFT, IUI, Egg Donation, and Micro-assisted fertilisation (MAF).

for ACS had increased, mainly in relation to the private sector. For example, Ross Hall, a private hospital, had been actively marketing this service on local radio and local newspapers, whereas NHST A was not allowed to do this.

There was a paradox however. With reference to a market, the BM said that this was more an idea than a reality. AHB's were still working on block resource allocations to the NHST's who contracted with them. Typically, last years budget plus an amount for inflation. Competition where it existed was coming more from the private sector such as with the ACS. West AHB may still control the majority of the "market area" where it exists. There had not been any major shifts in contracts. GPFH's were only buying "bits and pieces" of work, not whole packages of care. For this BM, the market, where it existed, was 'managed' either by the AHB's or the Scottish Office.

Another BM had a portfolio consisting of General Surgery, Orthopaedics and Cardio-thoracic surgery. She saw competition being evident in all these specialties. With Cardio-Thoracic surgery, there was no competition as such, but the *threat* of competition was present. Aberdeen treated Cardio-Thoracic patients from the North and North East of Scotland. Edinburgh did likewise with patients from the South and South-East of Scotland. NHST A treats patients from the West and South-West of Scotland. NHST A also competed with other UK Cardio-Thoracic transplant centres as well as with the private sector, such as Health Care International (HCI), a private hospital, near the City.

Eight months later in a follow up interview, the BM for these specialties said that competition had increased in certain areas. With Cardiac surgery, competition had increased from the private sector. The two main hospitals providing competition were Ross Hall and HCI. This had been as the direct result of increasing GPFH numbers. However, the NHST had not made any attempt to measure competition and its effects.

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37. Intracytoplasmic sperm injection which is part of the MAF techniques used for male infertility.

The impression given to the researcher was that competition was measured using 'soft-data' such as perception or reputation, and on figures provided by West AHB and the Scottish Office in relation to patient referral patterns.

In terms of reacting to the competition in Cardiac surgery, there was a specific staffing problem with ICU[38] nurses. There was a national shortage of trained ICU nurses. The only way of reducing costs and so being more competitive, the BM continued, would be to increase patient throughput. The Directorate was finding it difficult to increase throughput because it did not have the staff. HCI, for example, had no problem with staffing since it could fly trained nurses up from London, therefore could do the work.

At the end of 1995/96 additional funding was made available by the Scottish Office to reduce the waiting list for Cardiac surgery, and some of the Directorates patients were removed from its waiting list and had the procedure done privately. Both Ross Hall and HCI treated half these patients each. HCI at this time had only two full-time cardiac nurses, and the rest were flown up from London. NHST A could not compete with this, as it was limited to using the facilities and staff that already existed at the NHST. So there was a problem in reacting to competition from the private sector due to resource constraints at NHST A.

NHST A competed on several variables such as price, quality, and reputation. With Orthopaedics, its waiting times for out-patient consultations was very good in relation to competitor NHST's. With Cardiology and Cardio-Thoracic surgery and Burns and Plastics, it competed on reputation, as well as experience in handling difficult or unusual medical conditions. With Surgery, the NHST competed on price. Competition varied between specialties, Cardiology and Cardio-Thoracic surgery, for example, were very lucrative. However, the BM indicated that there seemed to be enough work going around outside the very specific specialties to keep all of the Trusts in the City 'going'. Table 21 at the end of the chapter summarises the state of competitive play at NHST A.

NHST B

Introduction

The Chief Executive of NHST B commented that there was a "quasi" market in certain aspects of healthcare, but it tended to be around what he described as the 'opportunistic' development money. It was not based around the core business of NHST's. There had been no attempt to rationalise the number of providers on the basis of an assessment of cost, quality and efficiencies in service provision. There was most certainly a market in development bids or funds where a sum of money was set aside by West AHB (see earlier) to develop or support existing services. A range of providers would then try to demonstrate why they should be chosen to take the service forward. There was also a "market" at the margin around growth in basic activity where an NHST marketed itself with a group of GP's who start referring to the NHST in different numbers to the historical level. However, the Chief Executive pointed out that this additional income was not gained at the expense of any of the other City NHST's.

> *"you use that as an opportunity to get growth out of the purchaser. If you take an example at the moment in* [the City]*, there has been a growth in Orthopaedic referrals to [NHST B]. That has not been matched by a significant drop in referrals to* [NHST A] *or to* [NHST C]. *That growth we use to persuade the purchaser to provide us with additional income, but it is not at the expense of* [NHST A] *or* [NHST C]. *It is out of the development fund"*
> (Chief Executive NHST B).

The contracts were supposed to be the mechanism through which purchasers and providers related to each other. However, the Chief Executive of NHST B said that the formal contract was not worth all the effort that goes into it,

> *"its, regrettably, a semi-legal way of expressing each parties rights and obligations. But the business of health is through a dynamic that the rights and obligations that both parties confer on each other are meaningless. We are an ill-health treatment service, and therefore we have to deal with patients. They turn up at the front door and we have to treat them. The true part of the contract is the relationship where if I pick up the phone and say, I don't have to money to treat the people turning up at the door, it is the relationship I have with the* [Purchasers] *that will move the Trust forward or not"*
> (Chief Executive NHST B)

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38 . ICU, Intensive Care Unit.

This supported the argument proposed by Granovetter (1985, 1992) and empirically demonstrated by Ferlie et al (1996) and Ranade (1994) that markets in the NHS were relational. The contracts NHST B had with West AHB were really service level agreements. They were not legal, had no legal status, were not enforceable, and there was no court of appeal. He saw these service level agreements as an attempt to move forward NHS management, but they did nothing except describe the resources that an NHST could have to treat a certain number of patients. The contract was simply words that gave no enforceable black and white answer. In reality, the Chief Executive stated, it committed West AHB to have talks about talks, and committed NHST B to have talks about talks.

> *"What they* [the contracts] *clearly do is they force you to understand that if the patients do not come you have no right to the resource. In the old days you got paid for being open whether anybody came or not. Now you actually get paid for delivering care. But when you treat more patients, you do not get more money, you get an opportunity to talk to the purchasers about treating more patients, and whether they generally want you to treat more patients or just put them on the waiting list. Then there is a clause which says that if the Health Board agrees that you should treat more patients, there's another clause which says the health board will then talk to you about talks to define costs which they might pay"*
> (Chief Executive NHST B).

The Clinical Director for orthopaedics at NHST B saw his Directorate's main competitors as being the other Southside NHST and NHST C. However, the Directorate did not intend to invade their territory. The Directorate was actively examining ways of providing services which were not already being provided, or if they were, on a small scale. The example given was a hand and upper limb service. A consultant who specialises in this field was appointed 3 years ago. NHST B had to show GP's, and indeed remind them, what services it could provide. The paradox of competition returned again. It was hard to say whether competition existed or not, the Clinical Director argued. In the short term he expected to see no change in referral patterns from GP's, nor AHB moving contracts.

The Orthopaedic Directorate had done quite well out of the changes at a local level but,

> *"The market is a complete non-event, and there are no signs of any changes. Having a full market would be folly if it meant that hospitals would be closed. Strategic change in the NHS has been stifled by the purchaser/provider split"* (Clinical director, Orthopaedics and A/E Directorate NHST B).

The BM for the Surgical Specialties Directorate at NHST B saw Urology as having the business 'tied up' for the South side of the City. However, there were other hospitals where patients had "leaked" to. These other hospitals included NHST C, NHST A, and NHST E. She said that she would have to examine why this "leak" had occurred, find ways of stemming it and attempt to get these patients back. This may include the prices offered to GPFH's, although there were not many of them, and improved transportation to NHST B. So competition, or the threat of competition was beginning to be considered at this NHST.

The BM for the Obstetrics and Gynaecology and Theatres Directorate within NHST B stated that there was no internal market in Scotland. He had worked as a BM within an NHST in the East of Scotland and used Lothian AHB in the East of Scotland as an example. Lothian AHB determined the prices that each of its 6 NHST's offered for clinical services, averaged them out, and paid the average price. Price did not matter, so where was the competition he asked?. Any additional activity to be gained was from GPFH's which would be only marginal. However, the paradox of competition and a market arose again. The BM then stated that the Directorate's competition came from the NHST E, NHST C, NHST A, and the other City NHST's.

> *"You cannot get a feel for market share. You can get some idea of a market. But data is very crude, as is the costing. The problem about such data is the question of what you are going to do with once you have it?. How are you going to compete with other hospitals?. The Directorate is good on quality, but price is one of the biggest problems in the NHS. There is only one purchaser for Obstetrics and Gynaecology services, and would they be willing to shift 500 or so patients from another maternity unit because* [NHST B] *offered better prices or quality?"* (Business Manager NHST B).

Eight months later in a follow up interview, the competitive position was still the same. There were still the same number of NHST's. What had changed was the depth of strategic analysis that was undertaken, and the perception that the Directorate had of its environment. For example, procedures were now broken down into which GP's referred the patient, the patients post code, demography, marketing strategy and market share. The Directorates were taking more cognisance of market information which was now becoming available. Table 21 at the end of the chapter summarises the state of competitive play at NHST B.

Introduction

The Chief Executive of NHST C saw the 'market' concept as implying that purchasers decide where to buy depending on service, price and other factors such as quality. To this extent there was not a particularly *active* market, although it is true that some services have moved. By and large there had not been much movement of services in so far that purchasers had decided that one NHST was doing a better job than another. The example of East AHB tendering its orthopaedic service came up again (see section one).

> *"One of the difficulties of course is that nobody is quite sure if they have got the right information to make purchasing decisions"*
> (NHST C Chief Executive).

She said that in true markets there is perfect information for people to make purchasing decisions, and using the example of East AHB,

> *"The Trusts who were losing the service, that is us, were quoting costs including our overheads, whereas the Trusts who were quoting to take over the service were quoting on marginal costs. While those sort of rules are still around in the system, it is going to be impossible for anyone to hang on to the services they have got. So there are some major difficulties in the rules and regulations of the market, and I would query just how good the information is to make purchasing decisions"*
> (NHST C Chief Executive).

Again there was the problem concerning market information being available to the purchasers to allow them to make purchasing decisions. The other issue was around quality, which in the Chief Executives view was not generally well understood by purchasers. Purchasing decisions were being made largely based on price. And the prices offered by NHST's could be either based on total costs as in the above example, or on marginal costs. There was no specific rules for pricing.

The issue of market competition was raised with her. In terms of new entrants to whatever market was beginning to evolve, she had definite thoughts. These were related to the issue of contestability and information being available to make purchasing decisions,

> *"but I don't think it's a wildly significant threat at the moment [new entrants], but it will probably develop into being a threat as we get more sophisticated in contracting, and again this is based on the information becoming available to purchasers"*
> (Chief Executive NHST C).

The Chief Executive of NHST C also thought that purchasers could use their power more than they were doing. Purchasers,

> *"have very significant power, but most of them don't use it at the moment. Again I would suggest partly because they don't have very good information on which to use it* [power] *and partly because of the political sensitivity"*
> (Chief Executive NHST C).

This political sensitivity reinforced what the Scottish Office had said concerning market development based upon custom and political feasibility. The contracts with West AHB did not clearly state what was expected from NHST C, but the implications were that the NHST delivered the contracted amount of activity and that it conformed to waiting time guarantees. The present system of contracting was also ineffective, she continued. There were a large number of people involved in purchasing, according to the Chief Executive, but they had no power. Ultimately, decisions were made by a small 'clique' at AHB level who on occasion would act opportunistically (Williamson, 1985). The AHB would be acting opportunistically by not paying the NHST for the work that had been done, while not agreeing to reduce activity.

> *"The difficulties arise, of course, where activity is going over contract, and hither to* [West AHB] *have not been willing to bite the bullet and either say to us control activity, which in many cases we are quite willing and able to do, nor would they say they were going to spend more money. We had a situation at the end of last year where we were most unhappy because we had gone over activity, but it was too late in the year to do much about controlling it, and* [West AHB] *wouldn't pay us"*
> (Chief Executive NHST C).

NHST C had also approached West AHB before the contracted level of activity had been reached when there was the possibility of going over contract. However the response from West AHB was non-committal. There was no assurance given by West AHB that additional funding would be made available and implied that NHST C would have to bear the costs of additional work undertaken without prior agreement, and hence the risk involved. With West AHB.

> *"They contract on the basis of historical patterns, rather than reviewing the situation. I would be very supportive of developing services, but there comes a time when you cannot develop your services and carry on with historical patterns, and then a choice has to be made by Health Boards, and I don't think that Health Boards choose, I believe it is being left to the Trusts"*
> (Chief Executive NHST C).

The significant change of referral patterns, for example due to the tendering of clinical services, was made by East AHB. This has been discussed earlier in the chapter. The question was just how NHST C's Orthopaedic Directorate, which did not win the tender, reacted to this exercise. The Clinical Director for Orthopaedics did not view this loss as a problem for the Directorate. The terms of the contract would have meant that a service would have to be provided at four hospitals in the West and upper West of Scotland. What East AHB were wanting was unrealistic in his eyes, and he would never have attracted the consultant staff to do it.

The NHST did this work on historical lines as East AHB, when it replaced the old Western Board in 1974, did not have the facilities to provide orthopaedic services. The Directorate never competed and lost the contract, according to the Clinical Director. The Clinical Director's opinion was that the NHST never really had it to begin with. The tender was much greater in scale and more involved that what the Directorate was actually doing. As a result of this "loss" the Directorate would now be able to reduce the waiting times and the in-patient guarantees for its main purchaser, West AHB. The BM for the Directorate saw NHST E as a

competitor primarily because East AHB tendered its Orthopaedic services for North of the river, and the Directorate, which was already providing the service, was not successful.

The Clinical Director saw the other NHST's in Glasgow as competitors for Orthopaedic work. NHST B, because of its close geography, was NHST C's main competitor, particularly due to what was perceived by the Clinical Director, as the 'predatory' nature of NHST B's Chief Executive. The Directorate competed for business in the broadest sense of the word. If there was a large number of GPFH's, or if West AHB decided to take either, all of its Orthopaedic business, or a significant proportion of it, and move it to any other NHST, there might be a problem. However, this was seen as being unlikely. There were potential competitors, but at the time of the research they did not have the infrastructure to take Orthopaedic business away from NHST C. This, if it occurred, would take place over a period of time. So competition may have been present but nothing like micro-economic text book theory would suggest, for example, with new market entrants, information available to purchasers and providers alike, and the advertising of products or services.

> "*There are competitors, but then again they are not really competitors. It is not the same competition as a new superstore opening on the other side of the river. The healthcare market in* [the City] *is sterile. It may be different if there were more GP FundHolders*"
> (Clinical Director, Orthopaedics, NHST C)

The Clinical Director for General Surgery and ENT[39] at NHST C did not consider that there was competition per-se, but a mini "managed market". HCI in Clydebank was seen as the main competitor and the Southside NHST's (which numbered 2) were attempting to 'take' vascular work away from NHST C, but the Directorate was not too concerned with this. These hospitals were trying to build up their services as they saw NHST C and NHST A as the two "big" hospitals in the City at the time of the research. The Clinical Director did not consider that there was a market for surgery in the West of Scotland. His Directorate could not

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[39]. ENT, Ear Nose and Throat surgery.

suddenly do the surgical work of another hospital, although it could perhaps do some of it by finding extra space. The paradox of competition and markets again appeared and it may have been related to confusion surrounding what a market was, how it operated and how competition was supposed to work.

The BM for general surgery and ENT considered that for most of the Directorate's services the main competitor was NHST A, but with the size of the City and its geography, it did not cause any problems. NHST B, as already indicated, was trying to develop vascular services which could cause some conflict in the future, so would be considered as a competitor. For breast cancer, the Western General Hospital in Edinburgh could be a competitor, as there are a few patients in nearby AHB's who could go either to the City or Edinburgh for treatment. East AHB's DGH's were seen as a potential threat, although not at present. She was also aware of East AHB's plans to develop its own services locally with a view of becoming more self sufficient. The Directorate's competitors provide a total service, rather than a niche part of its work. The Directorate itself was the main Regional Centre for breast surgery, and was the only hospital in the area which offered a lung perfusion service. The private hospitals in the area were not considered to be competitors, although some GPFH's had bought some surgical services from the private sector. At the time of the research, competition was more a threat than anything else. The market in healthcare in the West of Scotland was still in its infancy with patient referrals based on traditional patterns.

The Clinical Director for the Directorate of Surgical Specialties and Nephrology at NHST C felt that there was no market for the Directorate's specialties in the Glasgow area at the time of the research. All of the NHST's in Glasgow had to provide core services, and Gynaecology was one of these. This was for general procedures and services. He continued by suggesting that competition and a market would only exist on the margins of the Directorate's service.

> *"However, once you begin to sub-specialise this is where there will be a degree of flexibility, and a market could develop in these areas. These sub-specialties will vary from Trust to Trust. This could be described as a niche part of a service. It may well be that all patients requiring gynae-oncology go to* [one NHST], *or requiring termination of pregnancy go to another Trust"*
> (Clinical Director Surgical Specialties and Nephrology, NHST C).

The BM for the Directorate of Surgical Specialties and Nephrology saw competition for Gynaecology coming from West AHB's other NHST's. The Directorate did not provide anything different in relation to Gynaecology that the other City NHST's. Of the total number of Gynaecology patients, 98% were from the City and were local. However, the BM continued, the Directorate had to be aware of its costs compared to the other City NHST's. For renal medicine, the competitors were NHST A and the other Northside NHST, but they all served different areas. NHST A served Lanarkshire AHB, and NHST C served East AHB. Competition was not seen as being important as the other City hospitals were facing similar problems in these areas. She was surprised that urology patients, for example, were still being referred to the Directorate, as the waiting times for these procedures was much longer at NHST C, than its 'competitors'. There was nothing to stop GP's referring to other hospitals, but the services provided at NHST C were seen as being of good quality, and if they were emergency referrals, they would be seen by NHST C clinicians faster than at the other City NHST's. Referrals were also continuing along historical lines. The Directorate had a monopoly in renal transplantation for the West of Scotland, and was internationally recognised as a Centre of Excellence. There was also expertise in Renal Oncology with a urologist specialising in this field working with NHST C's oncology Directorate. Andrology was another area where the Directorate had specialist expertise, and there was the potential to increase the Directorate's activity.

> *"You have to look to your strengths, and there will be things that the Directorate does that nobody else does, and that there is a demand for"*
> (Business Manager, Surgical Specialties and Nephrology Directorate, NHST C).

Table 21 at the end of the chapter summarises the state of competitive play at NHST C.

NHST D

Introduction

NHST D was a specialist Paediatric hospital. For its Chief Executive, there was no evidence of a market but,

> "*people are playing "quasi" games around the market, but in essence the impact has been at the margins, not at the heart of their business. It is a very complex area"*
> (Chief Executive, NHST D).

The idea that competition, as opposed to the traditional definition of a market, did not exist before the NHS reforms was, according to the Chief Executive, nonsense. Medicine traditionally had been seriously competitive for the last 40 years, and had been particularly competitive in the City, but not in market share terms. Competition was based on seeking to enhance the share of funds, especially for service developments and reputation. Rather this was more in terms of the development of services, the development of sub-specialisation, and units being able to secure their reputation on the basis of specialist service developments which had strong links with research and the Universities[40]. The City hospitals had been intensely competitive well before the advent of the NHS reforms attempting to get their share of resources for major service developments.

> *"One of the tensions of the reforms has been, in allowing this competitiveness and market to behave in this way. It has become clear to many people that this has been a demand driven model, not a needs based model"*
> (Chief Executive NHST D)

NHST D's relationship with its main purchaser was seen by the Chief Executive as being collaborational. The SHARE problem created revenue pressures within NHST D. Purchasers had less money to buy more. West AHB was very supportive of NHST D, but recognised that NHST D might not get all that it wanted. NHST D had to find ways of finding investment

resources, while providing core services to its purchasers. The contracts which NHST D had with West AHB did not mean anything in terms of events that unfolded later in the year. However, the Chief Executive alluded to the fact that other components of the contract were seen as being valuable. The contracts did not cover all eventualities and risks outside the contracts. The discussions with West AHB had been difficult, not in regard to the nitty gritty of the wording of contracts but with regard to sharing risk.

> "[NHST D] *exposing what its underlying position was, and* [West AHB] *exposing what it can do about it, acknowledging what its financial position is. The contract is not the end all and be all of* [NHST D's] *relationship with* [West AHB]"
> (Chief Executive NHST D).

This was further evidence of social embeddedness as described by Granovetter (1985, 1992) and demonstrated by Ferlie et al (1996) and Ranade (1994). The Chief Executive gave the example of a consultant at NHST D, who by chance, discovered a new form of treatment for a child. However, this treatment would have cost the NHST in the region of £250,000. It posed a serious financial and political risk if NHST D said it could not afford to treat the child.

> *"We dealt with it and sorted it, the contract was no where to be seen. Healthcare is surprisingly unpredictable, but it is unpredictable in a way that very small changes in volume terms can lead to key financial pressures within Trusts. The contracting process is useful if it is managed properly, however, the contract document is a negative force in securing a long term relationship with purchasers. This is only one example of many things, they happen all the time.* [West AHB] *found the money to pay for the treatment"*
> (Chief Executive NHST D).

This was an example of Sako's (1992) comments in chapter 3 regarding obligational contracting. NHST was in a 'crisis' of sorts. It needed to treat the child, but did not have the resources to do so. The AHB responded in a manner that indicated a particular type of relationship had been built up with the NHST. This type of example could not be written into a contract, and West AHB could have said no as it was not written into the contract. However, the Chief Executive of NHST D was of the opinion that invoking contracts would not establish a long term relationship. Contracts, in this sense, were of very little value. The NHS market in

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40 . This was driven in the main by the internal politics of the academic chairs in a number of

the West of Scotland gave the impression therefore of being relational, and socially embedded. Table 21 at the end of the chapter summarises the state of competitive play at NHST D.

specialties attached to the City's teaching hospitals.

NHST E

Introduction

For the Chief Executive of NHST E, there was a mixed answer to the market and competition question. On the one hand you could claim that yes there was a market in instances, where for example, East AHB competitively tendered for clinical service, such as Orthopaedics. Information was also seen as being one of the main areas which had resulted in very little competition developing. The information was improving, especially on price, and NHST's had a better idea of comparing like with like than in the past. Market information was again problematic, but purchasers were also not using their purchasing power as much as they could according to the Chief Executive.

> *"So you could argue that yes, this is a feature of a market with competition and winning bids for contracts. On the other hand there is certainly not a market if you expect purchasing to be determined on price and relative price. This is just not happening. Both* [West AHB] *and* [East AHB] *are still operating on the basis of financial allocations to Trust's. So long as this continues you are not getting the influence of relative efficiency being brought to bear on purchasing decisions. By sticking to allocations they will continue to fund inefficiency and under-fund 'super-efficiency'"*
> (Chief Executive NHST E).

The Chief Executive continued to say that the other thing that was undervalued was the legitimate pressure to develop clinical services. When there were new techniques, equipment, or new drugs, that improved care for patients, it would be very difficult for NHST E to resist these changes. These changes came from a variety of external forces, and from the clinical specialties themselves. However, the purchasers view was to ignore them, "that is not our problem", and so the cost pressures are far more then simply the imposition of a 3% cash limited saving that all NHST's had to make each year. This was compounded by the pressures of keeping up to date with developments that were considered essential by NHST E. Table 21 at the end of the chapter summarises the state of competitive play at NHST E.

Table 20. A summary of the state of 'competitive play' within the five NHST case study sites.

State of Competition

Specialty	Variable: Waiting lists	Non-price competition	Price	Quality	New service developments	Reputation
NHST A		✔			✔	
Obs and Gyn (ACS)						
Cardiac Surgery	✔				✔	✔
Orthopaedics	✔					✔
General Surgery	✔			✔		
NHST B						
Urology	✔					
Obs/Gyn				✔		
NHST C		✔				
General Surgery	✔					
Gyn	✔		✔			
Urology	✔				✔	✔
NHST D				✔		✔
NHST E						
Orthopaedics	✔	✔	✔	✔	✔	✔
Orthoptics	✔	✔	✔	✔	✔	✔
Urology	✔	✔	✔	✔		✔

Conclusions

This chapter has examined the empirical evidence relating to the development of competition and an NHS quasi-market in the West of Scotland. The empirical evidence reported here supports and adds to work carried out elsewhere (see chapter 3). This indicated the limited extension of competition under the new arrangements, rather than an atomised market consisting of individual purchasers and providers.

We would seem to be looking at an approach to the development of a market where previously none existed. We are clearly seeing a market which has been designed by the Conservative Government to improve efficiency within the NHS. The Conservatives were anxious to avoid political instability and the problems that could arise from such instability. A market structure was set up between AHB's, GPFH's, and the NHST's which consisted of a number of interactions taken on behalf of patients. The operation and behaviour of the market was monitored and regulated directly by the AHB's under a framework devised by the Scottish Office ME acting as agents on behalf of the Conservative Government. This framework, rather than being tightly prescribed was a loose structure which saw around 80-90% of actual patient referrals continuing along the lines of the previous non-market activity, but 10-20% of activity in areas where some degree of competition unfolded. This 10-20% was in areas where there would not be the risk of political instability and volatility, but rather forced providers to increase their efficiency and reduce costs. We did not see widespread competition, but rather localised shifts in resources and some competition in certain marginal areas. This maintained the desired degree of stability and improved efficiency in areas where improvements could be made.

Although the NHST's were allowed to manage themselves, the purchasers from time to time appeared to 'flex' their muscles to indicate to providers that they still had considerable power and could use it if efficiency improvements and contractual obligations were not adhered to. The purchasers also made decisions which were not based upon market competition to

reconfigure services. This again indicated a 'quasi' market where decisions were still taken centrally.

Having outlined the development of an NHS quasi-market and competition within the NHS in the West of Scotland in this chapter, chapter 8 will now determine the level of strategic behaviour observable within the five NHST case studies resulting from the development of competition. Meanwhile we note a number of points that will be returned to in chapter 10:

- Although there were relatively large number of providers, there were limited number of purchasers in the shape of both AHB's and GPFH's. A fully competitive market would have had equally large numbers of purchasers and providers;
- Purchasers in the shape of AHB's, and to a lesser extent GPFH's very often did not have the independent information to allow them to make truly informed purchasing decisions.
- A confusion could be observed within all the NHST case studies concerning the managerial understanding of the operation of a market and competition. The idea of competition at the margin as a sign of competitive behaviour was not always understood, and instead the competitive process was often envisaged as necessarily involving frequent shifts in purchasing and supply behaviour and;
- The conservative nature of the Scottish NHS which at both the Scottish Office level (macro) and AHB and NHST level (micro) never envisaged that a fully competitive market would ever be possible within the NHS. In reality the process of resource allocation would continue to be managed, but with adjustments to squeeze out additional inefficiencies as opportunities arose within particular market segments.

Chapter 8: Strategy Development within the NHST Case Studies

Introduction

This chapter will examine the empirical evidence to investigate the extent to which NHST managers at a macro (for the whole organisation) level were beginning to act strategically within the NHS quasi-market in the West of Scotland. It is hoped to develop an understanding of the ways different NHST managers approached the issue of strategic management within their NHST's. We will examine what each NHST was doing within the framework of strategic thinking outlined in chapter 4 and try to tease out the underlying linkages with a view to developing an understanding of the motives and perceptions of the key players. The chapter consists of five sections. Each section will examine in detail the development of strategic behaviour within the NHST case studies named A - E (see chapter 6).

Section 1: Evidence of Strategic Behaviour within NHST A

Introduction

NHST A had produced a strategic plan covering the period 1994-1997. The Chief Executive indicated that the plan was designed to provide a framework within which the hospital could react to changes in its environment and/or develop strategies which could pre-empt possible changes. The strategic plan addressed eight key areas. These areas were: service delivery processes; manpower planning; strategic partnerships; clinical strategy; hospital infrastructure,: management structure; planning processes; and development of the Trust Management Group (TMG). The key areas were further divided into 'Action' strategies which were intended to create a focus for the NHST's strategic development in relation to its environment, and 'Delivery' strategies which were intended to create the framework for this development[41]. The key strategic themes in the plan, the Chief Executive stated, were flexibility and empowerment. Table 22 summarises the Action and Delivery strategies.

Table 21. NHST A Strategic Framework

Action Strategies	Delivery Strategies
Service Delivery Processes	Hospital Infrastructure
Manpower Planning	Management Structure
Strategic Partnership	Planning Process
Clinical Strategy	Development of the Trust Management Group (Which consisted of all the Executive and Clinical Directors)

41 . NHST A Strategic Plan, 1994-97.

The Chief Executive of NHST A , who had come into the NHS from the private sector in 1992, said that at the heart of the NHST's strategic plan was the belief that the NHST Executive Directors and Clinical Directors needed to focus their attention towards the development of the 'Action' strategies by empowering the Clinical Directorate management teams[42] to deliver yearly operational plans. The emphasis was on a participative approach to the NHST strategy process. The NHST TMG would be devolving more decision making to the Clinical Directorates. The Chief Executive continued to say that an interesting point with regard to strategy, was how much of this was vested with the institution and how much was vested with individual Clinical Directorates. From the Chief Executive's perspective, the question was how much more *added value* could the NHST make to the core competencies of the Clinical Directorates. The Chief Executive supported this type of approach and said that one of the NHST's most recent strategy documents had examined strategy from a different perspective which resembled not a deliberate, but an *emergent* strategy based upon the feelings of individual managers within the Clinical Directorates. Rather than conforming to a predetermined plan, these managers would be given scope to develop their own strategy which would be dependent upon their own Directorates' circumstances.

> *"one of the core strategies is to say maybe we should have no strategy, maybe it should be down to imbuing the individual within the Trust with such self confidence and authority that they can make up strategy individually when faced by changing circumstances. So we don't have a ten year plan which says, right we will now deliver fifteen, and next year sixteen, because life doesn't work like this. What we should have are Clinical Directorates who are sufficiently well confident and corporately minded that they can be trusted to go out there and find the best path through this for the Trust without having some huge corporate game plan against which they have to keep on referring, so allowing them a bit more freedom"*
> (Chief Executive NHST A).

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42 . These management teams will be discussed in more detail in chapter 9.

Strategic Analysis

As part of its strategic planning process, the Chief Executive indicated that the environment of the hospital would shape any strategy. The hospital had used a PEST analysis to examine its environment. This will be described in more detail below. The Chief Executive said that the main theme emerging from the PEST analysis was the uncertainty covering a number of areas including, a possible change in the political persuasion of the Government and a lack of robust purchasing strategies by both AHB's and GPFH's. Significantly, he continued, the only certainties were the fact that there would be no new cash in the NHSiS and purchasers expected the NHST to deal with increasing patient numbers while demanding annual cash releasing efficiency savings[43].

PEST Analysis

The NHST's environment was determined by two distinct relationships based upon what its Chief Executive called independent and dependent factors. The NHST had considered the independent factors using a PEST analysis. The independent factors were areas over which the NHST had little control, whereas the dependent factors were areas where a certain degree of negotiation could be possible. The independent and dependent factors were as follows:

Independent factors:

- *Demography*: NHST A was the local hospital for the East-end of the City, and indeed drew some 50% of its patients from this area. This was also the most deprived area in the City and indeed the West of Scotland. When the local population accessed acute care they did so for longer periods, and patients could be more clinically complex;
- *Demand for Healthcare*: the overall demand for acute services was expected to increase by 1-3% per annum up to the year 2000. This would increase pressure within the hospital to develop more flexible acute care options such as day case and out-patient services.

- Partnerships with outside agencies would also be considered in the shape of strategic alliances and joint ventures;
- *Purchasing Strategies*: at the time of the research, West AHB had been carrying out a number of service reviews in areas such as Acute and Maternity services.
- *Competition*: NHST A faced a number of different competitors in each of its areas of activity which included Local, Regional, National Services, and Training and Research Funds. The NHST was also aware that it provided services which were expensive[44] in relation to its competitors and if waiting time guarantees were not met purchasers could go to other provider NHST's.
- *Technology*: the NHST would have to keep abreast of developments in new technology, particularly where there were resource implications.

Dependent Factors: where negotiation could be possible

The Chief Executive then discussed how the hospital examined the internal factors that faced the NHST using a stakeholder analysis and the key issues associated with each stakeholder. This is illustrated in table 24. It was this group of stakeholders that the Chief Executive said that the NHST could attempt to influence and negotiate with in relation to its strategic intentions.

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43 . Cash Releasing Efficiency Savings (CRES) of 3% were imposed on every NHST each year.

44 . Engaging in teaching, training, research and development incurred additional costs for these NHST's. As result their costs and hence prices were more expensive than non-teaching NHST's.

Table 22. NHST A Stakeholder Analysis (Source: NHST A Business Plan 1994-97)

Stakeholder Group	Key Issues
Patients and relatives	Quality of infrastructure in parts of the NHST site. Quality of care received. Waiting times for certain specialties. Car parking.
People of the Trust	Communications. Uncertainty regarding AHB acute services review. Understanding of NHS reform process. Implications of efficiency demands. Organisational development.
Purchasers	Perceived costs of NHST. Waiting times for certain specialties. Quantity of day case activity. Increases in GPFH's. Reversal of cross boundary flows (patients treated in own AHB area, rather than in City NHST's).
University and other education/research bodies	Additional Costs for Teaching and Research (ACTR). Balancing service demands and teaching/research activity.
Partnerships in care (especially with GP's)	Communications. Agreement of joint priorities.

The Chief Executive of NHST A said that the external environment of the NHST had been analysed using Porter's three strategic options of focus, differentiation and price.

> *"The challenges facing urban teaching hospitals are very interesting. For example whether they re-invent themselves as local DGH's and forget the Regional work because it is going to happen increasingly out in the periphery, whether they forget the local DGH work because they are never going to be able to compete on price, and go for the Hammersmith model of pure research development, teaching and tertiary activity, or whether you try to continue to maintain the balance between local, National and Regional activities. It is a real complicated equation. So yes we have looked at trying to use Porter as a way through that kind of decision making process".* (Chief Executive NHST A).

The Chief Executive discussed the ways in which the NHST, as an organisation, had to *stand out* from the other City NHST's and indeed the local DGH's from nearby AHB's. In this way NHST A was attempting to *differentiate* itself from its competitors.

A SWOT analysis would appear to have been used. This had included building on the NHST's natural and historical strengths, accepting also that it had some weaknesses, and continuing to offer value for money to its purchasers. It would also mean finding some way of forming a synergy between the highly specialised services to the more general clinical work.

Strategic Options

The Chief Executive said that there were three broad strategic options that were available to the NHST following the PEST and SWOT analyses described above. These strategic options were as follows:

1. **Focus on a few Regional and/or National specialties**: this was considered but rejected by the NHST because:

- The NHST's position in the East of the City, its trauma and DGH responsibilities would limit the ability to reduce the hospitals span or depth of acute specialties;
- Other hospitals would need further investment to take over patients no longer treated by NHST A. This would be unlikely given the SHARE issue within the City;
- There would be economic consequences for the hospital to treat a reduced number of patients;
- The NHST was a large teaching hospital. If this strategy was pursued, the teaching element would be lost or could suffer, and so would the NHST's reputation and;
- There would be a conflict with West AHB's acute and maternity services review strategies.

2. **Set out to be the lowest cost NHST in the West of Scotland**: again considered, but rejected. NHST A would have to reduce its cost base by over 40% which the NHST could not achieve because of overheads relating to its status as a teaching, research, and tertiary referral hospital.

Two important factors would also prevent this option from being pursued:

- Efficiency indicators from the Scottish Office, for example average length of patient stay and patients treated per bed per year, already indicated that NHST A used its assets efficiently, so any efficiency improvements were limited and;
- Driving significant costs from NHST A would have a negative effect on its ability to offer tertiary referral and other specialist services. As a result NHST A would have problems in attracting specialist clinicians, research and teaching resources, and maintaining the volume of such work.

3. **Differentiation**: the Chief Executive of NHST A was of the opinion that this was the most promising strategy for NHST A. Differentiation could be achieved in a number of ways:

- A 'one stop' access to hospital care. GP's and other clinicians could access a comprehensive range of specialist services via the NHST. NHST A had clinicians of a very high calibre, and as such a wide range of clinical procedures, from the simple to the complex, could be managed from a single referral centre;
- Specialisation. NHST A was the only provider of certain specialties in the West of Scotland. These specialisms were 'unique' to the NHST and constituted its core competencies. These core competencies could be built upon and marketed to the NHST's purchasers, AHB's and GPFH's and;
- Geography. Major towns to the North of the City and the population in the East end of the City formed a natural catchment area for NHST A. Improved public and private transport facilities could build on this.

Having said that NHST A would be going down the road of a differentiation strategy, the Chief Executive was not that certain that the NHST could use a strategy of differentiation on its own to be successful. However, if used with a definite *focus* to the GP's in the East-end of the City with the NHST's Regional 'unique' specialties then NHST A would be,

> *"Top notch, highly supported, very credible, continually producing research based developments such that other (NHST's) cannot produce their own 'vanilla' versions, that we are always the brand of choice around plastic surgery, bone marrow transplantation, ACS, haemophilia, cardiac surgery etc, so that any prospective entrants are facing a large entry cost to the same league"*
> (Chief Executive NHST A).

Having considered the implication for the NHST of attempting to take a cost-leadership strategy and decided that it could not take this approach, the NHST was now using a *differentiation* strategy with a *focus* to GP's and AHB's in its immediate area. The NHST Chief Executive also considered that the NHST's competitors would face barriers to entry in the shape of large financial start-up costs if they wanted provide the same services as NHST A.

NHST A had also considered a number of other strategic options. Strategic Alliances had been formed outside the City. This was because it would have a more positive impact on the Trust according to the Chief Executive. These were more strategic alliances than they were joint ventures. NHST A had become aware[45] that more specialist services were beginning to be provided by local DGH's via the impetus of AHB's outside the City, and as such formed a threat to the NHST. In an attempt to reduce this threat and indeed to develop relationships with other NHST's, NHST A had focused on what it actually provided to patients and their referring clinicians. This was not just simply treating patients, the Chief Executive continued, but could also involve the training of clinicians and their 'learning' in a safe environment. The Chief Executive of NHST A said that good progress had been made in what he called "a more mature set of relationships". NHST A in this respect had attempted to reduce the rivalry and hence competition between itself and other DGH's in neighbouring AHB's which it thought

might develop if proposals to develop specialised services in neighbouring AHB's went ahead. If cardiology is used as an example,

> *"So at the end of the day who have we got?, we have got highly credible* [NHST A] *clinicians who were focused on cardiology. What we should be doing is looking at the fundamentals of what we are offering, and we are not fundamentally able to simply and solely sell a patient episode, what we should be offering is experience outcomes and the opportunity for learning, as well as good patient episodes. So we have got our cardiologists going out to other* [DGH NHST's] *angioplasty labs and teaching their clinicians and also we've got their* [DGH NHST's] *clinicians coming in to do angioplasty in our facilities, again with a safe cardiac surgery team on standby, a pretty good place to learn"*
> (Chief Executive NHST A).

There were also many joint ventures with purchasers. These happened naturally as the NHST worked through several service developments that needed to go to around four different West of Scotland purchasers in order to fund one service development. A good example was ITU[46], where with costs running at £350,000 per annum, it was advantageous to have several purchasers engaged in a single joint venture. However, the Chief Executive said there was disappointment concerning the lack of joint venturing within the City's NHST's which again could lead to a reduction in the rivalry and competition between the City NHST's. This was a very sensitive area. It was easier to form alliances and partnerships outside the City. City NHST's were more suspicious and insecure over their future.

This may have been related to the long political history associated with acute hospital provision within the City. There had been a debate concerning the number of acute NHST's that were actually required, and whether the existing five acute hospitals should be reduced to three.

> *"Everyone* [the City NHST's] *will push themselves back from the table and say it is a wonderful thing, we should do a lot more sharing, a lot more partnering, and we should look at service rationalisation, but after you"*
> (Chief Executive NHST A).

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45 . Many AHB's wanted to develop services locally rather than having their patients travel to NHST's in the City.

46 . Intensive Therapy Unit.

NHST A had also made an acquisition in the shape of care of the elderly patients. West AHB had made it clear that it wanted care of the elderly transferred to the City NHST's. This service would not be a simple transfer, but the City NHST's would have to bid for the service. NHST A , according to the Chief Executive, had to be careful not to gain a "pig in a poke". It prepared a full business case which suggested that the service would be beneficial to the NHST if acquired. This was passed by the NHST Board and the NHST was successful in bidding to provide the service for the east of the City.

Strategy, Resources and Capabilities

A resource-based approach to strategy could also be observed at NHST A, although it was more implied than explicit. The NHST, although not using the language of a resource-based approach, was creating resource barriers in a similar fashion to that discussed by Wernerfelt (1984). NHST A also had a resource base which could be used to build core competencies and distinctive capabilities. These included reputation, clinical specialisms such as cardiology with associated staffing, and research links with one of the City University's that other NHST's would never be able to match. These resources had value, were difficult to imitate, and the NHST's internal organisation (Clinical Directorate structure) was developing in such a way to exploit them (Barney, 1991). However, it is not enough to simply say that NHST A had resources which formed core competencies or distinctive capabilities with which it could build strategy. Returning to chapter 4, it is possible to tease out what the core competencies of this particular NHST were and how it used its distinctive capabilities to build and sustain its strategy. This will be attempted using Prahalad and Hamel's (1990) and Kay's (1993) framework.

This framework will be also be used with NHST's B - E in relation to their Clinical Directorates in chapter 9. To recap, Prahalad and Hamel's core competencies must meet three criteria of: providing access to a wide range of potential markets; make a significant contribution to purchaser expectation of the final product or service and; be difficult for competitors to imitate.

Kay's discussion of distinctive capability revolved around architecture, reputation, and innovation, and included a firm's strategic assets which Kay labeled monopoly and regulation, which could be used to build a competitive strategy.

NHST A did have a number of unique clinical specialisms in areas including organ transplantation's, ACS[47], and burns and plastics. These specialisms formed core competencies because they met two of Prahalad and Hamel's criteria. They, collectively, gave NHST A access to a wide range of potential markets, and would be difficult to imitate by competitor NHST's. They may also have met the expectations of purchasers and hence patients who would want to be treated in a hospital that was at the leading edge of clinical research and treatments with acceptable waiting times, although this last criteria is perhaps more subjective than the other two.

An organisations' distinctive capabilities are based upon its architecture, reputation, and innovation. With NHST A this was observable in the very close working relationships between the employees of the NHST. For example, between senior managers and the clinical specialties in relation to the re-configuration of the NHST's Clinical Directorates (see chapter 9), internal architecture. External architecture and networks were observable in the relationships formed between NHST A and DGH's in neighbouring AHB's. This also could be seen in a 'sharing' relationship with a City University, so allowing research and development activities leading to clinical innovation to be supported with highly skilled staff.

47 . ACS, Assisted Conception Service. This will be discussed in more detail in chapter 9.

These distinctive capabilities were not used in isolation from each other and in combination gave the NHST a competitive advantage over other NHST's. The NHST was also helped by possessing a number of strategic assets (Kay, 1993). In particular the issue of monopoly, regulation, and licensing/accreditation affected the NHST favourably. The NHST was the only centre in the West of Scotland that carried out organ transplantation and as such had a monopoly in these procedures. Such procedures were regulated by the Government in so far that only a designated number of hospitals would be funded centrally to carry out such procedures. Other NHST's, even if they wanted to develop these specialisms were prevented from doing so by Government regulation and funding, so NHST A had a competitive advantage over other NHST's who did not provide this service. The NHST was also accredited by the medical Royal Colleges for training purposes. This allowed it to be at the forefront of research and development as it would expect to be training the brightest junior clinicians and employing the consultants who were at the forefront of research and development. This would also help maintain the NHST's reputation in specific areas. These distinctive capabilities were not working in isolation from each other, but in combination.

Tables 24 and 25 the end of the chapter summarises the level of strategic behaviour observable within NHST A at a macro level.

Section 2: Evidence of Strategic Behaviour within NHST B

Introduction

NHST B had produced a strategic plan for the period 1993-98. The plan had two main objectives. These were to continue to seek to maximise and consolidate patient referrals from its own natural catchment areas, and to develop services for outlying communities on the West Coast of Scotland. Where capacity was available and opportunities existed, NHST B wished to increase patient referrals from other areas and sources. As a result of West AHB's purchasing plans, the NHST had been successful in bidding for development funding (see chapter 7) to provide dermatology, ophthamology, urology, and a genito-urinary service. NHST B was also a Regional centre for neuro-sciences and spinal injuries and provided these services not only to the City and West of Scotland, but to Scotland as a whole.

West AHB, at the time of the research had been carrying out a major review and consultation process regarding the future of the City's acute and maternity services. NHST B intended to be a full participant in these discussions by lobbying and demonstrating to West AHB that services should either be continued or developed on the NHST site. There was a political and social element attached to the NHST's strategic plan. The NHST Chief Executive had spent all his working life in the NHS, and had known senior West AHB managers for many years. In the 'old' NHS managers often moved between AHB and hospitals during their careers. The Chief Executive had previously been the Director of Strategic Planning at West AHB. He was in an ideal position to lobby West AHB with respect to service development resources.

Strategic Analysis

As an NHST, NHST B considered that it had a number of advantages[48]. These were arrived at through using a SWOT analysis:

- It was cost effective in relation to its City's competitor NHST's. It had significant site development potential allied to very good communication links such as road, rail and air. Many of NHST B's City competitor hospitals did not have the site advantage. Other City NHST's did not have the potential for site development and the Chief Executive considered the site issue as forming a possible barrier which may have prevented other City NHST's developing services and entering NHST B's existing markets;
- It had customised state of the art facilities for its centre of excellence services such as neurosciences and spinal injuries;
- It had invested heavily in the up-grading of existing facilities which the NHST believed had a positive impact on service delivery to patients and;
- The NHST considered that there was also a unique opportunity to develop an integrated trauma[49] and rehabilitation service. It had the critical resource of the neurological centre and the spinal injuries unit.

The Chief Executive continued to say that NHST B's strategic plan for the future would be realised through the development of a marketing strategy which would maximise the competitive position of the NHST. This was to be achieved through:

- The accurate identification of possible target markets that were available to the NHST;
- The provision of clinical and other services to meet the requirements of these markets and;
- The identification of the NHST's main competitors through a competitor analysis and an assessment of the opportunities competitors had in providing patient care as an alternative to NHST B.

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48. NHST B Strategic Plan, 1994-97.

The Chief Executive said that the Porter five forces model could also be used for strategic analysis, and he argued that much of the analysis that NHST B had done was a five forces model in all but name. For example, NHST B could fall into the potential entrants box in relation to new service developments. The NHST had also actively examined who it's competitors were,

> *"and what the market will sustain given the fact the current providers have saturated the market, in other words there is not unmet demand. What would* [NHST B] *do, as a new potential entrant, differently that would get some of the existing cake?. Currently there is no desire among purchasers to move the existing cake around. Potential entrants come into the service and market where there is a defined unmet need, and they put forward their credentials to meet part of this unmet need"*
> (Chief Executive NHST B).

The Chief Executive continued to say that the NHST was confronted by a number of what he called "alternative providers", rather than competitors as at the time of the research, NHST's were not allowed to compete in the 'real' sense. As an NHST, NHST B knew that its purchasers always had the option to go to another provider. The healthcare industry in the West of Scotland operated with spare capacity, so movement of business was open to all purchasers. He said that barriers to entry could not be put up to stop new entrants because the providers were not controlling the market. However, the high entry costs for competitors would be so high that they would decide not to come in. The fact the NHST had unique and highly specialist service formed barriers to potential market entrants.

> *"For example it would be almost impossible for* [NHST B] *to become a cancer centre in competition to* [NHST C]. *The costs of setting up a radiotherapy and oncology centre to match or even surpass the oncology centre at* [NHST C] *is the stuff dreams are made of. By the same token* [NHST C] *might lust after being the neuro-sciences trauma unit for the West of Scotland, but the entry costs for them would be too high, although not as high as it would be for* [NHST B] *and cancer services"*
> (Chief Executive NHST B).

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49. For many years West AHB had been examining the possibility of having one major trauma centre for the City.

There were also substitute 'products' or alternative methods of delivering care according to the Chief Executive. Day case surgery was a classic example. Day case surgery would allow more patients to be treated and use less of the more traditional surgical equipment. Patients could undergo surgery and return home on the same day.

Strategic Options

The NHST also thought that it could improve its position by using one or all of Porter's generic strategies of price, differentiation and focus. If cost leadership was taken as an example, the Chief Executive said that the NHST certainly had a strategy in 1992, when it was writing it's strategic plan, that said its cost base was too high for its productivity. The NHST had a strong view, relating to the concept of the market as it existed in 1992, that it would be significantly disadvantaged because of it's cost base. The NHST then attempted to address its cost profiles, although at the time of the research, they were still high in comparison to other City NHST's. This it did because the NHST thought that it would have to do this to stay in business, and if it got it right the NHST would win business. NHST B did see cost as an issue, and if the other areas such as product differentiation and focus were taken into consideration, the NHST took a very clear view that the "product" that it offered in 1992/93 was not meeting the total demands or needs of its resident population.

NHST B was well aware that to sustain it's existing cost base not only would it have to meet all the needs of its local population, but the needs of patients outside the hospitals' immediate catchment area. The NHST *had* to be seen as *the* provider of choice for a greater population to enable it to sustain its costs base. However, on the other hand the Chief Executive continued to say that all the talk concerning strategy might come to nothing, but that it had some advantages when talking to purchasers, as purchasers could take the view that NHST B had demonstrated its ability to develop services.

> *"Five years on with hindsight I could have probably done nothing in 1992, and I might not be that dramatically different than I am today, I don't know. You could argue that some of the aggressive posturing we did in 1992, 1993, and 1994 has put us in a perceived good light by the purchasers, and therefore they are more willing to talk to us about taking forward the leadership of developments, because they think that we will deliver more bang for the buck"* (Chief Executive NHST B).

The Chief Executive said that NHST B then decided to differentiate based upon the "unique" services which would meet the needs not only of the local population, but also of the wider population within the South of the City and West of Scotland.

Strategic management was concerned with more than just markets, product, or services according to the Chief Executive. Strategy can also involve mergers, alliances, diversification, and joint ventures. NHST B had also actively considered and adopted these strategies. At the time of the research mergers were actively being talked about within the NHS in Scotland according to the Chief Executive.

> *"Because as we strive to demonstrate value for money and added value of management, we will recognise that a few of the businesses are not capable of being developed. Therefore they don't need the costs of independent management. The economies of scale will come in, and I think we will see certain structural managerial mergers. We will see lots of clinical alliances, and services will still be delivered, but they will be delivered more and more by what we are referring to as a hub and spoke model"* (Chief Executive NHST B).

Healthcare was changing rapidly, and likewise its management would also have to change, the Chief Executive continued. More care would be provided out in the community as a substitute for hospital based acute care. Managing these services would become increasingly difficult because of the fragmentation involved. Management structures would have to evolve which addressed these issues, and one of these structures was the hub and spoke model. There would be a localised management team which would be the spoke, and a management Board which would form the hub.

Withdrawal from the provision of clinical or other services the Chief Executive said would be problematic for any NHST. This was due to the political ramifications associated with withdrawals and closures.

> *"Strategic management indicates that if an other organisation was providing a service better and cheaper, then an organisation should in theory divest itself of the service. However, clinical services and the publics perception of hospitals are so inter-twined that the practicality of giving anything up was not realistic, and the same could also be said of hospital closures"*
> (Chief Executive NHST B).

There was very little that an NHST could trade off if it wanted to become a 'big player'. It was very difficult in healthcare to have "win-win" scenarios according to the Chief Executive. No NHST wanted to give up anything. Withdrawal of services, for example, would not be considered unless part of a wider AHB strategic review as any decision would be made by AHB as purchasers, rather then individual NHST's (see chapter 7).

Joint Venturing/partnering: NHST B had entered into a number of joint ventures and partnerships. One such joint venture was with a private sector company which provided laser surgery equipment and facilities. The company ran a service within the NHST supported by the NHST's dermatologists. Decisions on use were not taken by the NHST or the private sector organisation, but were through a collaborative approach between both (Sternberg, 1994). In return for this the company provided the NHST with access to three state of the art dermatological lasers which were then used to treat NHS patients, while the company treated private patients on site at NHST B. This, the Chief Executive continued, could be expanded if the market was there. Opportunities for market penetration and development were present. For example, the Nuffield private hospital in the City bought laser sessions from NHST A (see chapter 9), and NHST B could now also provide these sessions. This would be akin to market development and penetration into the private sector. NHST B would be keen to see this development. This was an example of the NHST overcoming a resource gap, the new building and equipment, through a joint venture, and giving the NHST access to a new market, while at the same maintaining control over its own affairs (Waters et al, 1994).

Alliances: the NHST has alliances with another South City NHST. Both hospitals shared staff. NHST B shared consultants in Ophthamology, Dermatology, Urology, ENT and Vascular surgery who provide clinics at both hospitals. This alliance overcame a skills and resource gap for both NHST's (Craven et al, 1993). It also served to reduce the rivalry and hence competition between the two NHST's.

Strategy, Resources and Capabilities

In the same way as NHST A, the Chief Executive of NHST B implied that the hospital had considered using a resource-based approach to strategy. NHST B possessed a number of 'unique' services and had a site that could be developed further. These were valuable resources that could be exploited to build the NHST's strategy. The unique services were neuro-sciences, and a state of the art spinal injuries unit. The Chief Executive stated that the hospital was attempting to 'lever' these resources into the other services provided by the NHST. The Chief Executive used the idea of having a set of 'cards' which differentiated the NHST from its competitors. These 'cards' would then have to be combined with the rest of the clinical services provided by the NHST.

> *"The market and the current players came together in 1992. And we had cards, and games started with the cards that you had. And then you built your strategy, and you can gloss it up anyway you like, but the bottom line was I had a series of cards and one of those cards was I was a big player of international repute, because of that service* [neuro-sciences]. *The question then became how could I keep it, enhance it and build in some synergy between that and the rest of the hospital which would move the Trust forward?"* (Chief Executive NHST B).

The Chief Executive continued on the same theme of uniqueness and how he thought that competitor NHST's would probably be doing the same kind of market analysis as NHST B.

> *"You can't say, if you were talking to* [the Chief Executive of NHST E], *why did he do that when you didn't. The bottom line was he and I opened our boxes in 1992, and took out our cards. I could have lost some good ones if I didn't see that they were good, and he could have won some good ones if I took my eye off the ball. If he is good and I am good, then the key cards are still there. It is how you are able to use these cards to move forward"*
> (Chief Executive NHST B).

Returning to Prahalad and Hamel's model, neuro-sciences and the spinal injuries unit would provide access to potential markets outside the West of Scotland. These services would be difficult for other providers to imitate because of the start-up costs that would be required, and the regulation by the Scottish Office, which effectively maintained support for only one such site in the West of Scotland. There would be the expectation by purchasers that referred patients would be accessing state of the art clinical care with excellent outcomes and acceptable waiting times. As such they could be considered as the core competencies of NHST B.

NHST B's distinctive capabilities could also be determined. In the same way as NHST A, the highly specialised clinical staff shared knowledge and information which added value to the clinical care given to patients (internal architecture), particularly in the synergy with the rest of the clinical services at the NHST. External architecture was observable in the links the NHST had with another Southside NHST where staff and knowledge was shared. The joint venture the NHST had with a private sector laser company illustrated Kay's (1993) network form of architecture where both organisations were collaborating with one another. The architecture led to innovation in clinical services in the shape of day case surgery and in accessing state of art laser equipment which enhanced the reputation of the NHST. The distinctive competencies of NHST B were not used in isolation from each other but together architecture was combined with innovation backed by the reputation of the NHST.

The strategic assets of NHST B were not that dissimilar to NHST A, particularly concerning regulation. The neuro-sciences unit at NHST B was regulated from the Scottish Office in the sense that no other NHST could develop such services because of resource constraints. In this way the NHST had a monopoly in this area with the market for these services controlled by the Scottish Office. This also made it easier to put a case to the Scottish Office for developing a spinal injuries unit on the same site. Many of the overheads that would be associated with setting up a related unit had already been expended by the NHST and equated to sunk costs which would not have to be financed again thus saving on start up costs to the public sector. The medical Royal Colleges also only accredited certain institutions which provided a certain minimal amount of training for would be specialists and also gave explicit guidelines regarding patient treatment. NHST B had the accreditation in these areas.

Tables 24 and 25 at the end of the chapter provides a summary of strategic behaviour and development at NHST B.

Section 3: Evidence of Strategic Behaviour within NHST C

Introduction

As with NHST's A and B, NHST C had developed a strategic plan for the period 1994-97. This plan had seven key objectives. These included: a flexible approach to the needs of patients; a committed staff who were involved with the running of the hospital; the development of areas such as cancer, pain relief, minimal invasive therapy, stroke service, and health promotion and; an increase in the direct care staff the hospital employed. The strategic plan recognised that the NHST was dependent on income from the West of Scotland AHB's, and that the hospital had to work closely with them to make sure that they received value for money in the clinical services purchased from the NHST. The NHST also recognised that its activity was dependent on GP referrals. Communication with GP's had been improved by the use of a quarterly newsletter and the production of a GP handbook which set out the clinical services available from the NHST. A small number of contracts had been awarded to the NHST by GPFH's in the City, and some referrals had also been received from GPFH's Scotland wide and from Northern England.

The NHST's strategic plan recognised that it operated in five distinct markets. These markets were: Local, to the population in the West of the City; Regional specialist/tertiary services for the remainder of the City, the West of Scotland and other Scottish AHB's; National Services in cardiac surgery, cystic fibrosis, ophthamology, bone oncology, and other rare cancers; and for Research and Development funding which is attracted to the NHST by specialists working at the NHST and it's close links to one of the City's Universities.

Strategic Analysis

The Chief Executive said that using a SWOT analysis, NHST C had a number of strengths and faced a number of threats. The strengths of the NHST were based on a number of factors:

- Its breadth of service available;
- The integration of one of the City's University, and NHS departments;
- The level of research funding it attracted and;
- A highly trained and committed work force.

With reference to threats, there were a number of factors which resulted in the NHST having a higher cost profile than other City NHST's:

- The NHST operated in an environment where purchasing decisions were made on the basis of cost as well as quality;
- There was also the problem of the NHST working from a number of split sites[50] which tended to duplicate effort and;
- NHST C was also a teaching hospital and expended resources in training, research and development.

In relation to strategy formation the Chief Executive, who like the Chief Executive of NHST A had come into the NHS from the private sector, indicated that the NHST had used some of the concepts behind Porter's five forces model. In terms of new entrants to the market she did not think that there was any threat of new entrants, but rather any threat would come from existing 'players' in the market.

> *"But I don't think it's a wildly significant threat at the moment, but it will probably develop into being a threat as we get more sophisticated in contracting, then it becomes a more real threat that services will be moved"* (Chief Executive NHST C).

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50 . There were five sites all together spread over the West of the City.

Strategic Options

NHST C had also attempted to become the cheapest hospital in the City by using a cost leadership strategy for clinical services in what the Chief Executive called DGH general work. However, it no longer pursued this strategy. Price was important but service quality was also an issue. The fact that the NHST was a teaching hospital meant that it may not have been able to offer prices as cheap as a DGH, but the Chief Executive said that on top of price was the perception among purchasers that the NHST offered much more than just low cost clinical services. The NHST might not be able to reduce its costs to that of a DGH or a rival City NHST, but in a market according to the Chief Executive, contracts are awarded that are not just based on price alone.

> *"We are not going for the lowest price because we believe that there is a quality issue here which may not allow that to be deliverable. So our first criteria for all our services is that we want to be recognised as a Trust which gives very good quality, and then we start to come onto the issue of how cheaply we could get services. In other words we think that purchasers will pay a little bit more for those services because of the quality issues"*
> (Chief Executive NHST C).

The approach had now moved on to developing a strategy based upon *differentiation*. In relation to differentiation, NHST C had a number of clinical services which were very specialised, and in the Chief Executive's opinion might not be so market sensitive as general medical or surgical work. Indeed some of the NHST's tertiary services were less price sensitive and as a result the NHST had to concentrate on developing them into very high quality services based on the service given to specific patients. A focus strategy was not being pursued because the NHST provided a very wide range of clinical services on top of many tertiary services.

The issue of mergers and alliances was discussed by the Chief Executive, and she was surprised that there had not been more pressure to combine NHST's. However, she thought that there may be more pressure after the 1997 general election to do this. This may be the way forward because the overheads would be reduced in the system, and there were shortages of resources, in particular specialised trained staff.

In the Chief Executive's opinion, there had been a tendency in the NHS for more specialisation and strategic alliances would begin to be developed between NHST's.

> *"If you tend therefore to be a small Trust, and you have only got two surgeons, and there are four surgical specialties, there is a limit to how far down this road you can go. Having links with another Trust may well be very sensible in terms of providing a specialist service. However, at the moment everyone is trying to fight their own corner, and we could argue that there is not enough pressure in the system to make people make the ultimate sacrifice* [merger]"
> (Chief Executive NHST C).

One area of concern was that some West of Scotland AHB's had indicated that they were keen to develop specialist services locally, rather than send their patients to City NHST's. Whilst the Chief Executive saw this as a natural progression to provide services closer to patients, she was also concerned that patients did not suffer because they could not get access to specialist care. In a move to form alliances, for example, NHST C had offered the use of its equipment and facilities to clinicians working in other AHB's so that they could examine patients at NHST C and have the security of specialist advice and backup if they needed it. This would allow their patients to be examined at NHST C and have the security and backup of specialist advice and care. This was a move to retaliate to the AHB's outside the City developing services locally by offering NHST C expertise which would not cost as much as setting up a local service. It was also seen by the Chief Executive as reducing rivalry and competition between NHST's.

This had occurred with one of East AHB's NHST's, Lomond Healthcare (LHC). LHC provided specialist urology services to East AHB. East AHB were not happy with this situation as it was general surgeons who provided the service, not specialist urologists. However, East AHB did not have the resources to appoint specialist Urologists. NHST C in the City were already providing urology services to East AHB, so LHC and NHST C formed a strategic alliance where NHST C did the heavy and sophisticated urology work, including the in-patients, while the day-cases and out-patient work was carried out at LHC by NHST C's specialist urologists. Now rather than having general surgeons performing specialist urology, it was being carried out by specialists.

The Director of Strategic Development at East AHB saw this as a positive move which would not have an effect upon East AHB's resources.

> *"This was the starting point, there were other specialties. For example, if Lomond Healthcare lost a consultant, it is sometimes very hard to cover and it's expensive to get a locum. So what you've got is LHC looking to* [NHST C] *for a defined range of services, it will look to them for support where possible, and in return* [NHST C] *will get access to a patients, a hospital, and access to community based services"* (Director of Strategic Development East AHB).

NHST C also saw the opportunity for market development, market penetration, and new service developments. However, the Chief Executive said that these issues were at a very early stage and would probably be 'on-hold' until after the 1997 General Election.

NHST C had been involved with discussions surrounding a possible strategic alliance with a local private sector provider, HCI. The Chief Executive stated that it had been anticipated HCI would have an effect upon NHS providers within the City, but this effect was unclear at the time of the research. NHST C had approached HCI as there might be areas where the NHST could *form* closer working relationships with this hospital, and indeed NHST C had already provided them with a Clinical Physics service. Senior managers and clinicians had also been involved with discussions with one of the City's Universities and HCI concerning medical staff provision. NHST C was concerned that it could be disadvantaged by HCI over issues which included the loss of key resources such as clinical staff. A strategic alliance was seen as preventing this from happening as resources could be shared. The above two examples support Craven et al's (1993) and Waters et al's (1994) argument that strategic alliances and joint ventures could be used to fill resource gaps, while allowing an organisation to move in and out of particular markets while remaining in control of its own affairs

Strategy, Resources and Capabilities

The NHST operated in five distinct markets (see earlier). These markets were undoubtedly related to its resources which formed the NHST's core competencies and ranged from the very general to the highly sophisticated. Some of these specialisms such as oncology, renal transplantation and limb perfusion, would be difficult to imitate, and the expectations of purchasers were that the very best treatments would be available for their patients with acceptable waiting times. Using Prahalad and Hamel's framework these specialisms formed the core competencies of NHST C because they gave the NHST access to a wide ranges of potential markets (see earlier), and were difficult to imitate. Services such as bone oncology, cardiac surgery and cystic fibrosis would be difficult to imitate because of funding constraints and the Scottish Office indicating that it would only support one centre providing these services in the West of Scotland.

The NHST's distinctive competencies were also observable. Internal architecture was formed between the NHST's clinical staff in relation to the specialisms which were arranged as Clinical Directorates to provide the service. External architecture was seen in the sharing of knowledge between NHST C and LHC in a strategic alliance. Network architecture was demonstrated via the teaching, research and development links with one of the City's Universities. This was also seen as providing a resource barrier to other NHST's by the Chief Executive. The NHST's strategic assets could be seen in the monopoly it had in the West of Scotland in areas such as oncology and cardiac surgery where the market only supported one provider. The monopoly arose much in the same way as with NHST's A and B via regulation from the Scottish Office with reference to funding. These monopolies also restricted the market for these services to 2-3 centres in Scotland which benefited NHST C. The medical Royal Colleges only accredit certain institutions which provided a certain minimal amount of training for specialists and also gave explicit guidelines regarding patient treatment. NHST C had all the accreditation in these areas.

The NHST's core competencies, distinctive capabilities and strategic assets all determined the strategic direction of the organisation, which the Chief Executive was trying to develop. They could also be linked into other strategic options that the NHST was pursuing such as differentiation.

> *"The resources that you have in terms of staffing, skills and equipment, play a very major part in the way in which you decide the way you are going to pitch an organisation, or the way you are going to place it under all three strategies* [generic]"
> (Chief Executive NHST C).

Tables 24 and 25 at the end of the chapter provides summaries of strategic behaviour and development observed at NHST C.

Section 4: Evidence of Strategic Behaviour within NHST D

Introduction

As with the other NHST's, NHST D had developed a strategic plan for the period 1995-1998. Underpinning the plan was the NHST's strategic objectives for the period 1995/98[51]. The plan included a number of objectives:

- To collaborate with community and primary healthcare teams in order that the need for hospital based care was minimised whenever possible. This would be achieved either via strategic alliances or joint ventures;
- To continue to build on the philosophy that maternity and paediatric care delivery on an integrated site promoted excellence in research, clinical practice and service delivery;
- To support and develop staff to ensure they felt involved, and committed to the NHST's objectives. This would be achieved via a participative approach to the NHST's strategic development involving all it's Clinical Directorates and;
- To maximise the NHST's income to support the achievement of its strategic aim and ensure financial success.

Strategic Analysis

Using a SWOT analysis, the plan also recognised the hospitals perceived strengths which lay in the provision of paediatric and women's services. It also recognised that there would be significant changes in five key areas: continuing care; secondary and tertiary consultation; routine surgery and obstetric surgery; emergency services; and specialist services (tertiary referrals).

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51 . NHST D Strategic Plan, 1995-98.

The NHST considered itself to be in a monopoly position for paediatric and women's services in the West of Scotland and felt it did not need to develop a strategic approach based upon a competitor analysis. The plan instead focused on developing services for it's patients, in this case children and mothers, and making efficient use of its resource base.

In this way NHST D *differentiated* itself from other acute hospitals, and as such was confident that there would be a need for its services. The Chief Executive was of the opinion that the changes outlined above would involve a number of issues. These were:

- More services in future would be provided in a patient's home as a substitute for acute hospital care;
- There would be less hospital attendance's and;
- There would be more 'shared care' with consultants of non-specialist hospitals.

Competition for the NHST's services was located in other parts of the Country such as Edinburgh, Aberdeen, and the rest of the UK. The strategic direction of this NHST was thus fundamentally different from the other NHST case studies.

The Chief Executive of NHST D said that to sustain the strategic objectives outlined above, the NHST as an organisation had to remember the *nature* of the services it provided, and how these services would change in the future. Much of what the NHST did required a greater understanding of the *work* of the hospital. For many children, their contact with health services tended to both inevitable, but also for short periods of time. This was confirmed by hospital figures which indicated that there was an 80/20 split in patient referrals. 80% of children who were referred to the NHST were emergencies and would follow a pattern of illness/injury and a recovery period. There were also a small number of children, 20%, who would have a longer period of contact with the NHST.

This indicated to the Chief Executive that,

> *"Child care is complex. Regrettably, for many purchasers, it is just another specialty which consumes a disproportionate level of resource"*
> (Chief Executive NHST D).

Women's services were not immune to changes either, particularly those which would have an impact on the redesign of patient care services. The NHST's emerging midwifery led service, which was a new service development, had to be seen in the context of sub-specialisation which would also impact on the NHST as a whole according to the Chief Executive. Advances in, for example infertility services and pre-natal diagnosis and treatment, all would have what the Chief Executive called "a material effect on service design". There seemed to have been elements of a PEST analysis carried out as these changes were either politically, socially, economically, or technologically driven. The problem for the NHST, the Chief Executive continued, was how it could create a vision or strategy for the future as a result of all these elements and to create a clear focus of sustained planning and clinical intervention. Strategy should be of a longer term rather than based upon short term gain.

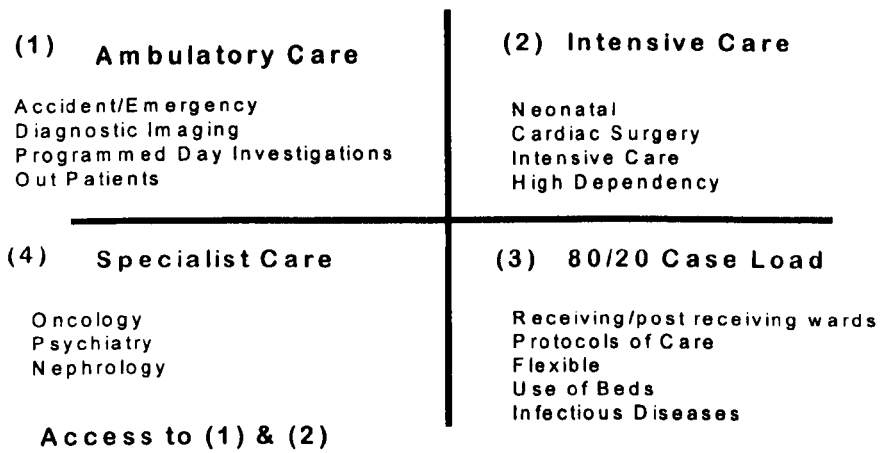
> *"The alternative is difficult to contemplate, a process of osmosis, where change is influenced by short term, tactical consideration, not coherent and structured change for the benefit of children, mothers, and families"*
> (Chief Executive NHST D).

These factors, combined with the specialist services, provided a conundrum that a service redesign and infrastructure had to be devised which met all the demands being put on the NHST, while at the same time not draining resources. The solution the Chief Executive indicated, may be linked to the concept of ambulatory care where there was the provision of comprehensive diagnostic facilities and programmed day investigation units. This would go a long way to address the problems of overuse of diagnostic tests and poor communication, as well as recognising the emphasis of moving care away from in-patient settings towards day care and community care settings. The strategic intention of the NHST was to focus on four key areas of, ambulatory care, intensive care, specialist care, and the 80/20 case load discussed earlier.

This would allow the hospital to deal with particular patient groupings and they would all be linked and be inter-related to form a seamless service. Strategy was emergent in nature, but also deliberate (Mintzberg, 1987) based upon the experiences of the clinicians, managers, and patients at the NHST. The vision of the Chief Executive is illustrated in figure 5.

> *"What emerges is a paediatric hospital which has a coherence in physical design and the potential for allocating resources more accurately and consistently"*
> (Chief Executive NHST D).

Figure 18. The Development of NHST D as a Specialist Paediatric Hospital.



Strategic Options

The Chief Executive said that there may well be a debate concerning the future of all Scotland's NHST's. The NHS had moved away from attempting to meet the needs of patients, to meeting the needs of NHS organisations and their staff.

> *"It is an open secret that what ever happens after the next General Election that there will not be forty seven Trusts in Scotland. It is an infrastructure that the NHS in Scotland cannot sustain in cost terms, and indeed many people would argue that it is not an appropriate infrastructure in the first place because it has tended to be organised around institutions, and not around client based needs.*
> (Chief Executive NHST D).

The Chief Executive continued to say that this had encouraged hospitals to behave perversely. The Government had created an animal, the NHST, that was required to be expansionist, ambitious, and protective. The fact that the 47 Scottish NHST's had expensive overheads, and tended to act perversely had dawned on everyone, according to the Chief Executive, that this model could not be sustained in the future, so there would be mergers of NHST's on the agenda in the near future. The Chief Executive argued that if the cost pressures become the driving force for acquisition and merger, some people might see it as a good idea that NHST D should be merged with another City NHST. This would be folly the Chief Executive continued, because there would be no service rationale for it, there was no natural client group, and there would be no sharing of service issues related to it. NHST D was unusual in that it was a combined child health service with a discrete client group which crossed the boundaries of community and hospital care and back again. His view was that there would not be any sense from within the City for a merger of NHST D with another City NHST.

However, he did see the potential for strategic alliances in the 'global' paediatric sense in Scotland, or at the very least the Scottish central belt. He thought that discussions would evolve in this way on a kind of hub and spoke model much in the same way to what the Chief Executive of NHST B had spoke about. The centre would have much stronger alliances with the peripheral units, and deal with the difficulties of medical manpower, skill mix and competencies, all working much more collaboratively. Strategic alliances and collaboration were the way forward for this NHST.

Strategy, Resources and Capabilities

Although NHST D considered itself to be in a monopoly position for paediatric care in the West of Scotland, its resources could be analysed in relation to strategic management. The specialist clinical services, such as renal medicine and paediatric cardiology, gave the NHST potential access to the paediatric market in these specialist areas as well as the general paediatric market. The expectation of purchasers for patients would be that they would get the best care available in this area with acceptable waiting times. Many of the NHST's specialist services would also be difficult for competitors to imitate. This could also be applied to the specialist maternity services that NHST D provided. So following Prahalad and Hamel's framework, NHST D's core competencies were in the areas of specialist paediatric and maternal care.

The NHST's distinctive competencies were also in evidence. Internal architecture was demonstrated by the close working relationships that had developed between clinical and support staff, and via the proposed ambulatory care developments where differing specialties would all be linked in a seamless service. This would be supported with the NHST's staff development activities which ensured that staff were involved with and committed to the NHST's strategic objectives. External architecture was evident in the sharing of knowledge with other NHST's in areas associated with paediatric and maternal care, rather then competing with them for knowledge and expertise. Network architecture was seen in the NHST's strategic objectives of collaboration with community and primary healthcare teams to reduce the need for hospital based care. Innovation occurred with the development of the ambulatory care design and midwife practitioners. The NHST also had a reputation of some years standing which taken together with architecture and innovation formed its distinctive capabilities. In relation to strategic assets, the NHST had a monopoly for specialist paediatric and specialist maternity services. The market for these specialist services would not support more than one provider.

Even if other NHST's wanted to develop such services, the start up costs would be too high. There was also the issue of regulation/accreditation. The Scottish Office would only fund one such centre in the West of Scotland, NHST D, so the market was regulated. The medical Royal Colleges provided accreditation for specialist training only in certain sites, NHST D was the site for paediatric care in the West of Scotland.

Tables 24 and 25 at the end of the Chapter summarise the development of strategic behaviour at NHST D.

Section 5: Evidence of Strategic Behaviour within NHST E

Introduction

NHST E had developed a strategic plan for the period 1994-1997. The plan addressed what the Chief Executive called 'corporate' objectives. These corporate objectives were to be attained through six priority action points and are illustrated in table 24. The success of the action points was to be measured through targets set within the three year time scale given above.

Table 23. NHST E Corporate Objectives (Source: NHST E Business Plan, 1994/97).

Contracts and Services	Quality and Innovation	Management	NHST Staff	Finance	Information
Secure contracts with purchasers. Expand catchment. Deliver contract requirements.	Reduce waiting times. Develop effectiveness measures. Maintain continuous improvement programme.	Develop communication strategy. Improve health and safety management systems. Promote best practice.	Develop pay and reward strategies. Extend multiskilling. Develop occupational health and health promotion.	Develop costing and pricing. Achieve financial targets. Develop long term financial strategy.	Develop and implement IS/IT strategy. Improve data accuracy.

In light of the priority action points, the plan focused on three major areas:

- the development of systems to facilitate better patient care;
- measuring the effectiveness of services and;
- reaching new levels of resource use.

These three areas were underpinned by a review and restructuring of the NHST's clinical services (see chapter 9). The NHST's strategic plan took cognisance of the fact that over 90% of NHST E's income[52] for the 1994/97 period would come from its main purchaser East AHB (see chapter 6). The NHST was effectively tied into East AHB as a purchaser, and while East AHB purchased services from other NHST's, NHST E was limited in attracting additional income. The NHST was aware that East AHB's purchasing intentions would be shaped by SHARE, and that as a result of this the AHB would in future have less resources available to buy health care services.

East AHB had also indicated that there would be a significant shift in resources from the secondary care to the primary care sector and had identified a number of priorities for clinical services including diabetes, coronary heart disease and cancer. NHST E, through its strategic plan, intended to develop services to meet the priorities set down by East AHB and hence maintain contract income. Other AHB's purchased care from the NHST, including West AHB in the City. As a result of this NHST E was also keen to promote its clinical services to the City and West AHB. The waiting times for certain specialties were known to be longer and more expensive[53] with the City NHST's, than at NHST E. The NHST saw particular *strategic* opportunities for extending clinical services to patients in the City who were waiting for certain procedures, for example cataract surgery and hip replacements. As such the NHST's potential for market penetration and development appeared promising. Although not representing a significant proportion of its contract income, NHST E had attracted a small number of patient referrals from GPFH's. In 1995/96, eight GPFH's referred patients to NHST E including some City GPFH's. The NHST thought this was important as there was, at the time of the research, no GPFH's within its local catchment area. The development of locality purchasing[54] by both East and West AHB had the potential to change the shape and pattern

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52. NHST E Strategic Plan 1995-1998.

53. Scottish Office figures.

54. With locality purchasing, AHB's devolve responsibility and funding for the health care needs of locations, hence locality purchasing within their area, to small groups.

of providing clinical services in the future. NHST E would be taking every opportunity to market itself in response to the requirements of the localities in relation to clinical services. Important areas in this marketing exercise was a risk assessment which included:

- Changes in AHB purchasing;
- The impact of GPFH's;
- The NHST's main competitors and;
- Strategic change in acute service provision in both East and West AHB's.

Strategic Analysis

The NHST had carried out a strategic analysis. Its Chief Executive indicated that NHST E had considered a number of factors, although not based on any particular model of strategic analysis. The issue of potential entrants/new entrants was used as an example. NHST E had considered how vulnerable it was to other NHST's taking some of its clinical business that the NHST provided such as ophthamology and urology. The nearest threat was NHST B. Alternatively, NHST E had been a new entrant in relation to orthopaedic (see chapter 7) and ophthamology services North of the river. This had been at the expense of both NHST C and the local NHST, LHC. The Chief Executive continued and discussed substitute products or services and how the NHST was attempting to counteract these forces and pressures. Although not using the language of Porter (1980) as such, the NHST's Chief Executive had considered elements of the five force model.

> "*If the business, or threats of substitutes, is taken as an example, you could argue that the concept lying behind a primary care led NHS is to encourage the development of substitutes to substitute locally based more responsive care for patients for the more expensive high tech hospital institutional care.* [NHST E] *in light of this is going to appoint a primary care adviser, a GP, who will be part of the NHST management team"*
> (Chief Executive NHST E).

This was a significant innovative approach as there had been in the past a distinct divide between secondary care and primary care, and the Chief Executive was not aware of any other NHST that had done this. This, it was hoped, would find ways of blurring the traditional border between primary and secondary care that could enable NHST E to develop a range of "products" that were much more consistent with a primary care led NHS. There were

elements of a PEST analysis having been carried out here, as the primary care led NHS was politically, economically, and technologically driven. The Government wanted care to be moved from the acute sector to the primary care sector as care was cheaper in the community, and advances in technology meant that many procedures could also be carried out easily in the community.

The NHST would also be entering a new market in primary care services, and was seen as a way to prevent primary care taking away part of the NHST's business. For example, the NHST could provide specialist nursing care and support out in the community, but also based upon the very close links into the hospital. It would be more sensible, the Chief Executive continued, for the NHST to develop and provide these services, rather than to leave it for GP's or Community based NHST's to do so. This indicated that there were two strands to this particular area of strategic behaviour. The appointment of a local GP to the NHST's management team would give an insight to the types of services that GP's wanted to see developed, and it would also allow market penetration and development in relation to community based clinical services which would be new to NHST E, another innovation. There would also be the opportunity to develop strategic alliances and joint ventures with GP's.

Strategic Options

NHST E did set out to follow a strategy of cost leadership, but abandoned it. The NHST quite explicitly followed the path of low cost, but it became clear that purchasers were not purchasing on the basis of price alone. As a result, the NHST began to use a differentiation strategy with a definite focus on quality targeted to GP's.

> "*They* [the purchasers] *were not taking into account relative efficiency, and money was not following patients. So there was absolutely no benefit to focus on cost reduction. What the Trust is doing now is focusing much more on quality and differentiation in terms of trying to be innovative in development of primary care led initiatives. Quality in the sense that the Trust pushes the continuous improvement of services within the Trust. Differentiation in the sense of wanting to develop relationships with GP's that may be innovative. The Trust has almost abandoned the desire to be the cheapest Trust"*
> (Chief Executive NHST E).

The NHST had been considering mergers, acquisitions, joint ventures and strategic alliances at the time of the research. The question of mergers was difficult. This the Chief Executive felt was because NHST's, generally, were yet not mature enough to sensibly discuss mergers. Too many NHST's, he continued, may have regarded mergers as a threat to themselves, and there was much defensiveness rather than examining some strategic sense in a particular geographical part of the country. The Chief Executive felt that any real mergers were perhaps 1-2 years away. However,

> *"It seems to me that one of the things that needs to be taken into account if we wanted to pursue mergers sensibly, is we would have to ask the question what is it actually going to add?. What value is it going to add to the process by merging two* [or more]*Trust's who a few years ago made successful arguments that by setting up on their own, they would bring added value to the provision of healthcare?. My fear and concern is that a lot of the initial talk about mergers is more aligned to the power and ambition of particular NHST's, rather than to bring about benefits to all the local populations that can be served by any super Trust"*
> (Chief Executive NHST E).

Mergers would therefore have to demonstrate added value. This added value could be a reduction of management and overhead costs if only one NHST was managed instead of two. However, the Chief Executive added that there would have to be safeguards against the perceived threat to the further centralisation of services. Mergers would be easier in a situation such as existed within the City where the distances between NHST's were far less than it was in the more widespread areas that NHST E operated within.

Strategic alliances were different altogether. NHST E had been trying quite hard to develop strategic alliances with a number of NHST's, some acute, some community. NHST E and these other NHST's had some mutual dependence on what the Chief Executive called "win-win" situations. These were not going to be easy to develop, he continued, as both sides needed to be comfortable that such moves were in their best interests in the long term. NHST E had also discussed the need to develop, on a specialty basis, proper strategic alliances with the major teaching hospitals in the City.

If vascular surgery is taken as an example, NHST E did not have this specialty at the time of the research[55]. There was a resource gap which would be expensive to set up, but value would be added to NHST E through a strategic alliance with a City NHST (Craven et al, 1993, Waters et al, 1994). NHST E patients who needed vascular surgery were referred either to NHST A or C, depending on which one of NHST E's own consultants were treating the patients. NHST E was attempting to determine where the best vascular service could be provided, both in terms of clinical outcomes for the patient, and the service in the sense of responsiveness to the needs of NHST E. NHST E would then try to influence its consultants to focus on referring their patients to one hospital thus improving the overall arrangements for patients.

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55. NHST E had been offered vascular surgical services by two different City hospitals, but did not want to "jump at the first offer", because it wanted to make sure that the clinical outcomes from this service would provide the best service for its patients.

At the time of the research the approach taken was that the consultants at NHST E would refer patients for vascular work to several NHST's in the City. These developments were only at an early stage, but indicated where the future lay. Switching to the issue of diversification, the Chief Executive was of the opinion that there was not a great deal of mileage beyond an NHST's 'core' business of providing healthcare. There had been some examples of NHST support services such as catering, vehicle servicing, and medical photography taking private work, but this had not amounted to anymore than 1% of any NHST's income.

Strategy, Resources and Capabilities

NHST E was different to NHST's A - D in that it provided very general clinical services, with some specialisation in urology and ophthamology services. The Chief Executive said that although the NHST had some specialist services, East AHB still referred patients to the City NHST's for the bulk of this work. Another significant difference was that 90% of the NHST's services were bought by one purchaser, East AHB. While NHST E had no specialisms by which it could differentiate itself from other NHST's, the general services it provided *could* be differentiated in terms of cost and quality via good waiting times for patient referrals. The clinical services provided the NHST with access to the local market for such services, but also to potential markets in the City in relation to costs and waiting times, and ultimately to the market for orthopaedic services North of the river at the expense of another provider (see chapter 7).

While other NHST's could imitate the general nature of the services on offer by NHST E, they could not imitate the cost of these services nor their quality, measured by better waiting times. This subtle change in imitability, in relation to price and quality, new market access North of the river, and good waiting times ensured that the general clinical services provided by NHST E were also the source of the NHST's core competencies.

A similar adaptation of Kay's Distinctive capabilities and strategic assets can be made in relation to NHST E. The NHST's *architecture* included: the relationships between the

managers and clinicians and between clinicians and support staff (internal) and via the intention of developing a strategic alliance between acute and community based NHST's in a collaborating exercise (network). The NHST had the *reputation* for providing low cost high quality general clinical services. Innovation was demonstrated by the NHST differentiating itself from other NHST's by developing primary care services from an acute site, and inviting a GP on to the NHST senior management team to advise on primary care issues. As for strategic assets, the NHST had no monopoly of clinical services. However, it benefited from a market testing exercise by East AHB. Finally, the NHST benefited from having a low cost structure hence its prices were cheaper than other NHST's.

Tables 24 and 25 summarise the development of strategic behaviour at NHST E.

Conclusions

This chapter has examined the empirical evidence to examine the development of strategic behaviour within the five NHST case studies. The evidence suggests that strategic management at NHST level was beginning to develop where previously none existed. These approaches developed as a direct result of the introduction of an internal market and competition into the NHS, and from the formation of NHST's who had (limited) freedom from AHB control. All of the NHST's had engaged in strategic planning and objective setting which covered a 3 - 5 year period. There was also an observable similarity in the types and forms of strategic analysis that were occurring within the NHST's. In chapter 4 we noted that the strategic management process included three stages: analysis; choice; and implementation. In none of the cases did respondents indicate that they had explicitly followed all three of these stages. The case studies also alluded to strategy processes which took account of the context the NHST's found themselves operating within, path dependency in relation to existing service provision, and the development of multiple relationships between the NHST's and within the NHST's.

There were distinctive differences in the depth of analysis carried out within the large City teaching NHST's, particularly between NHST A and C, and the smaller NHST's. This may have been due to the individual Chief Executives, at least two of whom had entered the NHS from the private sector (NHST's A and C). Chapter 2 indicated that both NHST's and AHB's consisted of Management Boards composed of Executive Directors and Non-Executive Directors. These Boards were modelled on Management Boards found in the commercial sector. The evidence reported in this chapter suggests that the role of these Boards in the formation of strategy at NHST level was minimal, and that any strategic decisions were made by the Executive Directors of the NHST's who were the senior managers of the hospitals. However, all major decisions regarding the strategy for the NHST's had to be ratified by their Boards which may have indicated that they existed merely to 'rubber stamp' decisions already

made by the NHST's senior managers. All of the NHST's had engaged in or intended engaging in a marketing exercise aimed at informing purchasers what clinical services they had on offer. Strategic alliances, joint ventures, and collaboration were also actively being pursued by all the NHST's.

Tables 25 and 26 provide a summary of the strategic behaviour observed within the five NHST case studies.

Table 24. A summary of the strategic behaviour observed as occurring within NHST's A - E.

Strategic Approach	NHST				
	A	B	C	D	E
Participative	✔			✔	✔
Planning (including objective setting)	✔	✔	✔	✔	✔
Five Forces:					
Threat of Substitutes -		✔			✔
Bargaining Power of Providers (suppliers) -		✔			✔
Bargaining Power of Purchasers (buyers) -			✔		✔
Threat of New Entrants -		✔	✔		✔
Industry Competition -		✔			✔
Core Competencies:					
Access to new markets -	✔	✔	✔	✔	✔
User satisfaction -	✔	✔	✔	✔	✔
Difficult to imitate -	✔	✔	✔	✔	✔
Distinctive Competencies:					
Architecture -	✔	✔	✔	✔	✔
Reputation -	✔	✔	✔	✔	✔
Innovation -	✔	✔	✔	✔	✔
Strategic Assets:					
Monopoly -	✔	✔	✔	✔	
Sunk costs already made -	✔	✔	✔	✔	
Regulation/licensing -	✔	✔	✔	✔	✔
Crafted	✔		✔		
Emerging	✔	✔	✔	✔	✔
Deliberate	✔			✔	
Stakeholder Analysis	✔				
Competitor Analysis		✔			
SWOT	✔	✔	✔	✔	
PEST	✔			✔	✔

Table 25. A summary of the strategic options either considered or used by NHST's A - E.

Strategic Option	NHST				
	A	B	C	D	E
Alliances	✔	✔	✔	✔	✔
Joint Ventures	✔	✔	✔	✔	✔
Diversification		✔			✔
New Service Developments	✔	✔	✔	✔	✔
Market Penetration	✔	✔	✔		✔
Market Development	✔	✔	✔		✔
Withdrawal	-	-	-	-	-
Merger	✔	✔	✔	✔	✔
Porter's Generic Strategies: 1. Cost Leadership - 2. Differentiation - 3. Focus -	 ✔ ✔ ✔	 ✔ ✔ ✔	 ✔ ✔ ✔		 ✔ ✔ ✔
Internal Development	✔	✔	✔	✔	✔

Although no respondents used the terms explicitly, it appears that in all the cases there was some evidence of a resource based approach to strategy being implemented which complemented the positional approach to strategy formation. The resource-based approach is of some interest concerning NHST's A - D. Penrose (1959) argued that a firm's resources were a product of the particular path a firm has followed through time. NHST's A - D, as hospitals, had been established for many years. These NHST's had 'accumulated' their clinical services because of history and opportunity. The Scottish Office funded specialist clinical services such as neurosciences, renal transplantation, and oncology only in certain areas. These NHST's were lucky enough to be chosen some time in the past, and provided these services as the result of history. NHST's A and C in particular were attached to a City University which gave them the opportunity to be involved with research and development in certain areas at the expense of other NHST's.

These NHST's had an advantage over other NHST's before the advent of the 1990 NHS reforms and internal market, and their Chief Executives were attempting to find ways of deploying their 'resources' which gave them an advantage over other NHST's, what Penrose (1959) referred to as 'strategic architecture'.

On a final note, some strategic moves were also seen to have emergent properties and in many cases could have developed as a direct result of the resources that formed the core competencies and distinctive capabilities of the NHST case studies. Meanwhile we note a number of points that will be returned to in chapters ten and eleven:

- All of the NHST's had engaged in some form of strategic planning as part of their strategy forming process;
- All of the NHST's (apart from D) had considered some elements of Porter's five forces model to assist them in developing their strategic development;
- All of the NHST's (apart from D) had pursued a strategy of cost leadership. This was abandoned in favour of them using differentiating strategy with a specific focus of their services to particular segments or groups;
- None of the NHST's wished to divest any of their clinical services and;
- Although not made explicit, all of the NHST's had considered their resource bases as a means for strategic development.

Chapter 9: Clinical Directorate Strategy, Operation, and Management

Introduction

Chapter 5 introduced the concept of clinical management and the form that it has taken within hospitals in the NHS, namely the Clinical Directorate. It also postulated Clinical Directorates as the strategic business units (SBU's) of NHST's because of their specialist clinical services that purchasers would want to buy. Chapter 8 examined the development of strategic behaviour at NHST senior management or macro level within the five NHST case studies at a macro level. Chapter 9 will now examine the development of strategic behaviour at individual Clinical Directorate (micro level) within the five NHST case studies. The chapter consists of five sections, each section will examine each NHST, and their Clinical Directorates in detail.

The Clinical Directorates were all represented in their NHST's strategic forum which consisted of all the NHST's Executive Directors and their Clinical Directors. This forum had a number of titles depending on the NHST. Typically it was either the Trust Management Group (TMG), Corporate Management Team (CMT), or Trust Operational Management Group (TOM). Of particular interest will be the relationships between the NHST senior managers and their Clinical Directorates. This will be analysed using the corporate parenting literature discussed in chapter 4. To re-cap, the corporate parenting styles were controller, coach, and orchestrator. The NHST senior managers, as parents, could either add or destroy value, value implying the degree of freedom that the Clinical Directorates had to operate as SBU's

Section 1: Evidence Related to the Clinical Directorates of NHST A

Introduction

NHST A had Clinical Directorate management teams consisting of a Clinical Director who was part-time, a Business Manager (BM), and an Operational Service Manager (OSM) who Were both full-time. The OSM would either be a nurse if a bed-holding Directorate or PAM[56] manager if a nonbed-holding Directorate. The management structure of the Directorates resembled the clinical triumvirate typology (chapter 5). The strategic management forum at NHST A was the TMG.

For the Chief Executive of NHST A, the issues associated with Clinical Directorates surrounded that of control and what he called 'corporacy'.

> "*One of the difficulties, I think, is the potential for the blurring of accountability, because of the model of devolution within the NHS. Where on the one hand you could say, Clinical Director, here's your business and operational support, here's your budget, please go away and run a £15M business, I'll see you in March and see how you got on. If the Clinical Director makes a 1% error on the Directorate budget, this could be £150,000 that the Trust has to find*"
> (Chief Executive NHST A).

The Chief Executive of NHST A said that a 1% error in industrial or commercial terms could be lost in the system, but in the NHS the £150,000 had to be found somewhere else as cost equaled price.

> *"So there is an element of, on the one hand I trust you* [Clinical Director], *please go away and do all the good things which Clinical Directorates are meant to imbue the organisation with, local ownership, creativity, making decisions quickly and close to the patient. But on the other hand, you've got to deliver absolutely as planned otherwise we are all in dire straits. This is the main difficulty and risk".*
> (Chief Executive NHST A).

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56 . PAM, Profession Allied to Medicine such as a Physiotherapist.

Part of this process would be therefore to devolve financial responsibility to the Directorates. This was evidence of the NHST senior managers creating value through their stand-alone influence by allowing the Directorates to take the financial responsibility for the clinical services they provided using a coaching style of corporate parenting. The Directorates' decentralisation contract had given a considerable degree of freedom over how the Directorates spent their budgets, according to the Chief Executive. However, their freedoms were very much at the margins as their budgets tended not to be very different from one year to the next. The Clinical Directorates had to produce operational plans for each year and had accountability reviews each quarter, where their performance was measured against their operation plan. These operational plans were then pulled together into the Trust's strategic plan. Although there appeared to be a certain degree of freedom for the Directorates, there still was control exercised by the NHST's senior managers.

The Clinical Directorate Strategy Process

Three BM's were interviewed at NHST A. They managed the specialties of Obstetrics and Gynaecology, General and Orthopaedic surgery, and Cardio-thoracic surgery. The BM's said that all the NHST's Clinical Directorates were supposed to examine the NHST strategy first, and then use this to inform their own particular strategies. The NHST's mission statement, and therefore its objectives, were agreed with all the Clinical Directors. Strategic analysis was based on a combination of SWOT or PEST analysis. The Directorates then built their business plans on the basis of the service developments that they wanted, and clinical activity levels. These were then compared to the NHST's objectives. The format for developing strategy in relation to the NHST was an iterative process. The Directorates Clinical Directors and BM's discussed with the Trust Board their activity projections for the end of the current and following year including service developments, proposals for service changes, and cost improvement programmes. This would also lead to the Directorate's budget allocation for the following year.

One Directorate will be examined in detail, Burns and Plastics.

The Burns and Plastics Directorate was considered as one of the 'stars' of NHST A. It generated large amounts of revenue for the hospital as no other NHST in the West of Scotland provided such a service. The BM said that NHST A had a monopoly for these services in the West of Scotland. This could be viewed as one of Kay's (1993) strategic assets. This monopoly was as a direct result of Scottish Office regulation of specific centres dealing with particular clinical specialties, in this case burns and plastics. The NHS would not support more than one such provider. There were a number of innovative service developments that the BM felt the Directorate had to offer which were backed up by the reputation of the NHST. These services were also being actively marketed to GP's and AHB's. For example:

- There had been a new service development in laser surgery which could successfully treat birth marks, scars and tattoos. The Directorate held an open day and it attracted many new contracts for the service. Another open day for this Directorate was planned, together with a brochure outlining the work of the laser suite. The Directorate had also 'sold' a session of laser treatment to the private healthcare sector. This had become a good income generator for the Directorate. It was something that was going to be developed in the future, and provided access to the private sector health care market.

- It had developed a new innovative aggressive treatment for burns which not only improved the quality of life for patients, but also reduced their length of stay in hospital and;

- The Directorate had the only oral-maxillary facial laboratory in Scotland. It produced life-like parts of the head and face for patients who have had surgery as a result of injury or disease.

This Directorates' core competencies (Prahalad and Hamel, 1992) were in burns and plastics. These specialties were difficult to imitate, gave the Directorate access to markets in both the public and private sectors, and the expectations of purchasers would be that their patients would be well treated with good waiting times. The Directorate displayed all three of Kay's (1993) distinctive competencies. Architecture was seen in the series of relationships that were formed between the Directorate, purchasers, and GP's which allowed the Directorate to respond flexibly to the demands of purchasers and GP's. Innovation in new areas and technologies was evident, and finally the reputation of the Directorate was enhanced by the architecture and innovation. Of course the Directorate had a monopoly (strategic asset) and the BM said that this was used as a lever upon which to build its strategy and market these specialised services.

Organisational Culture

However, all the BM's agreed that sometimes in reality the clinicians had to be reminded of what it was that they were working towards. Clinicians on the whole were not that business orientated, but some were better than others. This, she said, was down to the culture in which the clinicians were brought up with and within which they operated. The clinicians would have to learn to think strategically within the wider context of their Directorates and NHST's, rather than concentrating on the localised concerns of their professional interests in the 'new' NHS (Loveridge and Starkey, 1992). This issue concerning culture will be returned to with NHST's B - E. The important factors relate to the discussion of organisational strategy and culture in chapter 4. To briefly re-cap, culture is important in relation to determining the capabilities of an organisation, and if organisations are to compete successfully a synergy has to occur between strategy and culture. Underlying values and beliefs of organisational members have to change, and this is particularly so with new organisations such as NHST's. What we are seeing with NHST's, is a blurring between Mintzberg's (1979) machine and professional bureaucracies, where the two now had to work more closely than before and indeed it was paramount that they did so in the new NHS system that operated at the time of the research.

The cultural web of the clinicians effectively legitimised their behaviour through a long training process. This process did not take cognisance of the importance of working in a team, particularly with managers, and operating within a cash limited system based upon contracts for agreed levels of activity, brought about by Government policy at a macro level and implemented by AHB's and NHST's at a micro level.

Clinical Directorates and Contract Negotiation

There was an issue with the Directorates concerning contracting and contract negotiations with purchasers. The NHST had a central Contracting Department, and the Clinical Directorate management teams discussed with this department the source of their contracts, however, most of the contracting was done through the NHST Contracts manager. The Directorates were not happy from being excluded from the negotiations with purchasers as this could have an impact on their strategic programme. This was also at odds with the BAMM et al (1993) statement (see chapter 5) which recommended that for effective contracting there should be meaningful involvement of an NHST's clinical specialties in the contracting process. The Chief Executive though, felt that it was better for the NHST to negotiate on behalf of *all* the Clinical Directorates, rather than have them all negotiating separately with purchasers at the same time which would be time consuming for them and lead to increased transaction costs.

The Clinical Director for the Obstetrics and Gynaecology Directorate had some misgivings concerning the Directorates at NHST A. The Directorate would get "clobbered" if things went wrong, but when things were going well, it did not see the money it generated. The Directorate had a budget of £15M, but most of it was tied up with salaries, so the actual working figure was about 20% of this figure. The scope for managing the 20% was very restricted, he continued, and while there may have been potential for being innovative with the 20%, the way things were structured made this unlikely since there was still central control of financial matters by the NHST senior managers. This had a very tight grip on both the

Directorate, and wider NHST. As a result there was very little autonomy exercised by the Directorate, but the Clinical Director realised that there had to be some supervision if large amounts of money were to be devolved to Directorate level. He said that there was the feeling by all the Clinical Directors that they were there just to give the appearance of clinical involvement in management, but in truth the ability of any Clinical Director to influence management decisions was very limited. Again this was at odds with the BAMM et al statement (1993) that there should be a commitment to the decentralisation of authority and responsibility to Clinical Directorates.

The Clinical Directors had made it clear to the NHST senior management that there was a great deal of discontent about the way management decisions were taken. Instead of the NHST CMT, which included the Clinical Directors, influencing the NHST Board, information was simply fed back to the Clinical Directors, rather than the Clinical Directors providing advice and support to the NHST Board. This brought back the issue, the Clinical Director continued, that if you were going to give people the responsibility of handling large amount of money, they had to be given time to manage it.

As a Clinical Director he was allocated one session per week for management duties, but often did more with a full clinical load. He was of the opinion that there had to be a re-examination of the whole clinical management process, perhaps with fewer Clinical Directorates, but with a real commitment on their part to make the system work. There also had to be a commitment on the senior manager's part to enable the Clinical Directors to have the time to make it work. This was at odds with the BAMM et al (1993) statement on the involvement of Clinical Directors in the strategy process within NHST's.

> *"If you want clinicians to contribute usefully, and not just turn up and be seen to rubber stamp decisions, then resources have to be properly allocated to allow this to happen"*
> (Clinical Director, Obstetrics and Gynaecology, NHST A).

If you were dealing with a budget of £15M, the Clinical Director continued, it was critical that medical input should be recognised and that resources were needed to allow the system to work. Value was being destroyed by the NHST's senior managers not providing resources to allow Clinical Directors to 'free' time from their clinical loads to enable them to contribute more time to the strategic and other managerial work of their Clinical Directorates and wider NHST.

However, the Chief Executive of NHST A said that the Trust management team had done a number of things to get Directorates' closer to the contracting process. This appeared to have been reflected in the NHST's decentralisation contract with its clinical specialties:

- The *basis* of contracting was well worked through with the Clinical Directorate BM, and there was a weekly meeting with the BM and the Trust Contracting team;
- Clinical Directors and BM's were pulled into contracting for specific agenda items and;
- The Clinical Directors were also invited to every contract meeting, so if they felt strongly about something they had the opportunity to attend to voice their concerns.

Clinical Directorate Organisation and Configuration

Another area where the Clinical Directorates and Directors in particular had been involved in the NHST strategic management process involved the actual Clinical Directorate configuration. All the NHST's Clinical Directors had a met to examine the issue of changing the configuration, although at the time of the research, both the senior managers and Clinical Directors had not reached any firm conclusions on what form this would take

This had been continued by the NHST senior managers actively involving not only the Clinical Directors, but also the younger consultants and senior registrars.

> *"If we step back and look at the shape and future of the Trust, it has* [the NHST], *for the first half of this year, called together the "young Turks" from within the Directorates, the 30-35 year old senior registrars and consultants, to do some path finding around perhaps some of the more absurd ideas about the future of acute healthcare"*
> (Chief Executive NHST A).

With NHST A there was no definite plan for change, but talks were underway. A merger had already occurred between the Accident and Emergency and the Orthopaedic Directorates. One pilot Directorate was to be set up having devolved management with profit and loss accountability. The NHST senior managers were creating value to the organisation via both stand-alone influence and corporate development activities and would be 'coaching' this pilot Directorate. Table's 28 - 30 at the end of the chapter summarises the organisational arrangements and the strategic behaviour of the Clinical Directorates within NHST A.

Section 2: Evidence Relating to the Clinical Directorates at NHST B

Introduction

NHST B had 12 Clinical Directorates which were set up in 1995. The Directorate management teams consisted of a Clinical Director who was part-time, a BM, and a NM if bed-holding or PAM manager if nonbed-holding, who were both full-time. The management structure of the Directorates resembled the clinical triumvirate model (chapter 5). The strategy forum at the NHST was the TOM group. The Chief Executive saw NHST B as acting as a holding company with the 12 Clinical Directorates operating as 12 divisions. The Directorates were told what the parameters were within which the NHST was working. Strategy was very much based on a top-down approach. The senior managers were in parenting terms 'controllers'.

> *"They* [the Clinical Directors] *are told what the corporate policy is and they are told what the style is. They are then invited to work within it"*
> (Chief Executive NHST B).

Clinical Directorate Strategy Process

Because of the relatively new Directorates system at NHST B, the Directorate management teams were just beginning to determine their own strategic direction. However, of the three BM's interviewed at NHST B, a SWOT and PEST analysis were beginning to emerge as the tool of choice for strategic planning. One of the BM's was considering using the Boston Box, but there were problems with this tool, for example the Directorate could not 'harvest' any service, and the NHST Board would not give approval in any case. The BM's, although using these tools, were not that convinced of their utility, as each Directorate already knew what services they were good at providing. Strategy also had the habit of *emerging* from discussions between the BM's and their Clinical Directors. A Clinical Director, for example,

might come up with an idea and then approach the BM for support to develop it into a proposal that could be taken to the NHST Board for approval. Some of the Clinical Directors were very keen on this kind of approach while others were not. This was due to what the BM's called "attitude" and the culture that many clinicians were brought up with. The prevailing paradigm was that they should not be expected to bid for service developments in this manner and it was an anathema to the practice of medicine. The NHST's strategic plan was an amalgam of its Directorates business plans. This was done as a bottom up approach. What the Directorate's produced as business plans went towards the NHST's strategic plan. They formed a summary of where the NHST was going in the next 5 years.

The Clinical Director for Orthopaedics and A/E stated that there was a strategic forum, the TOM group where all the Clinical Directors met with the NHST Executive Directors to discuss strategy. However, he had the feeling that the NHST Chief Executive had already made the decisions before hand, and the Clinical Directors would simply rubber stamp them. The Chief Executive was described by the Clinical Director as "all powerful who was akin to a one man band with a group of helpers", although the NHST Board was supposed to make decisions. He went further to say that the Clinical Directors and their Directorates did not have very much managerial authority and responsibility. Another problem was the time available for a management role while at the same time having a full clinical commitment to the NHST. He spent three times as much time as was allocated by the NHST for Clinical Director duties. He was of the opinion that the other NHST Clinical Directors did likewise.

However, the Chief Executive stated that the actual involvement of the Clinical Directorates and Clinical Directors in the management and strategy of the NHST was based on three areas:

- They worked internally on their own Directorate business and development plans;
- They worked opportunistically with the NHST Chief Executive in attempting to influence and lobby him to allocate resources to their Directorate. This supported Eden's (1988)

argument that strategy was dependent upon negotiation and bargaining between different groups;

- They worked collectively or corporately as part of the NHST TOM group to 'pull' the NHST's strategic plan together.

The NHST had a business planning year which included two or three 'away-days' held off the hospital site with all the NHST Clinical Directors, their Directorate management teams and the NHST Executive Directors attending. At these away-days, as well as brain storming sessions on the future development of the NHST, the Clinical Directorates presented their individual business plans and why they thought that they should be funded. The NHST Executive Directors then gave their view of the NHST's environment and why some Directorates should be funded and others not. The strategy process was one of iteration and again involved negotiation and bargaining to reach a solution. Value was added by the NHST senior managers through corporate development activities, and functions and services influences.

> *"Then we go into the final contractual round* [with the NHST's purchasers]. *Having been through the first skirmishes, we come back and tell them* [the Clinical Directorates] *what we got"*
> (Chief Executive NHST B).

The Chief Executive said that there was also scope for individual Clinical Directorates to actively seek business for themselves and the NHST. The Clinical Director for Orthopaedics, could go and enter negotiations with, for example, HCI ,supported by his Directorate management team.

> *"He would have to write it up and present it to me. I in turn depending on what it is would need to make that to the* [Trust] *Board. And if we thought it was a good idea, me as an individual or the Board corporately would then send the* [Trust's] *Director's of Finance and Planning and Contracts to deal with the money, which says you've* [the Clinical Directorate] *negotiated the idea, we now want to look at the contracts conditions, the money"*
> (Chief Executive NHST B).

Despite the fact that it would be the Clinical Directorate which would be doing the work, it would be the NHST Chief Executive who signed the contract that effectively bound the NHST to do the work. Even though it could be a Clinical Directorate which found business for the

hospital, if the Director of Finance and Planning and Contracts did not think that the financial and contractual structure was in place, the Chief Executive would veto it. Value was created through the NHST's senior manager's functions and services and stand-alone influences in the shape of finance, planning, and contracts.

The BM for the Directorate of Obstetrics/Gynaecology said that the Directorate system at the NHST did not follow the practice of the actual work that was carried out. A patient may come into hospital and undergo a variety of tests and treatments, but the Directorate system did not reflect this. The Directorate system essentially reflected disciplines or functions. However, if the true sense of Directorates were added, for example in a strategic area such as Surgery, and everything in this area belonged to a Surgical Directorate, then they would work better. All surgical procedures would then be carried out under one Directorate, rather than being fragmented depending on surgical sub-specialty such as vascular or eye surgery. There also needed to be more management devolution, for example on spending. In a previous NHST he had worked for, the Directorates could spend up to £50,000 without authorisation from the NHST Finance department. At NHST B he could not even spend £50 without authorisation.

> *"With total devolved management there would be a much faster move towards Strategic Business Units, and the interest would then lie in the Strategic Business Unit, the Directorate, and not the Trust"* (Business Manager, Obstetrics and Gynaecology, NHST B).

This was the main criticism of NHST B's senior management team. According to the BM, instead of concentrating on strategic issues, they dealt mainly with operational matters. He said that if the Directorate BM's and their Nurse/Service managers were left to deal with the operational management of the Directorates and wider NHST, and the NHST senior managers managed the strategic issues of the NHST, the NHST would be more successful. Many NHST Chief Executives who had NHS management experience prior to the 1990 NHS reforms were not geared to deal with the strategic development of their organisations, but were more suited to operational management. This was perhaps related to the culture of these particular managers. While most of the debate in this chapter surrounding culture has focused on the effect of clinician culture on the NHST's, this BM concluded that the senior

managers at his NHST were still operating on hands on operational management mode which was the particular cultural paradigm that operated prior to the 1990 NHS reforms. The NHST senior managers were having difficulty in letting go of control and concentrating on strategic issues and this was causing problems at Directorate level. As with NHST A, there seemed to be some discrepancy with what the Chief Executive of NHST B said about the involvement of the Clinical Directorates in the NHST strategy process, their authority and responsibility, and what the Clinical Directorates said. This was at odds with the BAMM et al (1993) statement outlined in chapter 5.

Clinical Directorates and Contract Negotiation

The BM for the Surgical Specialties Directorate described the Clinical Directorates at NHST B operating in what she called a 'controlled environment'. The Directorate system at the NHST was still operating within an organisation that had much central control. It would work better if there was less control and 'interference' from the NHST senior managers. The contracting process was cited as a particular area of dispute. It was the NHST's Director's of Finance and Contracts and Planning who tended to negotiate contracts with purchasers. Only nominally were the Directorates involved. The Directorate were not happy with this situation, as they would like to be involved in negotiating the clinical activity that was "being signed up for". The BM for Obstetrics and Gynaecology Directorate suggested a far better approach would be for the Clinical Directors, their BM's and the NHST's Director of Contracts and Planning to negotiate 'corporately' as a team on behalf of the NHST. Clinical Directors would also let purchasers know about the complexity of producing a service outside the contractual aspects of the negotiations. The Directorates might see particular service developments as being important to them, but to be successful and gain support, they also had to be *strategically* important to the NHST as a whole. So value was added through the corporate development activities and linkage influence of the NHST senior managers.

Clinical Directorate Organisation and Configuration

The Chief Executive indicated that there may be plans to reduce the number of Directorates to around 9 or 10 in the future as some of them had developed as far as they could because of their size. As a result they would be merged with a larger Directorate. In other cases their Clinical Directors had not been performing managerially, or were approaching the end of their tenure with no identifiable replacement available. The Chief Executive said that these Clinical Directorates were not worth supporting because,

> *"You are taking all the decisions anyway, so therefore it would be better to link them in with a more forceful Clinical Director who is prepared to offer an opinion outside his or her own specialty"*
> (Chief Executive NHST B).

In general the Chief Executive said he could see at least two further reductions in the number of Clinical Directorates. In 1998 there could be a reduction to around 9, and two years after that a reduction to around 6. This was based on what the Chief Executive called their respective 'change agendas'. The NHST senior managers would be adding value through corporate development and linkage activities.

> *"A lot of Trusts have what they call a Surgical Directorate made up of General Surgery, Ophthamology, ENT, and Urology. We currently have four. They are all undergoing different change agendas, they all have got conflicting challenges. Each one of them should bottom out, in the sense that we will have taken them where they are going. After that they will be on a care and maintenance basis, keeping a close eye on how they use resources. But we will prioritise developments more corporately"*
> (Chief Executive NHST B).

The Chief Executive stated that each Directorate produced its own service development plan consisting of services which they hoped purchasers would want to buy. If urology was taken as an example, once the NHST had provided a urology service to a purchaser, the issue would then turn to how the surgical facility could be used more *effectively*. The NHST took the view that its *facilities*, in this case surgical, needed to get away from being solely a functional or discipline perspective dedicated to, in this case, urology.

Having a single Directorate and a powerful Clinical Director who would then manage it would be better than several smaller Directorates vying for theatre time or clinic time. Value would be created through the corporate development and linkage processes.

Clinical Directors provided leadership, but were not seen as providing management leadership according to the Chief Executive. They were expensive in terms of the actual management contribution they made both to the Directorates and their contribution to the management of the NHST. Some did not make any contribution to the management of the NHST but could not be forced to make a management contribution. There were elements of the clinical culture emerging. While many Clinical Directors were embracing management at this NHST, others had taken up the role to support their existing cultural paradigm which gave them symbolic leadership and power, but were not prepared to take on board the management decisions that came with it.

> *"Others have taken to it like a duck to water, and are making very difficult decisions because only they know where the money is being spent inappropriately, and people like me in ivory towers could never get to that level of change management. There are a number of Clinical Directors who came into the Directorate structure because of the leadership it would confer on them, but who also do not like taking management decisions. These individuals have to be tolerated as a result of the Clinical Directorate model"* (Chief Executive NHST B).

Tables 28 - 30 at the end of the chapter summarises the organisational arrangements and development of strategic behaviour within the Clinical Directorates of NHST B.

Section 3: Evidence Relating to the Clinical Directorates of NHST C

Introduction

NHST C had 12 Clinical Directorates, and strategy forum was the TMG. The Directorate management teams consisted of a Clinical Director who was part-time, a BM, and a NM/PAM manager, who were both full-time. The Directorate structure resembled the clinical triumvirate model (chapter 5). The Chief Executive was very supportive of the Clinical Directorate Model of clinical management. There were two main reasons for adopting Clinical Directorates at the NHST which saw the senior managers developing a parenting style akin to 'orchestrators'.

- The NHS in the past did not have a very good understanding of its costs and,

> *"One way of segmenting costs and looking at them in detail, and therefore in theory at least controlling them and spending the money where you see your priorities, is segmentation into business units of some sort, and that's one reason we have gone down the road of Clinical Directorates"*
> (Chief Executive NHST C).

- NHST C was a large organisation. If all the major decisions were taken by a small cadre of managers at the top of the organisation there would be problems. By introducing Clinical Directorates it was hoped that better management decision making would occur. Having decisions made at the top of the organisation would mean;

> *"Things wouldn't happen very much, because there is only so much time in the day for that small group of decision makers. Further, some of the decisions aren't very good ones because that small group is so far removed from the information"*
> (Chief Executive NHST C).

The Chief Executive said there was a certain degree of financial and management devolution within the Directorate structure of the NHST. The Directorates had their own budgets and could spend, within limits, in any area of Directorate work. They also had their own personnel function and could 'hire and fire' staff but,

> *"An awful lot of the further devolution to Clinical Directors and the enjoyment of Clinical Directors in the job is going to be based around purchasers empowering*

some of their people to interact with Clinical Directorates instead of everything being done on a contractual basis which means everything being done by me and my opposite number and our Directors of Finance each year"
(Chief Executive NHST C).

This had led to a great deal of frustration within some of the NHST's Clinical Directorates. The Clinical Directors, the Chief Executive continued, had actually thought that they would have had more power and responsibility. She suspected though that this was because the market had not developed in any meaningful way,

"And when I say the market, I mean issues about purchasing based on quality as well as on cost particularly. So the Clinical Directorates, for example, had discussions with purchasers [West and East AHB], *but those discussions have not led to anything meaningful happening, and therefore there is a degree of frustration about that"*
(Chief Executive NHST C).

One of the reasons for the development of Clinical Directorates was to involve clinicians in management (see Chapter 5). Clinicians would also have to interact more with hospital senior managers than they had done in the past. The relationship between the managers and the clinicians at NHST C was described by the Chief Executive as generally good. However, there were two areas of tension which had arisen which indicated a difference in culture between the managers and clinicians at the NHST. The first area concerned managerial and clinical differences.

"One is where the imperatives of people like myself in terms of money and control of activity are not medical, and therefore they are not something that medics think about on a daily basis, and we sometimes miss a trick as a Trust because of that. So it is not a question of somebody playing a game and being awkward or whatever, its that the framework for thinking is very different for somebody whose main criteria in life is seeing and treating patients"
(Chief Executive NHST C).

The second area concerned clinical activity.

"If activity is running over contract, then I would rather we stuck to the contract. The way to put pressure on purchasers is to work to contract numbers, therefore waiting lists rise, therefore purchasers are more likely to say, right here's more money, treat these additional patients. What a clinician wants to do is to treat patients who have been referred to him, and that makes it difficult for us to get money from purchasers because we are actually treating those patients, so purchasers think, well, you've got the money, so why should they give us anymore?"
(Chief Executive NHST C).

There was the problem of trying to control the activity of the clinicians at NHST C. The cultural paradigm was such that they would treat any patient referred to them and that resources would be available to do so. The managers on the other hand, were concerned that if activity went over the agreed contract level, the NHST would not get paid. Over time the accumulative effect of this may have meant that the NHST would face a significant gap in its income stream which could have an effect on strategic areas such as new service developments. For the NHST to be successful, the culture of the clinicians would have to change and they would have to work more closely with the NHST's managers particularly in relation to strategy. This mirrored Loveridge and Starkey's (1992) comments that NHS managers, in this case clinical managers, would have to learn how to think strategically in the post 1990 NHS and not solely concentrate on narrower professional issues.

The Clinical Directorate Strategy Process

Three BM's were interviewed at NHST C who managed three separate Clinical Directorates, Accident & Emergency/Orthopaedics, General Surgery and ENT, and Surgical Specialties and Nephrology. All three indicated that at Directorate level the tools of choice for strategic planning and analysis were SWOT and PEST analyses. The Directorates business plans had to tie in with the NHST's 4 year strategic plan and were summarised in the NHST's strategic plan. Although the Directorates could decide what they wanted to do from one year to the next, there were constraints. Having a corporate 'fit' was also seen as being essential, with no independence of action. Any new service developments also had to go before the NHST Board for approval before they could go ahead, as new developments could have an effect on the work of other Directorates. Value was added by the NHST senior managers through linkage influences and corporate development activities.

There were other areas where Directorate strategy was more focused. For example, the Surgical Specialties and Nephrology Directorate had a monopoly, a strategic asset (Kay, 1993), in renal transplantation for the West of Scotland and was internationally recognised as a centre of excellence. There was also expertise in renal oncology with a urologist specialising in this field working with the NHST's Oncology Directorate which itself was the only centrally funded cancer centre in the West of Scotland, another strategic asset. Strategy here was based upon building on this expertise and using it to form links with other NHST's for the purposes of patient referrals, network architecture. Andrology was an innovative new service development where the Directorate had developed specialist expertise. This service development had also seen the development of nurse led clinics in urology, prostrate, and incontinence. So as well as providing a urology service the Directorate had expanded its activities into other areas where there was unmet demand from both GP's and patients[57]. It was interesting to note that 50% of the Directorates patients and 30% of its urology patients came from outside the City. Even though waiting times and costs for these patients were longer than at other City NHST's, the BM continued, patients were still being referred by GP's. The Directorate and NHST had the reputation of providing very good services. The Directorates' distinctive competencies therefore were based around reputation, innovation, and architecture in the shape of relationships between purchasers, GP's and patients. The Directorates' specialisms were its core competencies because they were difficult to imitate, the expectations of purchasers would be that the outcomes for patients were good, and patients from areas outside the City were referred to the Directorate thus providing access to the markets for these services in other AHB areas.

> *"There is the potential to increase the Directorate's activity. You have to look to your strengths, and there will be things that the Directorate does that nobody else does, and that there is a demand for"*
> (Business Manager, Surgical Specialties and Nephrology, NHST C).

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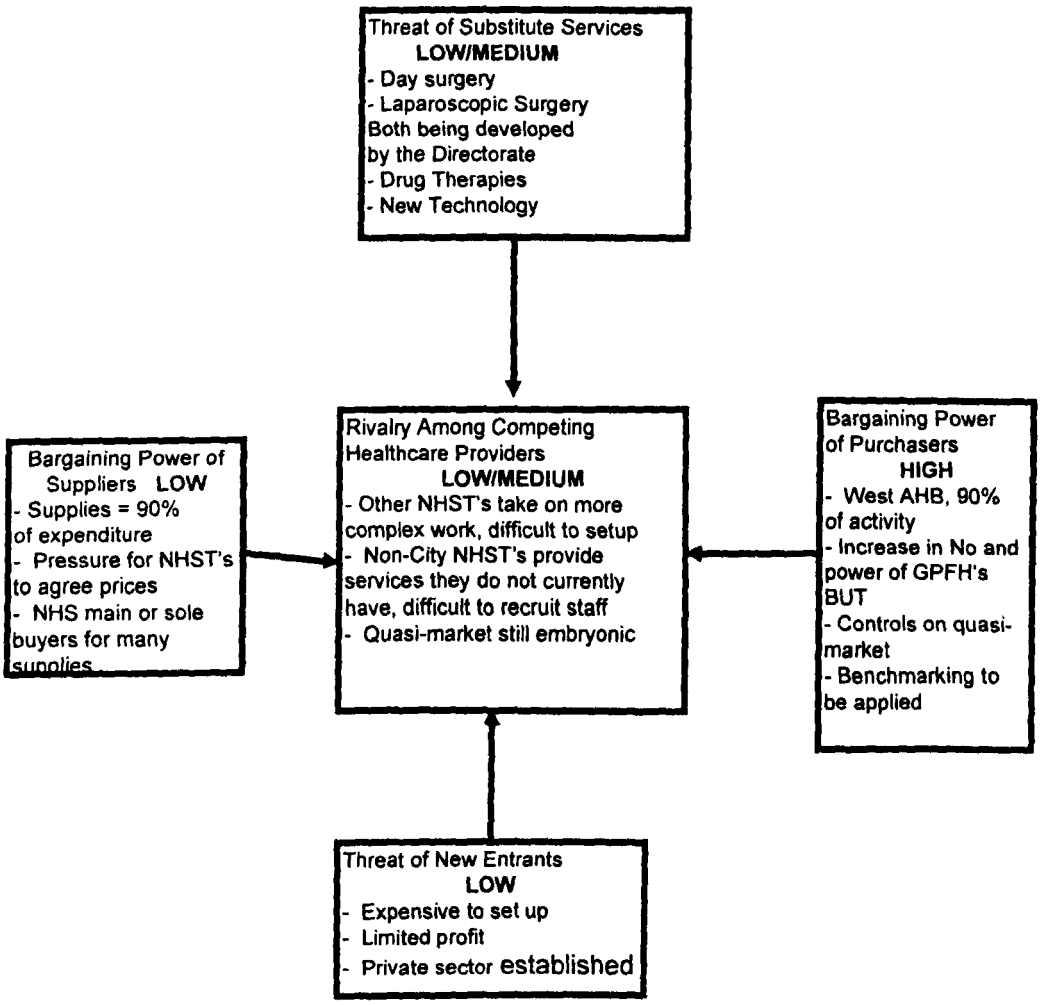
57 . Information had been gained from GP's and patients via questionnaires.

Although SWOT and PEST were the strategy tools mainly used at Directorate level, the BM for the General Surgery and ENT Directorate, as part of an MBA course, had carried out some analysis using a Porters five forces and a distinctive competence model. She was attempting to find a method of incorporating these approaches into the formal Directorate strategic planning and analysis. She did stress that this was at a very early stage and she had not attempted to apply it to her Directorate at the time of the research. The five forces model is illustrated in figure 19. Table 27 illustrates a typical SWOT analysis, in this case for the General Surgery and ENT Directorate. The BM examined the Directorate's current activity, resources, and future service development. She had also considered the challenges faced by the Directorates and its external environment which could have an effect on the Directorate fulfilling its strategic plan. Issues which may have had the most impact were prioritised, and the Directorates resources were identified which set the Directorate apart from other NHST's and potential market entrants.

Table 26. A SWOT Analysis for the General Surgery and ENT Directorate NHST C (Source: BM General Surgery and ENT Directorate, NHST C).

Strengths	Weaknesses
Breast Surgery	Split Sites - financial implications
Limb Perfusion Service	High Turnover of nursing staff
University Teaching Hospital, Research and Development	Ageing Equipment
Shortest length of stay for general surgery in Scotland	Limited allocation of capital resources to NHS
Highest throughput and turnaround, efficient bed use	Recruitment Challenge, particularly nursing and medical staff

Figure 19. An Analysis of the Quasi-market for Healthcare in the West of Scotland in relation to the Clinical Directorate of General Surgery and ENT, NHST C.



Clinical Directorate Organisation and Configuration

There were no immediate plans to reduce the number of Clinical Directorates, but discussions had taken place regarding their configuration. The Chief Executive said that one of the problems with having a large number of Directorates was that they could at times all behave like twelve cottage hospitals instead of one united organisation. If there were mergers and the number of Directorates were reduced, there would have to be some amount of thought and caution concerning the appropriate infrastructure of larger Directorates. The NHST senior managers would be adding value through linkage influence and corporate development activities if this occurred. Although talks had been held concerning Directorate mergers, there was some resistance particularly from some of the smaller Directorates. However,

> *"Some of the big ones are quite big already, some of the smaller ones, particularly the ones that have not got a major change agenda, yes I could certainly see that we would combine some of those in a beneficial manner in due course"*
> (Chief Executive NHST C).

There were three Directorates[58] that were going to be used as pilot sites for a new Directorate management structure which would have greater responsibilities. These pilots sites were to be for one year. Their management structure would consist of a Clinical Director who would be part-time, a Directorate Manager (DM) replacing the BM, and a NM, both of whom would be full-time. It was anticipated that the new structure would allow a team approach to the strategic side of things. The DM would manage the day to day operational issues, and the Clinical Director would concentrate on the clinical and strategic areas of the Directorate. The NHST senior managers would be adding value through stand-alone influence and corporate development activities in a coaching and orchestrating parenting role.

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58 . These were the Orthopaedic and A/E, the Imaging, and the Beatson Oncology Directorates.

The Clinical Director for the Surgical Specialties and Nephrology Directorate indicated that the Directorate structure was still evolving, but had made decision making on the ground easier than in the past. Previously the management structure at the hospital followed several stages and many people were involved. The Directorate has had a major impact on the organisation of clinical care for his specialty, and as such had created value. However, he said that most of the Directorate and NHST TMG meetings tended to be dominated by financial matters. As a full-time clinician he felt he could not devote enough time to the Clinical Director's job. He was paid one session per week to carry out management duties. This was not enough time, but he did think that this would change in the future. It could be that Clinical Directors would have to give up more of their clinical time to devote more time to the management role as it was becoming more and more difficult to combine the Clinical Director and clinical role simultaneously.

The Clinical Director for the General and ENT Surgery Directorate said that in the past these two specialties were managed separately. The specialties had now been brought together and were working well. There could be however, in his opinion more groupings of specialties under the one Directorate, for example, Surgery. But the NHST senior managers were not keen on this. He still had a full clinical load and juggled his times between the clinical and managerial roles. This tended to invade his own personal time and he considered the role of a full-time clinician and part-time manager to be incompatible with each other.

The BM for General and ENT Surgery considered that the structure of the NHST's Directorates suited what each clinical specialty was actually doing, but there were some issues that would need clarification. She was concerned with the issue of just how much responsibility and authority the NHST senior managers would allow to be devolved to the Directorates, as there were some powerful people who would not want to let go of control. Tables 28 - 30 at the end of the chapter summarises the organisational arrangements and the development of strategic behaviour within the Clinical Directorates of NHST C.

Section 4: Evidence Relating to the Clinical Directorates of NHST D

Introduction

NHST D consisted of 9 Clinical Directorates. The Directorate management teams consisted of a Clinical Director who was part-time, a BM, and a NM if a bed-holding Directorate or PAM manager if nonbed-holding, who were full-time. The Directorate management structure resembled the clinical triumvirate model (chapter 5), and the strategy forum was the CMT. The Chief Executive said that the benefits of Clinical Directorates were consistent with redefining the organisation's shape. For example, making it more decentralised with less bureaucratic decision making, and transferring the balance of both opportunity and responsibility to lower levels of the organisation. The parenting style seemed to be a combination of coach and orchestrator. There will not be any discussion relating to core competencies or distinctive capabilities as these were covered in chapter 8.

The other advantage was that doctors had become involved with management. However, the mistake that had been made was the development of wrong assumptions about the *involvement* of doctors in management. Clinical Directors, and their Directorates had become very operationally focused, and the NHST assumed that its Clinical Directors would have the skills to run their Directorates as businesses. Generally, according to the Chief Executive, Clinical Directors were not managers, and did not have the competency profiles of managers to run their Directorates in terms of operational management. The balance at the NHST had not been right. Clinical Directors should have been providing vision, strategic direction, leadership, contributing to the NHST strategic plan, and generally representing the interests of their Directorate.

However the Clinical Directors were managing down and not managing upwards and outwards. The Clinical Directors would have to be persuaded by the NHST senior managers of the appropriateness of their strategic influence at NHST level, rather than simply operating within their own narrow professional area (Loveridge and Starkey, 1992). The Clinical Directorate model had reinforced this and the process needed to be matured and developed in a different way. Another issue was the way the Directorates had been organised which had reflected the prevailing culture within the NHST. The Clinical Directorates had been set up reflecting existing powerful specialties. This had maintained the status quo within the hospital of existing groups, and the Clinical Directors had built on their cultural paradigm and the power and status that went with it. There may have been what BAMM et al (1993) referred to as a 'disconnection' with the roles and responsibilities of the Clinical Directorates as perceived by the NHST senior managers and as perceived by the Directorates themselves. BAMM et al (1993) argued that if there was a confusion over roles and responsibilities, there could be a re-emergence of old hierarchical networks which could undermine the whole system of decentralised management. Rather than contributing to the corporate agenda of the NHST, the Directorates were 'doing their own thing' according to the Chief Executive. Particular groups had benefited from power bases which did nothing for the delivery of health care.

> *"This led to the reinforcing of professional tribalism that exists within health service organisations, and probably, with some regret, its has reinforced functionality which the Trust is having to dismantle if the Trust is going to deliver effective healthcare"*
> (Chief Executive NHST D).

The Directorates, in the Chief Executive's view, had to manage the clinical service's strategy that the NHST was trying to implement over the next five years. The NHST had developed a five year clinical services strategy (see chapter 8) which described how the organisation would change in caring for children and mothers. A review of the NHST's Clinical Directorates had been established in an attempt to match the organisational design to deliver this 'product'. The development of an Ambulatory Care Directorate (see chapter 8) indicated that the NHST

senior management team were trying to create value through linkage and through corporate development activities.

Some 85% of the NHST income was now devolved to the Clinical Directorates, and each year the NHST pushed more of the ownership of this income to the Directorates. The NHST had a clearly agreed negotiated position on income streams generated above the targets that were set for Clinical Directorates to bring the NHST into balance. The Clinical Directorates in other words would get to keep this extra income. The NHST senior management team were adding value to the Clinical Directorates through their linkage influence and corporate development activities.

The Chief Executive then discussed the issue of the relationship between what he called the centre (the NHST senior managers) and its parts (the Clinical Directorates). He said that the NHST had negotiated an operational framework document which described the relationship and accountability between these two groups in terms of their authority to spend, to vire, and income generate. So the nature of the decentralisation contract would appear to have been made clear to the Directorates. The Chief Executive was convinced that by not doing it this way would prevent the NHST from taking a strategic view of the whole organisation. Again the senior managers were acting in a 'coaching' and 'orchestrating' parenting role.

The Clinical Directorate Strategy Process

The Clinical Director for Paediatric Surgery said that as a Directorate, it did not sit down to formulate ways of attracting business. He considered that NHST D was in the unique position in being the only paediatric hospital in the area, and because of this it did not have to attract business in the same way as the other acute provider units within the City. It had in effect a monopoly in child care. In terms of strategic planning, the Directorate began from the previous years activity. This activity was used as a base line. There was a business analysis carried out once a year using SWOT/PEST, but he thought that this was done more for the whole Trust at CMT level. Added to this were regular monthly meetings of the Directorate

management team with the lead consultants of each of the departments contained within the Directorate where they decided what they could do/not do. The major strategic theme of a long term nature was to attempt to get all surgical paediatric referrals for the City referred to NHST D.

Two Directorate BM's were interviewed at NHST D. They covered the Paediatric Medicine and Paediatric Surgery Directorates. In theory the BM's said that they and the Clinical Directors should sit down together to formulate the directorate's strategy using strategy tools such as SWOT and PEST. However, in reality this did not happen because some of the Clinical Directors did not see the point of the exercise, and it was not appreciated by some clinicians who did not think that these tools were appropriate in a clinical setting. The BM's were of the opinion that this process would have to undergo a culture change to enable it to develop. The clinician's cultural web at the NHST had reinforced and supported their organisational paradigm. BM's were new to NHST D and were still new to the Directorates. It was also an education process for clinicians to apply this kind of analysis to their work. Strategy also tended to develop, or *emerge*, the BM said. For example, a Clinical Director could come up with an idea, and then may want help to support the idea from their BM, rather than the BM and the Clinical Director developing the strategy together. It might not even be a strategy, the Clinical Director could simply ask for an opinion of how the Directorate should go forward with a particular service.

The Chief Executive said that the Clinical Directors of the NHST had a key role to play in the development of the NHST business plan and its strategic direction which underpinned the coaching style of corporate parenting,

> *"As an example the Trust produces a written negotiated corporate plan every year which has names and time frames in it. The other evening the NHST had a two hour session completing the final negotiation on completing the corporate plan for Trust. This was clinically focused, not business focused, and the people at this meeting were the Clinical Directors, along with the Executive Directors of the Trust. However, the major "shakers and movers" in this group are clinical. This pattern tends to repeat itself within the Trust"*
> (Chief Executive NHST D).

All the Clinical Directors were very much involved with the NHST's strategic direction according to the Chief Executive. All of the NHST's key planning groups were made up of Clinical Directors, or their representative clinical staff. The NHST had also established two short life working groups composed of Clinical Directors and Senior Managers. One group was carrying out a review of the NHST Clinical Directorate structure and configuration. The other group was examining responses to strategic alliances, mergers, and acquisition issues for the next year. This latter group was also examining the NHST's position in the revamped and reconstituted NHS post - April 1997, after the expected General Election.

Clinical Directorates and Contract Negotiation

A particular issue concerned the Clinical Directorate's involvement in the contract negotiations with purchasers. The BM's for the Paediatric Medicine and Surgical Directorates both said that contracting for the Directorates was done through the NHST's contracting team headed by the NHST's Director of Contracts. Although the Directorates did have an input, this was mainly specifying activity targets. The Directorates tended to be excluded when it came down to discussing money and they were unhappy about being excluded from this stage of the negotiation cycle as this could be when the negotiations became 'interesting'. This was again at odds with the BAMM et al (1993) recommendations. There might be, the BM continued, a maximum of 100 elective surgical patients. The purchasers could argue that they were prepared to pay the NHST what they paid last year for the NHST treating more patients (getting more activity for the same price), or they could argue that the NHST undertook less activity, but if it did this it would get less money.

> *"This is when the negotiations really get going, and it is when the activity that has been agreed all along the way suddenly gets changed. As a Directorate, we would want to become involved at this level in the negotiation cycle"*
> (Business Manager, Paediatric Surgical Directorate, NHST D).

This was confirmed by the Clinical Director for Paediatric Medicine. However, there were also areas of tension within the Clinical Director role and with the Directorate's consultants. This existed because the Clinical Director did not have the full opportunity to negotiate with purchasers therefore ensuring appropriate income for her Directorate. She said that all the

sub-specialties within her Directorate were organised and run as Clinical Business Units. They were wanting to enter negotiations with purchasers who *wanted* to negotiate with them, according to the Clinical Director. However, the Directorate was blocked by the NHST central contracting process. There was no flexibility nor opportunity for the Clinical Directorates to have an impact within the contracting system.

There also seemed to be a communication problem with the NHST senior managers and their Clinical Directors. The Clinical Director for Paediatric Medicine said that she did not know the policy of the NHST Chief Executive and Director of Finance when it came to purchasing and contracting. This would have been decided unilaterally between the two of them as the next contracting period approached, with little involvement from the Clinical Directorates. Within NHST D the Chief Executive was all powerful. This position was untouchable and it was not a personality issue. The Trust Board as a group of people did not have any influence or power. The Trust's Clinical Directors only had the authority and power the Chief Executive gave them, and the TMG had only the power that the Chief Executive allowed it. The Clinical Directors vision of her Directorate was that it would do all the contract negotiation with purchasers according to the service developments that were required. However, the reality was that as a Clinical Director liaisoning with other clinicians, she was prevented from working with this vision because of the contracting system operating. This effectively prevented the Clinical Directorates operating as strategic business units. To enable this to work there had to be commitment from the NHST's senior managers to allow the Clinical Directors and Directorates to operate their units and transform the NHS for the benefit of patients. The Clinical Director continued to state that the Chief Executive had set up two groups, one examining the place of the NHST in the market, and the other examining the re-organisation of the Clinical Directorate system within the hospital.

She questioned why two groups were set up instead of one. One could not operate without the other.

> *"What's a Clinical Directorate structure without a market?. If we as Clinical Directorates are to be strategic engines, there is no point in keeping us apart from discussions about the role of the Trust, or in terms of interacting with other major entities in the market"*
> (Clinical Director, Paediatric Medicine, NHST D).

Tables 28 - 30 at the end of the chapter summarises the organisational arrangements and development of strategic behaviour within the Clinical Directorates at NHST D.

Section 5: Evidence Relating to the Clinical Directorates of NHST E

Introduction

NHST E had 9 Clinical Directorates and had introduced Directorates in 1991 well ahead of what the Chief Executive called the "vogue encouraged by the so called Resource Management Initiative " (see chapters 1 and 5). The strategy forum was the CMT. The major advantages of Clinical Directorates, according to the Chief Executive, were that a management structure would be created which would be capable of exercising significant delegated authority, and there would be the direct involvement of doctors in management both at *operational* and *strategic* levels within the NHST. NHST E's Clinical Directorate management arrangement was different from NHST's A-D. There was not a Directorate Management team as such but a Directorate Management *structure* consisting of a Clinical Director, who was part-time, and a Service Manager (SM), nurses for bed-holding Directorates and PAM's for nonbed-holding Directorates, who were full-time. The Directorate management arrangements resembled the two-person pendant structure as outlined by BAMM et al (1993) in chapter 5. This was odd in relation to NHST's A - D, but illustrates that Clinical Directorates emerged in each NHST depending on circumstances and the particular contexts each NHST was operating within (chapter 5). Directorates were also set up before the hospital became an NHST, and may have served the organisation well in this form. The Directorates were in turn supported by a Business Support Manager (BSM, see Chapter 7) who provided business and strategic advice to the Directorates.

> *"A total of nine Clinical Directorates were established between 1991 and 1992 and these have proven to be largely successful. As a result* [NHST E] *has become a well managed, effective and very efficient hospital, with significant clinical involvement being an integral part of the process"*
> (Chief Executive NHST E).

The Chief Executive of NHST E was a great believer in devolved management. All the Directorates had budget devolution and their Clinical Directors were accountable for the budgets. The Chief Executive was of the opinion that this devolution of authority and

responsibility needed to be continued to be pushed down to Directorate level so that there were fewer levels of control from Corporate to Directorate level. Clinical Directorates had allowed doctors to become involved with the management of the hospital, and provided a mechanism to allow budget devolution to the clinical specialties. The Chief Executive said that the Directorates were allowed to spend their budget as they wished to deliver their clinical service, however, there were fairly tight reins on issues such as staff grading and staff recruitment. The NHST senior managers had added value by stand-alone influence and corporate development activities and the adoption of both a 'coaching' and 'orchestrating' parenting style. Budget management had provided an incentive in allowing the Directorates to develop their services. The decentralisation contract (see chapter 4) between the NHST senior managers and the Directorates had been made quite explicit to the Directorates.

> *"They have been given a certain degree of power to change things without it having to go higher, or just standing back and complaining that nothing ever happens"*
> (Chief Executive NHST E).

For the Clinical Director of Adult Medicine, the use of a Clinical Directorate was the best way to organise the work of the specialty. The introduction of Clinical Directorates and Clinical Directors had meant that someone could now be seen to have responsibility for the Directorate, could take blame if needed, and delegate responsibility. Everything concerned with the Directorate had to go through the Clinical Director. He also was much more aware of what channels to go through on behalf of the Directorate if needed. The most important role for the Clinical Director, he continued, was to ensure that the Directorate's consultants were committed and took a consensus approach to Directorate matters. He was allocated one session from the NHST for management duties, but probably spent around a fifth of his contracted clinical time on management areas.

The Clinical Director for the Head and Neck Directorate had some reservations over the tiers of management within the Directorates at NHST E. There was duplication of effort because both he and his SM had to reply to memos and requests for information. He saw the way forward as having BM's who covered several Directorates, and having Nurse managers who

dealt with ward administration. He also felt that his Directorate was isolated from the other Directorates within the NHST. There were no regular meetings or communication between the other Clinical Directors in the Trust except at CMT meetings, or when problems occurred. This lack of communication was due to time, as all the clinical directors were extremely busy in their management role while maintaining a clinical load. The official time allocation to the post was supposed to be 1 session per week. However, in reality he put in between 2-3 session per week to manage the five specialties within his Directorate.

Organisational Culture

The Chief Executive stated that main vehicle for the Clinical Directorates to become involved with the strategic direction of the NHST was the CMT. All the Clinical Directors were members of the CMT. In the past the CMT has had an annual 'away-day' to allow 'strategic thinking' to develop and to develop the NHST's strategic plan. This was an attempt by the NHST senior management team to add value through linkage influences and corporate development activities. However, this had not worked that well, the Chief Executive continued, because a number of Clinical Directors had difficulty in adjusting to the corporate role. The prevailing culture was to try to get as much for their own Directorates as possible,

> *"And when life becomes tough, they* [the Clinical Directors] *have had difficulty in slipping off their representative role of what they can get for their own Directorate"* (Chief Executive NHST E).

The prevailing culture at NHST E was the Directorates operating as distinct and separate 'firms' who did not want to affiliate to a much larger organisation. The Directorates did not have any shared values with each other. And when the senior NHST managers had tried to pull the Directorates together as a corporate body these tensions and problems had prevented this from occurring. Clinical Directors would appear to have to learn new management techniques and practices in light of the 1990 NHS reforms (Loveridge and Starkey, 1992).

The CMT had also become, argued the Chief Executive, less influential since the NHST Board began to operate properly. In the past year the Clinical Directors had become almost sidelined because the Executive Directors of the NHST had tended to work very closely

together. They were also all full-time managers, whereas the Clinical Directors were part-time and still had a full clinical load. This had led to the NHST senior managers rethinking the Directorate organisation and configuration. This will be discussed later.

The Clinical Directorate Strategy Process

NHST E was one of the few NHST's who did not have BM's attached to its Clinical Directorates, but instead had Service Managers (SM's) supported by a BSM. The BSM had been working her way around the NHST's Clinical Directorates. She used the strategic management tools of SWOT/PEST analysis and also examined the strategy of the local AHB and what services it would like to see developed. In this way each Directorate would be able to have a focus. These tools gave an indication of what each Directorate's environment consisted of in relation to the West of Scotland, although she said it was fairly obvious, for example, a growing demand in the community of services provided by the Directorates, and an ageing population. However, it did reveal some interesting things that had been forgotten. For example, the increase in the use of sophisticated procedures, such as endoscopy, had led to delays in their introduction because of the time taken to train staff. Some of the NHST's consultants had been very positive with this type of planning and identified where they were going and what the key issues were. However, there were other consultants who were not as keen, and there had been some hostility, as these clinicians felt the process was just another paper exercise and they had experienced many before.

Another problem was finding out what the capacity of the NHST was, where the NHST was at present, where it wanted to go in the future, and how it was going to get there. Not much thought had been put into this in the past. Some of the Directorates were very large with a number of smaller specialties contained within them. Part of the problem in relation to Directorate strategy, and NHST strategy in particular, was trying to balance where they all fitted in relation to each other. Rather than simply having a "wish" list of what each Directorate would like for the next year, which had been the situation previously, a more focused strategic planning outlook was now being developed. National programmes such as cardiac

rehabilitation and stroke initiatives all had to be considered at Directorate level. As the AHB's had to focus their purchasing in these areas, the BSM continued, this was where resources could be found to fund service developments. The Directorates had to examine their individual strengths, what they were doing well, what could be developed, and also the threats from other local hospitals who may have been providing a better service or wider range of services.

This had been particularly successful with the NHST's Head and Neck Directorate. It had conducted a SWOT analysis for Head and Neck services in the East AHB area, and discovered that there may have been an opportunity for developing a pre-school orthoptic service for North of the river. This was already being undertaken in a piecemeal fashion by NHST C in the City, but local GP's wanted a better service. The GP's were approached by NHST E on behalf of the Directorate and asked via a questionnaire whether they would support a revamped service provided by NHST E. The GP's overwhelmingly gave their support to this, and NHST E successfully produced a business case for the orthoptic service, presented it to East AHB who then agreed to fund the service. As a result NHST C lost the service. The core competency of this Directorate was in ophthamology/orthoptics. It had enabled it to access the market for these services North of the river. Although NHST C provided a similar service, it could not provide the service GP's were wanting, and NHST E had the reputation of good waiting times and prices for general clinical services. The Directorate's distinctive capabilities were thus in the relationships it had formed with local GP's (network architecture), and the reputation it had built up for good waiting times.

Clinical Directorate Organisation and Configuration

Of the five NHST's used in the research, NHST E was the only NHST which was actively reorganising its Clinical Directorate and CMT structure. The Chief Executive felt that there were *too many* Clinical Directorates. The balance between local identity and the difficulties of flexible working between specialties and different Directorates had led the NHST to rethink the structure. Clinical Directors were also finding it increasingly difficult to carry out their management responsibilities with the existing arrangements at the time of the research. This had led to a conflict of interest between their clinical and managerial roles. The Chief Executive described how the existing Directorate system had become less flexible, and there was the danger that this could be further reduced as pressure mounted to meet clinical aspirations, reduce costs and increase value for money. He stated that,

> *"Directorates more jealously guard their own budgets and staffing and can be reluctant to share, even though this might be in the best interest of the Trust as a whole"*
> (Chief Executive NHST E).

Of the 9 Clinical Directorates, the majority were seen as being too small to justify and pay for the managerial skills required to operate at the level necessary to be innovative and responsive to the environment within which NHST E operated. The number of Directorates were going to be reduced from 9 Clinical and 1 Support, to 4 Clinical and 1 Facilities[59] from September 1996. Value would be created by NHST senior management through linkage influence and corporate development activities using the 'coaching' and 'orchestrating' parenting style.

The Directorate management structures were to be replaced by Directorate Management Teams (DMT's). These DMT's would consist of a Clinical Director, who would be part-time, Lead Consultants from each specialty not represented by the Clinical Director, a Directorate Manager (DM) and a Nurse/PAM Manager, who both would be full-time. The Directorate management structure would be moving to the clinical triumvirate model (chapter 5). The

DMT's were to receive new management training, with the Clinical Directors and Directorate Managers in particular receiving training in areas such as strategic and business planning. Value would be created from the NHST senior management team's functional and services influence.

The NHST itself would have a "new" NHST management team, which would replace the old CMT. The new management team would be smaller than the existing CMT and consist of the four Clinical Directors and the Facilities Director, together with the five NHST Executive Directors. It was intended that this group would work much closely with the NHST Board, and there would be at least two occasions in the year where the new NHST management team and the new DMT's would meet and spend the day reviewing strategy together. The intention of this new structure was to bring the influence of the Clinical Directors much higher onto the agenda in terms of the NHST's strategic thinking, and of course working much more closely with the NHST Board.

At the time of the research, the Directorates could not actively attract new sources of funding. This was to change from September 1996, and the new DMT's would have the responsibility to generate income. Negotiations with purchasers would also be carried out by the individual Directorates from September 1996. There had to be a close working relationship with the NHST Contracts Director, the Chief Executive commented, but there would be no central NHST Contracting team. This would be a significant difference between NHST E and the other NHST case studies. It would also be much nearer the recommendations made by BAMM et al (1993). Directorate budgets would be based on a certain amount of business that the NHST was contracted to provide. If a Directorate under-provided this business, its budget would be reduced, if it over-provided business, and this resulted in additional income, its budget would be increased.

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[59] . The Support Directorate was non-clinical and included the estates and services department. These were renamed as the Facilities Directorate.

In this way, the Clinical Directorates would assume a strategic business unit model with income generation powers and would have a significant input to the NHST's strategy direction. Tables 28 - 30 at the end of the chapter summarises the organisational arrangements development of strategic behaviour within the Clinical Directorates at NHST E.

Conclusion

Clinical Directorates are new organisations which emerged within the case studies when the hospitals became NHST's, although NHST E had set them up prior to becoming an NHST. They can be best described as hybrid organisations attempting to combine clinical professionals managing a distinct decentralised management structure, including its budget, within a larger organisation.

This chapter has examined a number of factors associated with the Clinical Directorates of the NHST's used as case studies. The development of strategic behaviour was an important area, and it has been demonstrated that in general all of the Clinical Directorates followed much the same process in developing their strategies and used the same strategy models and tools. The individual strategies of the Clinical Directorates informed the strategic plans of their NHST's. With no exceptions, the main strategic direction and vision was developed at the level of NHST senior management as indicated in chapter 8. It has also been shown that the number of Directorates and their configuration would be undergoing change in due course. This has certainly been the result of the NHST's re-evaluating the role of their Directorates and striving to improve their efficiency both clinically and managerially. There was a need to have decentralised management arrangements within NHST's to operate with the 1990 NHS reforms, but in the case of NHST's A -E, the structure and configuration may not have been the most appropriate for the tasks required to work within the new NHS arrangements. This was similar to Ferlie et al's (1996) argument discussed in chapter 1 that public sector organisations were conforming to 'organisational templates' or structures because this was the done thing at this time. The Directorate organisation in this case was certainly an organisational template that four of the NHST case study hospital set up. This took time to develop through the NHST system and it was only after operating for 2-3 years that the weaknesses of existing configurations became apparent. The relationships between the NHST's and their Directorates varied considerably in relation to their decentralisation contract, particularly with regard to degree of control, responsibility, authority and expectations. This

indicated in places, a conflict of financial control with an intent to devolve management responsibility (chapter 3). Finally the issue of organisational culture emerged as a key theme in relation to the corporate identity and strategic development of the Clinical Directorates and their NHST's. This was particularly evident with the clinicians and their approaches to strategic management models and concepts. Chapter 10 will now discuss the findings from the empirical chapters 7 - 9.

Meanwhile we note a number of points that will be returned to in chapter 10.

- The most common Directorate management structure was the clinical triumvirate model;
- The strategic management models of choice at Directorate level was SWOT/PEST analysis;
- The resources of the Clinical Directorates could be identified as core competencies and distinctive capabilities using Prahalad and Hamel's (1990) and Kay's (1993) criteria;
- There were a number of corporate parenting styles in evidence, typically involving coaching and orchestrating the Directorates;
- In general all of the NHST's were considering reducing the number of Directorates, decentralising more decision making to them, and giving them more responsibility;
- Although the NHST Chief Executives gave the impression that they supported devolution of control and responsibility, this could be at odds with the impression given by their Directorates and;
- The Clinical Directors were often struggling with a combined role of clinician and managers which prevented them providing the leadership and strategic vision needed for their Directorates that chapter 5 indicated they should have been providing.

Table 27. The Management and Organisational Arrangements of the Clinical Directorate with NHST's A - E.

Clinical Directorates	NHST A	NHST B	NHST C	NHST D	NHST E
Business, Directorate, or Service Manager	BM	BM	BM	BM	SM supported by BSM
BM/DM/working with more than one Clinical Directorate	Yes, 2/3 to each BM	Yes, 3	No, 1 only	No, 1 only	No, 1 only
Number of Clinical Directorates within NHST	11	13	12	9	9
Clinical Directorate Management Team/Structure	CD, BM OSM	CD, BM NM/SM	CD, BM NM/SM	CD, BM NM/SM	CD, SM, supported by BSM
Clinical Director	Yes, part-time	Yes, part-time	Yes, part-time	Yes, part-time	Yes, part-time
Time allocated to Clinical Director for Management Duties	1 session, (4 hours)	1 session, (4 hours)	1 session, (4 hours)	1 session, (4 hours)	1 session, (4 hours)
Changes proposed in NHST Clinical Directorate Structure	Yes, pilot study proposed	No, but discussions underway	Yes, pilot studies planned	No, but discussions underway	Yes, complete re-configuration
Budget Devolution to Clinical Directorates	Yes	Yes	Yes	Yes	Yes
Clinical Directorates directly involved with contract negotiation	No	No	No	No	No
Model of Clinical Directorate	Clinical Triumvirate	Clinical Triumvirate	Clinical Triumvirate	Clinical Triumvirate	Two-person Pendant
Clinical Directorates seen as Strategic Business Units within NHST	Yes	Yes	Yes	Yes	Yes

Table 28. A summary of the strategic behaviour observed within the clinical directorates of NHST's A - E.

Strategic Approach	NHST Clinical Directorate				
	A	B	C	D	E
Planning (including objective setting)	✔	✔	✔	✔	✔
Five Forces: Threat of Substitutes - Bargaining Power of Providers (suppliers) - Bargaining Power of Purchasers (buyers) - Threat of New Entrants - Industry Competition -			✔		
Core Competencies: Access to Markets - User satisfaction - Difficult to Imitate -	✔	✔	✔	✔	✔
Distinctive Competencies: Architecture - Innovation - Reputation -	 ✔ ✔ ✔		 ✔ ✔ ✔		 ✔ ✔
Strategic Assets: Monopoly - Sunk Costs already made - Regulation/Licensing -	 ✔ ✔		 ✔		
Crafted	✔		✔		
Emerging	✔	✔	✔	✔	✔
Deliberate					
Stakeholder Analysis					
Competitor Analysis					
PEST	✔	✔	✔	✔	✔
SWOT	✔	✔	✔	✔	✔
Boston Box		✔			
Culture	✔	✔	✔	✔	✔

Table 29. A summary of the strategic options either considered or used by the clinical directorates of NHST's A - E

Strategic Option	NHST Clinical Directorate				
	A	B	C	D	E
Alliances					
Joint Ventures					
Diversification					
New Service Developments		✔			
Market Penetration	✔	✔			
Market Development	✔	✔			
Merger					
Porter's Generic Strategies: 1. Cost Leadership - 2. Differentiation - 3. Focus -					
Internal Development					

Chapter 10: Findings and Discussion

Introduction

This chapter will address the key findings arising from the research questions raised in chapter 6. The main research question asked to what extent were NHS managers, clinical and non-clinical beginning to act strategically within the NHS quasi-market in the West of Scotland? There were also six supplementary questions. These were: what was the nature of the market and level of competition developing in the West of Scotland?; what evidence was there of strategic behaviour developing within the NHST case studies?; what was the nature of the strategic management process within these organisations; where was the locus of strategic decision making within the NHST case studies?; what was the involvement of the Clinical Directorates in the strategic decision making process within the case study NHST's and finally; what was the nature of the relationships between the case study NHST senior managers and their Clinical Directorates?.

The chapter will attempt to answer these questions by focusing on two main areas:

- The main evidence relating to the key questions and;
- Conclusions from this evidence.

The chapter will be in four sections. Sections one will examine the nature of the quasi-market in the West of Scotland. Section two will examine the development of strategic behaviour at a macro level within the five NHST case study hospitals. Section three will examine the development of strategic behaviour, the nature of the relationship between the NHST senior managers and their Directorates, and the organisational arrangements within the Directorates of the NHST case study hospitals. Finally, section four will integrate the economic and strategy frameworks used in the thesis.

Section One: The NHS Quasi-Market in the West of Scotland

The empirical evidence reported in chapter 7 supports empirical work carried out elsewhere (Le-Grand and Bartlett, 1993, Walker and Craig, 1992, Ranade, 1994, Ferlie, et al 1996) and the literature on social aspects of market operation (Granovetter, 1985, 1992, Sako, 1992). Rather than an atomised market consisting of individual buyers (purchasers) and sellers (providers), the NHS market consisted of a number of 'players' who had developed a series of relationships with each other. There were a number of reasons which led to the market developing in this way. These reasons were as follows.

Market Structure

Although there were relatively large number of providers (see chapter 7), there were limited number of purchasers in the shape of both AHB's and GPFH's. In some cases one purchaser bought as much as 90% of an NHST's business. By increasing the number of purchasers the structure of the NHS market in the West of Scotland could have been improved. This would only have been achieved by increasing the number of GPFH's. However, as a result of the 1997 White Paper *'Designed to Care'* (SODoH, 1997) GPFH's are to be replaced by GP Co-operatives and Primary Care Trusts, so this can now be seen as an unlikely outcome. The number of AHB's could have been increased by dividing the existing configuration, particularly the larger ones such as East AHB and Ayrshire and Arran. This could have provided an additional five to six AHB's in total, but would have been unlikely given the 1996 Shields Report (see chapter 2).

A Relational Market

The NHS quasi-market in the West of Scotland could be described as a relational market that was socially and institutionally embedded. Although prior to the 1990 NHS reforms AHB's and their hospitals had close relationships, in general they were on a command and control basis. Relationships had formed between the AHB's and the NHST's, which although supposed to be mediated through contracts between these two organisations, often developed using

'softer' characteristics such as trust and reputation. Examples of this relational market included, West AHB and a City NHST coming to an 'arrangement' over the funding of drug treatment for a child, and East AHB and a City NHST coming to an 'arrangement' over a piece of equipment for a patient.

Market Information

As purchasers, the AHB's very often did not have accurate information concerning quality and price to allow them to make rational purchasing decisions. This information in many instances came from the NHST's themselves. This may have indicated that the NHST's either could not provide the information, or indeed were intentionally limiting the information they made available to AHB's so behaving opportunistically to take advantage of asymmetry of information (Williamson, 1985). AHB's, in general, continued to make block allocations to providers based on historical referral patterns, rather than using competition to allocate resources between NHST's, although East AHB did engage in a market testing exercise. West AHB in attempting to make sense of poor information applied a cost benchmarking exercise to average the prices that it was willing to pay to its NHST's. West AHB's considered view was that there would never be a real market for healthcare within the NHS. As a result of the reduced level of resources allocated to West AHB via the SHARE formula, one option West AHB could have pursued was to use its purchasing power to force its NHST's to compete with each other to provide clinical services. In this way West AHB could have extracted a high level of efficiency savings thus allowing it to live within its SHARE allocation. The Board decided though that this would not be the best way forward for healthcare provision within the City. It would have been damaging both politically and pragmatically to put some of the City's NHST's under severe pressure, as one or more of them could collapse. If West AHB had decided to take such an agenda forward its existing NHST's would also not have the capacity nor infrastructure, at the time of the research, to take on additional work from any NHST's who had 'lost out' under competition. This concurred with the ME who had indicated that the development of the NHS market in the NHSiS would be established through custom

and practices which were politically feasible within a healthcare system which was also a political system.

Evidence of a Market

Although in general, there was not much in the way of a competitive market operating within the West of Scotland NHS, some examples of competitive market behaviour were identified. The City AHB would occasionally tender some clinical services, but from the perspective that it was to specifically tackle hospital waiting lists, and this was resourced from the Scottish Office. Resources were made available because of the price averaging exercise and were used to provide some competition between the City NHST's (chapter 7). However, this was only for selected new service developments at the margins of the City NHST's core business. This was an example of institutional embeddedness (Ferlie, at al, 1996), where the market was 'managed' and structured by West AHB, competition being introduced as and when required.

East AHB had engaged in a more aggressive tendering exercise then West AHB for some clinical services, specifically orthopaedics. This AHB had also used 'contestability', one of Enthoven's key concepts (chapter 3), in a covert way to force another of its NHST's to reduce its prices for services. The NHST in question had information 'leaked' to it that the AHB was considering another market testing exercise, and as a result the NHST reduced its prices by 25%. This equated with what the ME said about markets and competition in the Scottish NHS, the AHB's *did not want* competition, but the mere *threat* of competition, *contestability*, although this AHB's considered opinion was that efficiency savings would only be made through the market testing of services.

A confusion could be observed within all the NHST case studies concerning the operation of a market and competition. The idea of competition at the margin as a sign of competitive behaviour was not always understood, and instead the competitive process was often envisaged as necessarily involving frequent marginal shifts in purchasing and supply of major

parts of an NHST's work. Although price competition was considered important by the NHST's, competition could also be based on other variables such as reputation and waiting times for clinic appointments.

To conclude this section, the conservative nature of the Scottish NHS at both the Scottish Office level (macro) and AHB and NHST level (micro) ensured that a fully operational market would never be possible within the NHS. In reality the process of resource allocation would continue to be managed, but with adjustments to squeeze out additional inefficiencies as opportunities arose within particular market segments. Nevertheless, there was evidence of contestability and some real competitive behaviour at the margins that did put pressure on the NHST case study hospitals to improve their efficiency. There were too few buyers and sellers and not enough information. The existing purchasers and providers formed strong relationships with each other which made the operation of the market difficult. Having examined the evidence relating to the NHS market as it developed in the West of Scotland, we will now examine the evidence relating to the development of strategic behaviour within the NHST case studies. Meanwhile we note a number of points:

- There were too few buyers and sellers to form a fully effective competitive market in healthcare in the West of Scotland;
- Market information was often poor or non-existent;
- There was no desire by the Scottish Office and the AHB's to engage in full blown market relationships and;
- Competition, where it existed, was only at the margins of an NHST's business. These were in areas where the AHB's considered that there would be very little political unrest.

Section Two: The Development of Strategic Behaviour with the NHST's

Introduction

The thesis seeks to determine the extent to which NHS managers were beginning to act strategically within the NHS quasi-market that was developing in the West of Scotland. The previous section highlighted a number of elements of this market and the level of competition. Leading from this would be the expectation that NHST strategies would be built around the perception of the market and the level of competition generated within it. This section will concentrate on two areas in relation to strategic behaviour. In the present context, chapter four defined strategic behaviour as *the range of strategic decisions than an NHST and its managers are pursuing within particular resources constraints: these decisions are arrived at by the interactions and influences of individuals and groups through a process, and which takes place within a context specific to the particular NHST.* Using this definition, the two areas to be examined in the section are the nature of the strategy process and the content of strategy within the NHST case studies.

The Strategy Process

All of the NHST's had engaged in some form of strategic planning. The form of strategic planning discussed in chapter four consisting of analysis, choice, and implementation, was not readily observable. It was also however, difficult to ascertain whether strategic planning was a deliberate strategic move or was required by the Scottish Office NHS Management Executive (ME). The ME had issued guidance in 1993, which was updated in the summer of 1996, that expected *all NHST's* in Scotland to develop and implement strategic plans. The plans had to be lodged with the ME providing a means of gauging the NHST's spending intentions, and evidence that they were providing services consistent with the requirements of their purchasers. Planning would therefore appear to have been an important aspect of the NHST strategy process.

Each of the NHST's operated within a specific context (Pettigrew, 1992, Schoemaker, 1993). Their outer contexts were broadly the same, the backdrop of the new NHS reforms and working arrangements. However, their inner contexts were substantially different and had an effect on their strategic processes and hence content of strategic decisions. The teaching NHST's in particular, were limited in the range of strategic options that were open to them. Strategic management would suggest that pursuing a low cost or differentiation strategy, for example, is an appropriate course of action for an organisation to take. However, there were wider social and political processes which prevented these NHST's from undertaking such strategies. Such strategic choices would impinge on other city NHST's and the wider plans of the AHB's, who often took an area wide strategy rather than the essentially local strategy of the NHST's catchment areas. The result was a limited choice, which had to take into consideration these restrictions. The majority of the case study NHST's tended to have to rely on one AHB for their funding, and as GPFH had not taken off in any meaningful way, the NHST's were essentially locked into long term relationships with the. The AHB's therefore had the power to dictate which services they wished to buy, see developed, and indeed the prices they were willing to pay (see section one). The NHST's, even if they saw an opportunity to develop services, would have to be guaranteed funding if such services were to go ahead. What emerged was often a series of complicated relationships between the NHST's and their purchasers. Some of these relationships could be traced back in time, particularly with the people involved which could give advantage to one NHST over other NHST's in relation to service developments. The political ramifications of the NHST's case studies withdrawing particular services was also observable. This again limited what they could do/not so and restricted the range of strategic management options demonstrated in the strategy literature that were open to them. If competition was to get off the ground in a serious way in this area, the AHB's would have to 'signal', and if necessary back up, their willingness to redistribute resources significantly. This would have been the signal in turn for the NHST's to respond to the competitive environment. However, all the indications were that this was not the aim of the AHB's perhaps conditioned by the ME, and the result was, at best, limited competition in marginal areas. The development of a serious transfer of resources by GPFH's

could also have been an alternative vehicle for a competitive environment to develop, but again this proved to be of limited value in this area. So, although in the early stages of the new NHS arrangements, with severe uncertainty concerning their environment, the NHST's had to face the prospect of developing a competitive strategy, the evidence fairly rigidly suggested this was not going to happen. Stability would be the guiding rule, catering for the political requirements of the Scottish context. This was enough to pursuade the NHST's to (eventually) take a more relaxed view of strategy, and to play on the stability theme, of which they would be reasonably sure – especially if they all played the same game. This might be expected in, for example, an oligopoly where the market was stable, and could be argued existed in the West of Scotland at the time of the research.

The NHST senior managers gave the impression that on the one hand they were using a tightly controlled and directive approach to strategy development processes, while on the other advocated a participative or empowering approach (Hart and Banbury, 1992). Culture had an important role to play within the NHST's in relation to their strategy development. Over the years, for example, a specific medical culture had developed and indeed had become embedded in the NHST's which had led to a tension or conflict between the NHST managers and clinicians who may have been pursuing different goals (Shoemacher, 1993). The managers were trying to grasp a new system of working, whilst the clinicians found the new system an anathema to their training and working arrangements, which were often individualistic rather than team based. This could be seen in attempts by the managers of one NHST to ensure that all its clinicians made tertiary referrals of patients to one City NHST, rather than to several for the same procedure. This illustrated Shoemaker's (1993) argument that strategic decisions are often pushed and pulled between context and planning, with the final decisions being a balance determined by circumstance, time, control, and goal alignment.

This new way of working for the managers could also be viewed as a learning process for them. They had *learned* through experience, and over time, how to see an opportunity or a threat, and had begun to form new relationships with AHB's and NHST's. AHB's wanted to

see services provided locally rather then have their patients referred to the City NHST's, but did not have the resources to do so because of SHARE.

The City NHST's were aware of this move and the associated ramifications and problems for them. They had actively sought out these AHB's and formed relationships with their NHST's which allowed their clinicians to carry out procedures in the city NHST's thus maintaining a supply of patients and the resource that went with the patients. This was an example of Hart and Banbury's (1994) concept of multiple modes of relationships, except rather than intra-firm behaviour, it was inter-firm behaviour involving many people in a series of incremental, participative, and empowering relationships. This *learning* continued as a result of Government policy regarding the move to a primary care centered NHS, a change in context which would have a bearing on the NHST's strategic processes and hence strategy content. The binary divide between primary and secondary care had led to power and resources being vested in the acute sector, but this was set to change. Managers in one of the NHST case studies were *learning* to adapt to this policy and were actively examining ways of adapting, developing and shaping their strategy to take advantage of this 'opportunity'. Part of this process involved appointing a primary care practitioner to their management team who could then advise the NHST on developing services with a primary care flavour and so attract income from AHB's as purchasers. This also indicated that the UK health care context could change, and in this case was politically and also technologically driven. This supports Pettigrew's (1992) work which has indicated that although context can shape the environment within which strategic process are arrived at, other factors are at play. It is often the interpretations of individual managers based upon their perception, learning, and what they remember that constrain and shape context and thus strategy development. NHST strategy, in this case would therefore have to evolve and develop based upon closer working relationships with GP's. Perceptions of GP's would have to change, and managers would have to learn how to manage these new relationships.

Mintzberg and Water's (1985) discussion of emergent and deliberate strategy in chapter four provides a useful aid in analysing the strategy process that was developing within the NHST case studies. The Chief Executive of one of the City NHST's, for example, indicated that its strategic process involved giving impetus to the Clinical Directorates for strategy formulation rather than working from some large deliberate, and potentially inflexible plan '*because life doesn't work like this*' (chapter eight). Strategy was thus also allowed to *emerge*. The fact that the NHS was also a political system (chapters one and seven) may also indicate that strategy would tend to emerge rather than be deliberate as change in the NHS has occurred at regular intervals in its 50 year history. Emergent strategy implies a learning process of what works and leads to some consistency or pattern. Strategic planning at NHST level could never foresee every possible change event or policy, and as each of the case studies has illustrated, particular strategies worked in a sense for each NHST.

The strategic processes of these organisations were also operating under an overall *umbrella* strategy that was determined by the Government through the 1990 NHS reforms. These NHST's faced a number of constraints such as the market, strategic boundaries in terms of the actions they could feasibly pursue, and they operated in an unpredictable environment which was *context* specific. The strategy process was thus partly deliberate, partly emergent, and indeed could be deliberately emergent. There were a number of constraints upon the strategy processes within the NHST case studies. These constraints developed as the result of social phenomena based upon history, the use of power, an embedded clinical culture, national and local politics, and the setting up of a series of relationships based upon social networks. These factors colluded to limit the range of strategic choices available to the NHST's and ensured that their strategy development processes could be long and protracted having to satisfy a number of stakeholder groups. This in turn would inform the content of their strategy.

Strategic Content

All of the NHST's had engaged in some form of strategic analysis which was perhaps related to the *expectation* that competition was going to take off in the West of Scotland. The large City teaching NHST's had conducted much more in-depth strategic analyses of their environment than the other NHST case studies (see chapter 8). This more detailed strategic process may have been related to the fact that both NHST's operated within similar markets and were centres of excellence for some clinical specialties. Income to these NHST's, unlike the other NHST's, could come from more than one purchaser, so these hospitals were developing strategies to maintain or attract additional purchasers. Apart from serving the City these NHST's provided clinical services to the West of Scotland, other parts of Scotland, and the rest of the UK with some overseas referrals. The inner context (Pettigrew, 1992) of circumstances, internal organisation, and scope of these NHST's were different to the other NHST's. Although all this implied that there was competition, chapter seven indicated that this competition was not so much for economic gains, but for status, power, security, and was driven by professional values.

Another significant factor was that both the Chief Executives of the City teaching NHST's had come into the NHS from management careers in the private sector. This may have accounted for the much richer strategic analysis carried out than within the other NHST's whose Chief Executives had spent all their management careers in the NHS. The Chief Executives of the City teaching NHST's would have been exposed to competition and market forces in previous organisations. This may have enabled them to think of strategy more in private sector terms than their NHS counterparts whose interpretation (Pettigrew, 1992) of strategy development was some what different from these Chief Executives. Although the differences were not major, there was a discernible approach to strategy which were observably different between the City teaching NHST's and the other NHST's.

Three of the NHST case studies had considered using elements of Porter's generic strategies of cost leadership, differentiation, and focus as strategic option to compete in the quasi-market. The context of the market had informed their strategy processes, which indicated that in content terms, cost leadership should be pursued. All of the hospital case studies had set out in 1993/94, when they became NHST's, to be come the cheapest NHST for clinical services in the West of Scotland using the *cost* of services as the basis for competing with other NHST's. This was in the expectation that competition would be on the basis of price alone. However, it became apparent to the NHST's that this strategy would not be successful for different reasons and by 1996/97 the NHST case study hospitals no longer pursued a cost leadership strategy. The ability of the NHST's to learn how to work within the new system was again becoming apparent. What is significant is that the learning was beginning to develop a *temporal* or time dimension. Over, a 3 year period, the NHST's strategic behaviour was evolving as they learned to work within the new arrangements and the 'rules' of the system.

The two City teaching NHST's would have a problem in reducing their costs and hence prices down to that of local DGH's for clinical services. This was because of their specific circumstances, their inner context (chapter eight). The NHST outside the City was the cheapest DGH in Scotland for its clinical services according to Scottish Office figures. It thought it could capitalise on this factor and use it as a lever to promote the hospital, treat more patients and so increase its contract income. However, the AHB's were purchasing services on the basis of historical referral patterns and through block resource allocations, as well as engaging in market testing exercises (chapter seven). Price, as a market signal, was not an influencing factor. The AHB's, as gradually became clear, were not taking into account the relative cost-efficiency of the NHST's. Any extra patients that the NHST's treated may not have generated additional income, and as a result some of the NHST's felt they were being penalised for being efficient in relation to the other NHST's. All of the NHST's therefore, while still viewing cost as an issue, came to recognise, and learn, that competition where it occurred would not be on the basis of price alone. This led to the adoption by four of the NHST's of Porter's generic strategies of differentiation and focus. These NHST's learned that

competition, where it existed, would be based upon other variables than price, for example, quality factors such as waiting times.

By far the most common tool used for strategic analysis was the SWOT and PEST model. This was probably because of its simplicity, but the NHST's indicated that in many cases they already knew what they were good at and what they could improve upon. Four of the NHST's had used elements of Porter's (1980) five forces model which proved useful to aid decision making. They had considered potential new entrants to the market such as other NHST's and private hospitals, substitute services such as community based care, and the power of purchasers such as an AHB averaging prices for clinical services and for strategic service changes. Two of the NHST's also saw themselves as potential new entrants to the market. The Porter model also provided information on possible threats to the NHST's, how vulnerable each of the NHST's were to other providers taking away some of their business, and whether they should concentrate in certain areas at the expense of others. Evidence of the NHST's using a resource-based approach to strategy was in many cases more implied than explicit and although this was perhaps more evident at Clinical Directorate level (micro), it could also be seen at NHST level (macro). The NHST's 'resources' could be used to form core competencies and distinctive capabilities.

There were a number of strategic developments that were open to the NHST case study hospitals. These ranged from market penetration and market development, to service acquisitions. Service withdrawals were not considered by any of the NHST's, partly because of political reasons, partly because of statutory reasons. Such decisions could only be made by the AHB's as purchasers. There were examples of services being moved around the City, but these changes were not based upon price competition. Innovations in service developments were demonstrated, particularly by the City teaching NHST's, and the NHST outside the City. None of the NHST case study hospitals had considered diversification as a means to develop services. All of the NHST's were actively pursuing internal development as

a means of building on their existing services. Of increasing importance was the move by all of the NHST case study hospitals to form strategic alliances and joint ventures. Strategic alliances and joint ventures could be seen as typical strategic management responses, for example, to reduce the level of rivalry and competition and as a means by which the NHST's could gain access to new facilities equipment and markets. However, what was becoming more implicit was alliances and joint ventures due to political reasons. A General Election was coming in to the horizon, and the overtures from the Labour Party concerning the NHS was that there would be a move away from competition to co-operation if they came into power. The moves by the NHST's could have been pre-empted by future developments (see chapters one, two and eleven). This argument would also support the debate that the NHSiS had a more conservative nature than the English NHS, and a lack of support for the 1990 NHS arrangements.

The Key issues to emerge from this section are:

- Strategy could be deliberate [and] or emergent depending on the circumstances of the NHST case study hospitals;
- The strategy processes within the NHST's illustrated the development of a complicated social nexus based upon relationships influenced by power, culture, history, politics, and organisational context;
- Strategic analysis was carried out using predominantly SWOT/PEST models, some application of Porter's five forces model, and generic strategies;
- The use of a resource-based approach to strategy was implied which complemented the positional approach the NHST case study hospitals;
- There was an adaptive learning process going on within the NHST's. The initial uncertainty about what competition might mean for them, and the growing recognition that broad stability would remain the order of the day, led to the adaptation of strategic behaviour to accommodate this realisation and;
- The observations of strategic behaviour were taken on a real-time dimension and time was becoming a significant factor in understanding this behaviour.

Section Three: Strategy Development within the Clinical Directorates, and Clinical Directorate/NHST Relationships

Introduction

Chapter 5 suggested that Clinical Directorates would be the strategic engines of their NHST's, and Clinical Directors in particular, would have influence over the strategic direction of their Directorates and NHST's. The issues, in relation to the Clinical Directorates were: the development of strategy at Directorate level; the level of centralisation vs decentralisation; the structure and configuration of the Directorates within the NHST case studies; contract management and negotiation and; the time available to Clinical Directors to enable them to carry out their roles. These issues will now be discussed in turn.

Strategic Development within the Clinical Directorates

The strategy process within the NHST case studies was continually negotiated and bargained over. This was demonstrated by the Clinical Directors bargaining and negotiating with their NHST senior managers. At NHST 'away-days', the clinical directorates often gave their own view of service developments and opportunities that they considered their NHST's should fund, and their NHST senior managers gave their view of the world that the hospital operated within (chapter 8). This was similar to Pettigrew's (1992) analysis describing that it was often the interpretations of the actors involved with the organisation that helped to shape the strategy process. Often the final result would be decided by negotiation and bargaining. This illustrated Hart and Banbury's (1994) discussion of a 'systems' approach to strategy which involved the whole organisation and the relationships which developed therein. Externally this was demonstrated via the Chief Executives of the NHST's lobbying the AHB's for additional resources.

In general the involvement of the Directorates in the NHST strategy and decision making processes was seen to be limited and the control over many key NHST strategic issues remained strongly vested with NHST senior managers, especially NHST Chief Executive's. This again can be informed by Hart and Banbury's (1994) discussion of patterns of interaction between managers and employees. There was evidence of their 'modes' or processes of strategy decision making. Symbolic by giving Directorates a management team to run their 'businesses', translative in providing the Directorates with the template of the NHST strategic plan to work with, and generative via input at away-days. There were therefore multiple modes of strategy processes. While the NHST Chief Executives indicated that the Directorates were given a degree of freedom indicating a participative and empowering strategy process, there was also evidence of more directive and controlling 'modes' in operation.

It can also be argued that the decisions and responsibilities that the Clinical Directors were taking were not 'strategic' but operational. None of the Clinical Directors interviewed stated that they had any corporate role of significance within their NHST's, although they gave the impression they certainly were key managers within their Directorates. Although the focus of the thesis was the strategic involvement of managers, including clinical managers, not all decisions in the NHST's were corporate or strategic. This is particularly true if 'strategic' is taken to imply the development of policies constructed under an over arching or 'umbrella' strategy. Although none of the Clinical Directors interviewed operated at corporate level, they would have a strategic role to play in their NHST's.

Many Clinical Directors also felt that at their NHST strategy forums, important decisions had already been made for them. They did not have enough time to give an opinion or input to the NHST's strategy because of both their time constraints and the lack of training. Although each of the NHST Chief Executives indicated that their Clinical Directors had the opportunity to influence the strategic direction of the NHST's, this was often at odds with the views of the

Clinical Directors. There was almost certainly an element of the use of power at work here, as the NHST senior managers appeared to take most of the strategic decisions on 'behalf' of the Directorates.

The NHST Directorates, their Chief Executives and Directorate BM's indicated that the particular culture of the clinicians presented an obstacle when either developing or trying to implement NHST or Directorate strategies. This manifested itself in two ways. Firstly, the professional values of the clinicians, who wished to treat all patients who were referred to them, were different to the business values of the NHST managers who wished to keep to contracted levels of activity. Secondly, when Directorate BM's attempted to involve clinicians in strategic analysis, the clinicians did not feel that such approaches were appropriate for a health care setting. This may have been due to the clinicians not being well versed in management principles and indeed their training processes emphasising individual working practices rather than team work and shared decision making. The medical culture as described in section two was often embedded in the NHST and could prevent the progress of strategy developing within the Directorates. The initial setting up of the Directorates often reflected existing specialisms where power bases continued to be maintained and be built. The strategy development processes of the Directorates could therefore be dependent upon internal politics, power, and culture (Pettigrew, 1992), and as a result could have been a compromise.

With reference to strategy content, in each of the NHST case studies the commonest form of strategic analysis at Clinical Directorate level was undertaken using the SWOT and PEST models. One Directorate had used the Boston Box, another was beginning to experiment with a Porter Five Forces model. There was also evidence of Directorates using a resource-based approach to strategy by identifying their core competence and distinctive capabilities. The strategy process did not vary much between NHST Directorates. This typically involved using the previous years activity levels to plan for the following years activity and any proposed new service developments. Occasionally Clinical Directors would come up with an idea and ask

their BM's to develop a case for funding, or find a way to incorporate it into the Directorate's existing portfolio of activities, so strategy could also emerge. Generally, new service developments proposed by the Directorates would have to be presented to the NHST Board for funding approval. Often this would occur at NHST "away days" where the Directorates would put their cases to the NHST senior managers.

Centralisation Vs Decentralisation of control

The NHST system was financially led and if increased activity by the Directorates resulted in additional work carried out over the agreed contractual limits, their NHST might not be paid. This may have been ultimately responsible for the limited degree of freedom enjoyed by the Directorates, and the style of management used by the NHST senior managers. Although the NHST Chief Executives indicated that a coaching or orchestrating parenting style was often employed, in reality a very strong controlling parenting style was. This was perhaps due to the realisation by the NHST senior managers, that the new arrangements would be based upon stability and steady state. As such the clinical directorates may have had to be reined in a bit more to prevent them upsetting the system. The NHST senior managers were doing most of the contract negotiation with purchasers. They might have not been providing the clinical directorates with all the information on these negotiations, but enough to allow the clinical directorates to work within the new arrangements. The Chief Executives of the NHST case studies although implying that decentralisation was the order of the day and more decision making should be devolved, nontheless demanded that short-term annual financial targets be met. The problem over centralisation Vs decentralisation may have arisen over role ambiguity between the NHST senior managers and the Clinical Directorates. The senior managers had definite views on the role of Directorates and where they fitted into the NHST organisation, however, this view was not always shared by the Directorates and they often had a different view to what they should be doing. It could also be argued that the clinical directorates were not being allowed to see the whole picture as it affected their NHST's.

Structure and Configuration of Clinical Directorates

Four of the NHST's had set up Clinical Directorates soon after becoming NHST's, the non-City NHST having set them up in 1991 two years prior to becoming an NHST. In the majority of cases the groupings of clinical specialties within a Directorate was based on history and internal politics, rather than being based upon any strategic agenda. The number of Directorates within the NHST case studies varied between 8 and 13 and could be very diverse in relation to the specialties represented within each NHST. Groupings of specialties were also not related in some cases and this caused problems in relation to strategic direction. Internal politics often played a part especially when it came to sharing staff and ideas. The fact that all the City NHST's were considering a reduction in Directorate numbers and changes to configurations with different roles and responsibilities may have indicated that the existing configurations were taken when the hospitals became NHST's, without sufficient consideration of the future ramifications of their role and responsibilities. This may, however, have been done in the expectation of a more recognised active form of competition. Once it became clear this was not happening, and that a strong central steer was probable, the decentralisation emphasis could be reduced. Over time, and with experience, these sub-unit organisational structures had evolved, and would continue to evolve in ways that would allow them to provide efficient clinical services and contribute to the overall strategy of their NHST's.

Contract Management and Negotiation

The degree of involvement that the Directorates had in contract negotiation with purchasers was fairly consistent. On the whole, all of the contract negotiations were carried out centrally by a contracts and planning department at each of the NHST's. This was a significant issue for the Directorates, as they felt that they were simply told the level of activity that had been agreed between the NHST and the purchasers. If they had more involvement with the purchasers they felt that the purchasers would become more aware of the complexities of the clinical services and indeed the individual work of the Directorates. This lack of involvement may have been linked to the fact that the Directorates were not involved to any degree with

the strategic direction of their NHST's. If they were they might have had more involvement in the negotiations with purchasers.

Time available to Clinical Directors

This key factor suggested that the Clinical Directors were not allocated enough time to allow them to manage their Directorates and have an input to their NHST's strategic direction. All of the Clinical Directors interviewed carried out a combined role of a part-time manager for one session per week, while maintaining full clinical load. They managed their Directorates with budgets of between £5M-£15M. The NHST's allocated one session per week to the Clinical Director management duties, which together with a clinical load was extremely difficult to carry out on their allocated time.

The Key issues to emerge from this section are:

- The Clinical Directorates had little involvement in determining the strategic direction of their NHST's. The process tended to be based upon the development of a series of relationships between the Directorates and NHST senior managers with limited empowerment and participation with a backdrop of control and direction.
- The degree of corporate parenting varied between each NHST, and although the NHST Chief Executives indicated that this tended to be that of a coach and orchestrator, the controlling style was evident in all of the NHST case study hospitals.
- There was a conflict of interest over the professional values of the clinicians of the NHST's and the business values by their NHST managers.
- This led to a role ambiguity between the NHST senior managers and their Clinical Directorates in relation to specific functions and operation of the Directorates;
- The time allocated to Clinical Directors was insufficient to allow them to carry out a combined clinical and managerial role;

- All of the NHST case study hospitals were re-examining the organisation, management, and configuration of their Clinical Directorates. This process was adaptive and was part of an on-going learning experience for the NHST's.

Section Four: Combining the Economics and Strategy frameworks

This chapter has discussed three main areas in relation to the empirical evidence of the thesis. These were: nature of the NHS market developing in the West of Scotland; the development of strategic behaviour within the NHST case studies as a result of this market and; the operation and development of clinical directorates within the NHST case studies. This section will now use these three areas to integrate together the economic and strategic concepts discussed within the context of the thesis.

Economics tells us something about the nature of markets and competition. This is essentially concerned with resource allocation and the types of approaches that have been developed to analyse the function and operation of markets (chapter three). Strategy is often seen, or can be viewed as, a means to deal with competition between rival firms in the market place (chapter four). The literature would suggest that the NHS market is 'relational' with relationships developing between NHST's, Health Authorities and GPFH's (chapter three). The strategy observed developing between the NHST's case studies in this thesis were a direct response to the particular type of market demonstrated - a relational market - which supports the literature (chapters seven, eight, and nine). This strategy evolved from the perceived expectations of the NHST case studies of how competition would unfold within the new NHS arrangements. The context of strategy and competition was an important factor in this analysis. It was not the intention of the research to develop a new theory. However, a theoretical framework can be offered which could explain the phenomena observed, and link the various threads operating within the NHS relational market in the West of Scotland.

The key to this analysis is the relational market. The NHST case studies were seen to be developing strategy within a relational market with 'constraints'. This was supported and is consistent with the empirical work. Strategy over the four year period of the research emerged, changed, and evolved from generic approaches, to approaches based upon alliances, co-operation, and joint ventures.

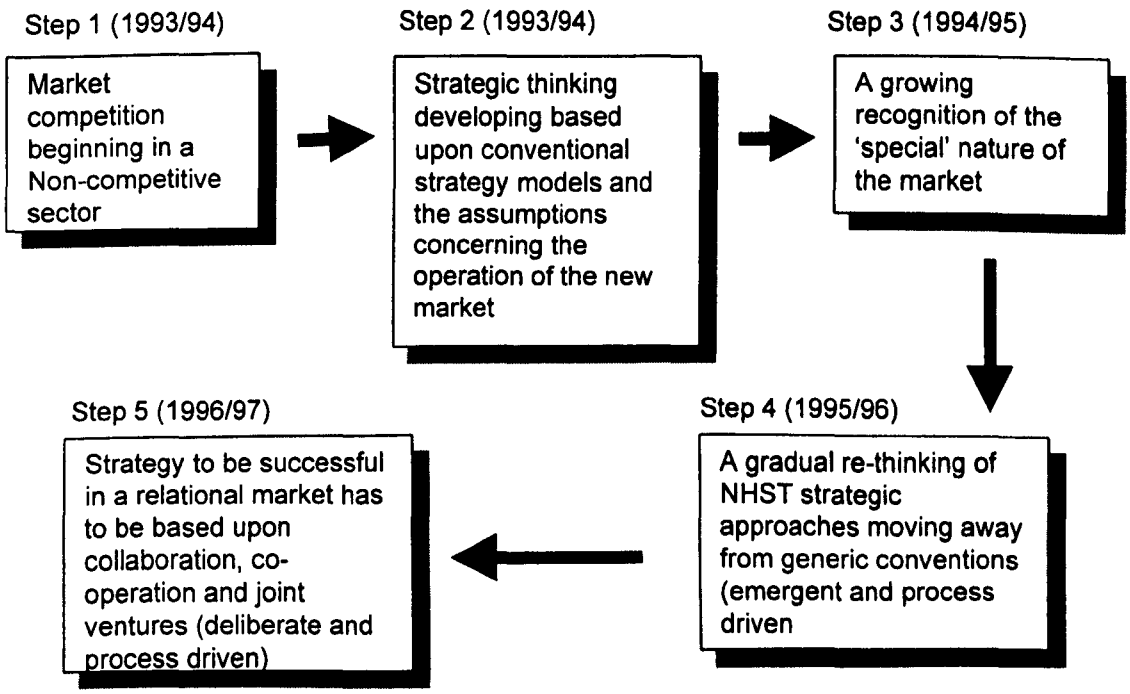
This initially was between the NHST case studies and the AHB's. However, these subsequently developed between the NHST cases studies and other NHST's. There was a certain degree of change undergoing during the conduct of the research, with the researcher continually re-visiting the NHST case studies over a time period of 2-3 years. The key to understanding this change was the time factor. The research was essentially carried out in 'real' time within the NHST case studies. This allowed strategic behaviour to be observed developing, adapting, and emerging as the NHST's learned to operate within the new arrangements. This change was both in their strategic behaviour and internal working arrangements.

Any change has receptivity associated with it. Receptivity itself can be considered to consist of two factors, incentives and ability. When the NHST case studies were moving away from generic approaches to strategy development, their take-up of strategic approaches would depend upon incentives and ability, but also the restriction of the relational market. There was the incentive to compete 'aggressively' for resources from AHB's, and where they existed GPFH's, as purchasers. However, in reality competition was only occurring at the margins. Ability may have been restricted by the lack of business skills of the NHST case study senior managers and clinical directorates, apart from the Chief Executives of the two City teaching NHST's. Then again, there could have been ability, as demonstrated by the NHST's actively pursuing a low-cost strategy, but having no incentives to pursue this strategy in so far that they were rewarded by more resources from the AHB's. As a result, the NHST case studies

pursued other strategies and over time. had begun to form or had formed relationships with AHB's and other NHST's.

If we now return to economics, we then can see a stable oligopoly, the NHST case studies, with no 'players' able to make changes. The NHST case studies were all equally powerful or weak due to the rigidities of the NHS resource allocation system. Apart from political considerations (see section two), this could explain why the NHST case studies were moving from competition to collaboration: there were no incentives for them to act otherwise within the new arrangements. This can be illustrated in figure 20.

Figure 20. The evolution of strategic thinking within the NHST case studies.



Steps 1 – 5 indicate the move away from generic strategy approaches based upon conventional models associated with a competitive market. In brackets is the time sequence, between 1993 until 1997, which in the context of figure 20 indicates that the NHST case studies were learning to adapt their strategic behaviour to the emerging operation of the new NHS arrangements. The significance of strategic processes discussed in section one are also included in figure 20.

The internal structure of the NHST's had been designed based on 'off-the-shelf' models of clinical directorates in the majority of the case studies. These structures were designed to allow the NHST's to operate within the new NHS arrangements and the market and competition that was expected to follow. However, as time went on it became apparent to the NHST case studies that the exact nature and operation of the new system was not based on a fully competitive market model. This in turn had in one NHST case study NHST reconfiguring its clinical directorates to cope with the developing relational market.

There had also be discussions concerning the re-configurations of the clinical directorates of the other NHST case studies. This was demonstrated by the NHST Chief Executives indicating their clinical directorates had much freedom and autonomy, but on the other hand the clinical directorates stating that this freedom was restricted, and in some cases an illusion.

Strategic behaviour developing within the NHST case studies therefore could have developed as a direct result of the relational market and the restrictions that came with this market. The new arrangements, over time, developed and became more stable, rather than a free for all that economic theory consisting of a market and competition would suggest. There was a strong interaction between the relational market and the evolution of NHST case study strategy. Strategy was important, but it was different in relation to outcomes. Although strategic behaviour can be about securing [and] or maintaining resources, the process of developing suitable strategies took on more meaning and significance, especially as the new system operated with constraints. Had the new NHS arrangements led to a more fully competitive market we may have seen the emergence of strategy based upon such a market.

Chapter 11 will now form the conclusions of the thesis.

Chapter 11: Conclusions

Introduction

The 1990 NHS Reforms introduced an internal or quasi-market into the NHS, and led to a number of structural changes including the formation of NHST's. NHST's were to compete with each other for resource allocations from AHB's and GPFH's as purchasers. In this way the NHST's would examine ways to improve their efficiency in relation to the provision of clinical services. NHS managers in these NHST's for the first time were now in a position to develop strategies for their organisations to secure resources from purchasers. It has been demonstrated that NHS managers, if given the opportunity, can think and act in a strategic manner. This was seen at both senior NHST manager level (macro) and at Clinical Directorate level (micro). There were a number of similarities that all the NHST case study managers were considering in their individual strategies, but also a number of differences. The argument of this thesis is that these differences are the result of the individual contexts each NHST was operating within. In a sense they were operating in the same external context, though they may have perceived it differently and also learned the reality of this at different rates. The important point is that the internal context of the NHST's, such as their configurations and the opportunities that were open to them were different. It is also to be remembered that the NHS is a national organisation and a political organisation. There was a limit to the extent to which NHS managers would be 'free' to develop a full strategic management framework given that resources were limited and NHS managers felt that in many instances they would not be allowed use a full strategic management framework because of the political repercussions that this could throw up.

Although the thesis was not designed to evaluate the success of the 1990 NHS reforms, a number of observations could be made. Separating the managerial control of the hospitals and allowing the hospital managers a certain degree of freedom from the AHB's via the

purchaser/provider split did force managers to seek efficiency savings. However, this has to be seen in light of a number of factors. Irrespective of competition for services between NHST's, all hospitals were required by the ME to make annual 3% cash releasing efficiency savings and 3% would be reduced from their budgets each year. The limited competition would not itself lead to savings in efficiency as intended by the 1990 NHS reforms, although it could be argued that competition was intended to yield better allocative efficiency. Efficiency savings were seen in other ways such as the City AHB averaging the prices offered to the City NHST case study hospitals. This forced the more expensive NHST's to examine their efficiency, but again they were given support from the AHB to gradually improve their efficiency. This though, seemed to improve the x-efficiency of the NHST's. NHST's were to seek ways themselves to improve their efficiency, rather than be assisted by their purchasers. This was a particular weakness of the 1990 NHS system as it operated within the City resulting from a combination of a lack of the political will for competition by the AHB, poor market information, too few purchasers, and the AHB funding formula.

The internal market worked in places (around the margins) where the AHB's wanted competition to occur and we saw some very good examples of this. This was an expected benefit of the 1990 NHS reforms. To have been more successful the internal market would have needed significantly more purchasers, either Health Authorities or GPFH's who had access to better information. Scotland has only 15 AHB's, whereas in England there are over 140 Health Authorities. GPFH in Scotland developed in specific clusters but was not comprehensive enough to provide large numbers of purchasers who could create the stimulus of competition between the NHST's.

The 1990 NHS reforms also provided hospital managers with the opportunity to actually 'manage' for the first time and to mimic the behaviour of managers in the private sector. This was, however, only partially successful because of the restrictions and regulations imposed by the Scottish Office on the operation of the NHSiS.

In chapter four a definition of strategic behaviour, in the context of the thesis, was given as: *the range of strategic decisions than an NHST and its managers are pursuing within particular resources constraints: these decisions are arrived at by the interactions and influences of individuals and groups through a process, and which takes place within a context specific to the particular NHST.* The NHST case studies seemed to be using a rational planning approach to strategy development which was seen in the analyses carried out. However, the they often had to back-track as information might not have been available, be inaccurate, or because of political reasons certain strategies would not be allowed to be pursued. Not all developments in the future could be foreseen. Strategy was part of a learning process which developed incrementally and allowed the NHST's to make sense of very complex environments, relationships, and situations which evolved over time. In effect the NHST's learned to cope with their environments, adapted, and then shaped themselves to specific contexts. Strategy was also informed by the culture of the NHST's. Social norms evolved and developed into a paradigm, new working relationships formed, aspirations of the NHST's were framed, and cognitive maps shaped in light of the growing awareness of what competition meant – and did not mean. Political, cultural and learning dynamics (Johnston, 1988, 1990) left the NHST's in effect with little power over the system that the Conservative Government introduced.

The NHST's attempted to work with the new system and strategy developed more as the result of the often chaotic internal dynamics of the new NHS, rather than via any formal rational strategic planning. The NHST's initially considered strategy development from a standard 'textbook' approach, and when this did not give the desired results, they moved to an approach based upon organisational learning and adaptation to the new system. This often involved building new relationships with the AHB's and between NHST's, again when it became apparent that the operating parameters of the new system was that of a steady state with limited competition.

Significantly the NHST's could not have developed strategy in any other way. The new system culminated in 1996/97 and there was then the realisation by the NHST's that a change of Government was likely. The Labour Opposition were making overtures that competition in the NHS would be a thing of the past if they were elected, and co-operation would be on the agenda. The NHST's were in effect pre-empting this move away from (limited) competition and developing relationships based on a co-operative approach. The political climate in the Scottish NHS may have also had an effect in so far as the culture of the Scottish NHS was such that the idea of competition between hospitals was an anathema to many of the managers and clinicians who worked in the organisation. Competition, where it existed was seen as more of an 'English' phenomena for an English problem.

What this demonstrates is that organisations, in this case NHST's, are very complex social systems comprising many stakeholders - groups and individuals who could be pursuing their own agendas. Strategy development in these circumstances is therefore an inherently political process which is shaped by the history, culture and the power distribution of stakeholders. These organisations also operate within a context (internal and external) which then impinged on their strategy development processes. In this way context shaped the NHST strategy processes, which then in turn informed the content of their strategy. These are issues that the strategy literature is only now beginning to acknowledge. Of some significance for the research was that the content and the process side of strategic management were seen to be operating together, rather than being separate. This is a key conclusion and observation, both content and process are not mutually exclusive as some of the strategy literature indicates, but have to operate together. Again of significance is the time element that saw the NHST's over a 3-4 year period adapting their strategies to 'fit' with the NHS arrangements. This allowed the observation in 'real' time of the adaptation and learning processes that unfolded within the NHST case studies between 1993 and 1997.

This highlights again how important strategy processes are within organisations, the degree of influence that many factors can have in this process, and the eventual content side of strategy that is a product of the strategy process. Examining the resource based approach to strategy as highlighted by Schendel (1992) in this research has brought strategy content and process closer together and is consistent with Pettigrew's (1992) argument that both are inseparate.

We saw frustrations on the part of NHS managers and clinical directors because they were not allowed complete freedom to 'manage' and had, for example, to taper the activity of their hospitals because they would not get funded for additional work undertaken, or were not involved with contract negotiations with purchasers. Another weakness of the system was thus observed. Although money should have followed patients, it was the case that patients were following the money, and NHST's were not being rewarded for their efficiency. The research though, suggests that strategic management concepts and models that have been developed in relation to the private sector can also be applied in the public sector, although they may need to be adapted because of the specific *context* of the public sector and NHS in particular. This was seen in the overarching ability of the resource allocating organisation (the Scottish Office) to control or regulate, in a way not generally applicable to the private sector, except where regulatory institutions are in place.

Another interesting factor which arose because of the 1990 NHS reforms was the acceleration of the creation of decentralised management structures, the clinical directorates, within NHST's. They also were an important structure in relation to the environments that each NHST operated within. This was demonstrated in the differing structures and reporting mechanisms between each NHST. These management structures consisted of their own management teams which involved clinicians in the management process of their clinical specialties and allowed faster decision making to occur nearer the patient than would have been possible under the previous management arrangements. This empowerment was an unexpected benefit of the reforms.

These management teams had also considered the strategic development of their 'businesses' so this allowed the observation of strategy development at a second level within the NHST case studies and the nature of the relationships between these decentralised management structures and the NHST senior managers. We saw a weakness emerging from these arrangements. We observed an unclear articulation of the Directorates into the overall NHST strategic agenda, which in some instances led to a mismatch between the goals and objectives of the Directorates and their NHST's (Schoemaker, 1993). This was particularly noticeable with the NHST clinicians who wanted to treat patients, and the managers who wanted to keep within budgets. The lack of involvement in the contract negotiations with purchasers led to the frustration of the clinical directors and their BM's. There was a distinct lack of integration of the Directorates into the NHST system, which led to these problems. Although all of the NHST Chief Executives indicated that their clinical directorates, and clinical directors in particular, had the opportunity to engage in the strategic agendas of their NHST's, there was little evidence to suggest that they did. It appeared that strategic decisions were taken on 'behalf' of the Directorates by the NHST senior managers with little involvement by the Directorates. This though, may have been the result of the realisation by the NHST senior managers that the new NHS arrangements were to be based on stability, and so their control over the clinical directorates thus allowing some form of stability further down the organisation is not such a surprise. Of significance was the role of the clinical director. Clinical directors were to provide leadership, vision and strategic direction for their Directorates *and* have an input to the strategic agenda of their NHST's. This would have been an extremely difficult, if not impossible act, to accomplish under the existing arrangements because many carried out their role as clinical director on a part-time basis, while still maintaining a full clinical load.

The role of the clinical director was perhaps not that well defined nor understood. In relation to strategic issues, it was important to view their Directorates and NHST's in the wider context of the NHS environment in which they operated. However, clinical directors could tend to focus on narrow professional concerns, and this undoubtedly led to a failure to think and act in

the manner that was expected to be associated with the role of clinical director in a effective competitive model. There may well be an argument that clinical directors and their Directorates should not have been involved with setting the strategic agendas of their NHST's, as their time could be better spent on patient care. Instead such matters should legitimately be confined to their NHST senior managers who were full time and they would consult with the clinicians concerning strategic decisions so would be adding value to their organisations. Perhaps the expectation that clinical directors would be willing and equipped to take on a strategic agenda was unrealistic. However, this is a rather simplistic solution to a problem which fails to see the need to involve those who are making decisions concerning patient care with the strategic dimensions as these key individuals from the link between the patients and the managers of the NHST's. Invariably this surfaces as a battle with lay managers and health care professionals over control and power. There is no easy answer to this issue. Perhaps having clinical directors with reduced clinical loads and NHS managers making allowances for this, or having a reduced number of Directorates per NHST with four or five clinical directors involved with the senior managers in strategy formation could improve things. All options were problematic.

There was the opportunity to make some broad comparisons between the Scottish NHS and English NHS in relation to the 1990 NHS reforms. The Scottish NHS is organised and managed differently to that of England. The particular culture of the NHS in Scotland appeared not to welcome many of the 1990 NHS reforms such as the internal market and GPFH's. This was most noticeable with the clinicians, but could also be detected among the civil servants at the Scottish Office and senior NHS managers at AHB and NHST level. The Scottish NHS has always been politically more stable and with a stronger ethos of concern for management in the public interest, rather than efficient management stimulated by market signals.

Scotland also tends to receive its own White Papers outlining Government policy. This appears to have been the case with the 1990 NHS reforms. The geography of Scotland, for example, renders much of the 1990 NHS reforms meaningless. There are only two major Cities that had large numbers of provider NHST's. Private medicine is also less established in Scotland than in comparison to England, and this may have accounted for the lukewarm reception of the clinicians in Scotland. With the exception of the 1989 Community Charge legislation, Scotland has often lagged behind the rest of the UK in relation to legislation and the adoption of new organisational arrangements resulting from Central Government policy. The contributions of this work to the literature is therefore the examination of Central Government policy within a *Scottish context* and the issues and problems that were observed in the policy implementation process. This is of importance since it is clear that the Scottish NHS is different from the rest of the UK NHS and as such merits separate study and evaluation. It also supports the strategy literature which indicates that strategic management develops within a particular context which in turn influences both the process and eventual content of strategic decisions within organisations.

The researcher made a number of conclusions concerning the conduct of the research. The research was conducted exclusively within the acute sector of the NHS in the West of Scotland. It may have proved beneficial to have used, as a comparison, a community based NHST as a case study. This may have thrown up interesting issues in relation to organisational strategy and design as community based NHST's tend to be more diverse in their operation and geography, often being spread over much larger geographical areas. However, researching management issues within the NHS is fraught with difficulty considering that it is a political system, and access however limited has to be seen in this light. Access was granted to five NHST as case studies. The researcher was going to initially concentrate on three NHST's as case studies, but having gained the support of the NHST's, access to key individuals within these organisations proved difficult. In some of the NHST's, access to clinical directors was straightforward, but access to NHST senior managers was more difficult.

In other NHST's the opposite occurred. After a period of time the researcher eventually gained access to key people at the five NHST's, and because of the richness of the data decided to use as much of it as possible.

If repeating the process, the researcher would probably have conducted the research in the same way involving the same people, but attempted to access more of the Non-Executive Directors of the NHST's. The Non-Executive Directors were part-time and were to provide an impartial opinion concerning the decisions of the Executive Directors or full-time managers of the NHST's. However, the Chief Executives and other managers interviewed never mentioned them except in the context of the 'NHST Board' which consisted of all the Non-Executive Directors and the Executive Directors. The involvement of the Non-Executives in the strategic process might have been important, as it seemed that they appeared to only 'rubber stamp' decisions already made. The researcher benefited from the experience of conducting independent work and learned that it is important to be patient, particularly with access, and to persevere. Interviewing was a skill which the researcher developed and handled sensitively, particularly when there were conflicting statements within different NHST's, and sometimes within the same NHST's.

The main contribution of the research was the fieldwork, which allowed access to key managers and decision makers in the NHSiS. It provided significant insights into the development of strategic thinking. The literature involving economics and strategy was fairly comprehensive. The empirical work was tried and tested against existing theories and models. The researcher was identifying two sets of issues, one of economic approaches to markets, and one of strategic decisions in light of the market that developed in the West of Scotland. At no time was the researcher deliberately setting out to develop a new theory or make a theoretical contribution to the literature. The main contribution of the thesis was an examination of an emerging market and emerging strategy processes within this market.

There was an intended focus on both economic and strategic approaches in this analysis. The research was examining the key interactions in an 'atypical' market which saw a number of new inter and intra-organisational relationships forming. Using the generic literature it might not be possible to generalise the broad generic approaches as they may not be suitable themselves. The nature of the problem required such an approach. Constrained NHS resources planners thought they were entering a new era. They picked up various economic and strategic concepts from the literature, short courses, and MBA courses. This was a 'learning' process for them. When they came to the conclusion that standard or generic strategic approaches were not working, or were not suitable, their strategy development processes began to be influenced by the relational market and the network of relationships between NHST's, the AHB's and GPFH's. Section four of chapter ten attempted to illustrate this process by bringing the economic and strategic approaches together in a framework that was consistent with the observed empirical work. The key to this analysis was the relational market and the observations made by the researcher in 'real' time.

The 1997 change in Government has brought about a new set of changes to the NHSiS which is to include an end to the internal market, GPFH's, and a reduction in the number of NHST's. This though should not see the end of strategic development within these organisations. The NHS managers involved in the research appear to have benefited from the experience in strategic decision making. While it is likely that all five NHST case studies will not survive in their current form, any new NHST will have to develop an operational strategy in the shape of a Trust Implementation Plan (TIP) based upon their AHB, and other AHB's, Health Improvement Plans (HIP's). Previous experience gained at an individual NHST should prove invaluable in any new NHST in the development of a TIP, particularly the processes involved. However, by removing strategic management from the NHST's to be replaced by operational management (see figure 7) may be a weakness in the new system and could be viewed as a step back to the command and control management of the pre 1990 NHS Reforms.

NHS managers may now be unable or prevented from using their initiative in the same way that they have become used to in the 1991-97 period, and any innovation and creativity could become stifled with the new arrangements.

Although the 'new' NHS will no longer be based upon competition, but collaboration and partnership, the fact that some of the case study NHST's were actively engaged in strategic behaviour which included forming strategic alliances, co-operation and joint ventures, should accelerate such moves. The involvement of individual clinical directorates or specialties may be enhanced given the drive in *'Designed to Care'* for more clinical involvement in decision making. Potential problems could come from the former GPFH's who, after years of working alone, now have to actively work in partnership with a number of agencies such as the AHB's and the NHST's. This will be a new learning process for the former GPFH's.

The issues surrounding strategy development processes may become more relevant in the 'new' NHS. Previously NHST's developed strategies, in the main, for their local catchment areas. This is now to be carried out by the AHB's on a 'collective' basis. We are moving to a top-down approach to strategy, and the use of power and developing political processes may become more relevant and inform the content of the HIP documents. Although the NHST's are to have an input to this process, the exact nature of this involvement remained unclear at the time of the research. A certain degree of tension and potential conflict could therefore arise between the NHST's and the AHB's. This will almost certainly unfold over another time frame of 3-4 years in a similar fashion to that observed in this thesis. More involvement with other agencies is also to be encouraged to provide a holistic view of 'health' rather than health care. These agencies are to include primary care, local authority social services and housing departments, and the voluntary sector. These new arrangements provide an indication that these groups will bring elements of old suspicions, uncertainty, inexperience, and prejudices.

This will ensure that the strategy development processes that inform the AHB HIP will continue to be based as much upon the effects of history, culture, power, and politics, as on rational planning. All these agencies are to have a say in the AHB HIP, and they will not be easy to bring together. New relationships will have to be formed based upon new working arrangements in contrast to the past. The context of health care is now to be changed to that of health. It remains to be seen how this will unfold.

The content of strategy will change to encompass the AHB's HIP's, the process of which will be informed by the new working relationships and arrangements brought together by the new system. Strategy for health although deliberately determined by the Scottish Office, will continue to be *emergent* in nature and *crafted* to suit the particular context of individual NHST and AHB needs under an *umbrella* strategy designed by the Scottish Office. Future research in this area could examine the interface between strategic planning at the centre, implementation of these plans at a local level, and the development of strategic processes between the agencies that inform the HIP document. Other areas could include a study of how well the new NHST's are adapting to more central control after a brief journey into (relative) autonomy. An examination of the effect of NHST mergers and the difficulties of combining two or more NHST's while developing an operational strategy could also prove fruitful future research.

References

Ackroyd,S; Hughes,J; Soothill,K (1990): Public Sector Services and their Management. Journal of Management Studies 26, No 3, 603-619.

Akehurst,R; Brasier,J; Normand,C (1988): Internal Markets in the NHS: A Review of the Economic Issues. Discussion Paper No 40, Centre for Health Economics, University of York.

Amit,R; Schoemaker,P (1993): Strategic Assets and Organisational Rent. Strategic Management Journal 14, No 1, 33-46.

Andrews,K (1980): The Concept of Corporate Strategy. 2nd ed. Irwin, Homewood, Ill.

Ansoff,I (1965): Corporate Strategy. 1st ed. McGraw-Hill, New York.

Ansoff,I (1977): Business Strategy. Penguin, Harmondsworth.

Ansoff,I (1991): Critique of Henry Mintzberg's 'The Design School: Reconsidering The Basic Premises of Strategic Management'. Strategic Management Journal 12, 449-461.

Appleby,J (1992): Financing Health Care in the 1990s. Open University Press, Buckingham.

Armstrong,J (1982): The Value of Formal Planning for Strategic Decisions: Review of Empirical Research. Strategic Management Journal 3, 197-211.

Ashburner,L; Ferlie,E; Fitzgerald,L (1996): Organisational Transformation and Top-Change: The Case of the NHS. British Journal of Management 7, 1-16.

Barker,P (1990): The Leicester Experience. The Health Service Journal 101, 27/9/90, 1428-1429.

Barlett,W (1991): Quasi-markets and Contracts: A Market and Hierarchies Perspective on NHS Reforms. Public Money and Management Autumn, 53-61.

Barnard,K; Harrison,S (1986): Labour Relations in Health Services Management. Social Science and Medicine 22, No 11, 1213-1228.

Barnard,K; Lee,K; Mills,A; Reynolds,J (1980): NHS Planning: an Assessment. Hospital and Health Services Review August, 262-265.

Barney,J (1986): Strategic Factor Markets: Expectations, Luck and Business Strategy. Management Science 32, 1231-1241.

Barney,J (1991): Firm Resources and Sustained Competitive Advantage. Journal of Management 17, No 1, 99-120.

Bartlett,W; Le-Grand,J (Eds.) (1993): Quasi Markets and Social Policy. Macmillan, London.

Bauer,M; Cohen,E (1983): The Invisibility of Power and Economics: Beyond Markets and Hierarchies'. In: Power, Efficiency and Institutions. (Eds: Francis,A; Turk,J; Williams,P) Heinemann, London, .

Baumol,W (1982): Contestable Markets: An Uprising in the Theory of Industry Structure. American Economic Review 72, 1-15.

Bazzaz,S; Grinyer,P (1981): Corporate Planning in the UK: The State of the Art in the 1970's. Strategic Management Journal 2, 155-168.

Berg,N (1973): Corporate Role and Diversified Companies. In: Business Policy: Teaching and Research. (Eds: Taylor,B; MacMillan,K) University of Bradford Press, Crosby-Lockhead, .

Borgonovi,E (1991): Competition in the Public Health Care System: A Reference Framework. In: Paradoxes of Competition for Health. (Ed: Hunter,D) Nuffield Institute for Health, Leeds, .

Bowman,E (1974): Epistomology, Corporate Strategy, and Academe. Sloan Management Review 15, 35-50.

Bracker,J (1980): The Historical Development of the Strategic Management Concept. Academy of Management Review 5, No 2, 219-224.

Bright,J (1958): Automation and Management. Harvard University Press, Boston.

British Association of Medical Managers; British Medical Association; The Institute of Health Services Management; The Royal College of Nursing (1993): Managing Clinical Service: A Consensus Statement of Principles for Effective Clinical Management. Institute of Health Services Management, London. 56 pages.

Bunning,C (1992): Effective Strategic Planning in the Public Sector: Some Learnings. International Journal of Public Sector Management 5, No 4, 54-59.

Burke,C; Goddard,A (1990): Internal Markets: The Road to Inefficiency. Public Administration 68, 389-396.

Butler,J (1992): Patients, Policies, and Politics: Before and After Working for Patients. Open University Press, Buckingham.

Buxton,M; Packwood,T; Keen,J (1989): Resource Management: Process and Progress. HERG, Brunel University, Uxbridge.

Capewell,S (1992): Clinical Directorates: A Panacea for Clinicians Involved in Management. Health Bulletin 50, No 6, 441-447.

Caulfield,I; Shultz,J (1989): Planning For Change: Strategic Planning in Local Government. Longman, Harlow.

Central Consultants and Specialist Committee (CCSC) (1990): Clinical Directorates - CCSC Guidance. British Medical Association, London. 12 pages.

Chalkley,M; Malcolmson,J (1996): Contracts for the National Health Service. The Economic Journal 106, November, 1691-1701.

Challis,L; Day,P; Klein,R; Scrivens,E (1994): Managing Quasi Markets: Institutions of Regulation. In: Quasi-Markets in the Welfare State. (Eds: Bartlett,W; Propper,C; Wilson,D; Le-Grand,J) School for Advanced Urban Studies, University of Bristol, Bristol, .

Chandler,A (1962): Strategy and Structure. MIT Press, Cambridge Mass.

Chandler,J; Cockle,P (1982): Techniques of Scenario Planning. McGraw-Hill, London.

Chaston,I (1994): Assessing Strategic Behaviour within the Acute Sector of the National Health Service. Journal of Management in Medicine 1, No 5, 58-67.

Connor,K (1991): A historical comparison of resource-based theory and five schools of thought within industrial organisation economics: Do we have a new theory of the firm? Journal of Management 17, 121-154.

Corbridge,C (1995): Pandora's Box: clinical directorates and the NHS. Journal of Management in Medicine 9, No 6, 16-20.

Craig-Smith,N (1991): The Case Study: A Vital Yet Misunderstood Research Method for Management. In: The Management Research Handbook. (Eds: Craig-Smith,N; Dainty,P) Routledge, London, .

Craven, D; Shipp, S; Craven, K (1993): Analysis of Co-operative Inter-organisational Relationships, Strategic Alliance Formulation, and Strategic Alliance Effectiveness. Journal of Strategic Marketing, 1, No 1, 55-70.

Culyer,A; Brasier,J (1988): Alternatives For Organising the Provision of Health Services in the UK. Working Paper No 4, Working Party on Alternative Delivery and Funding of Health Services, Institute of Health Services Management, London.

Department of Health (1979): Patients First. HMSO, London.

Department of Health (1989): Working for Patients, Cmnd, 555. HMSO, London.

Department of Health (1997): The New NHS Modern, Dependable, Cmnd 3807. HMSO, London.

Department of Health and Social Security (1976): Priorities for Health and Personal Social Services in England, Cmnd 7615. HMSO, London.

Department of Health and Social Security (1977): Sharing Resources for Health in England. Report of the Resource Allocation Working Party (RAWP), HMSO, London.

De Witt, B ; Meyer, R (1998): Strategy: Process, Content, Context – An International Perspective. 2nd ed. International Thomson Business Press, London.

Dierickx,L; Cool,K (1989): Asset Stock Accumulation and the Sustainability of Competitive Advantage. Management Science 35, 1504-1513.

Disken,S; Dixon,M; Halpern,S; Shocket,G (1990): Models of Clinical Management. Institute of Health Services Management, London. 25 pages.

Duncan,W; Ginter,P; Swanyne,L (1994): Strategic Management of Healthcare Organisations. 2nd ed. Blackwell, Oxford.

Eden,C (1988): Strategic Development as a Social Process. Working Paper No 3, Management Science: Theory and Practice Series, University of Strathclyde.

Eden,C (1992): Strategy Development as a Social Process. Journal of Management Studies 29, No 6, 799-811.

Edmonstone,J; Havergal,M (1994): Business Planning for Clinical Services: Towards Good Practice. Management Development Group, National Health Service in Scotland, Edinburgh. 64 pages.

Enthoven,A (1985): Reflections on the Management of the National Health Service. Occasional Paper No 5 ed. Nuffield Provincial Hospitals Trust, London.

Ferlie,E (1992): The Creation and Evolution of Quasi Markets in the Public Sector: A Problem for Strategic Management. Strategic Management Journal 13, Winter Special Edition, 79-97.

Ferlie,E; Pettigrew,A; Ashburner,L; Fitzgerald,L (1996): The New Public Management in Action., Oxford University Press.

Fitzgerald,L (1991a): Made to Measure. The Health Service Journal 101, 31/10/91, 24-25.

Fitzgerald,L (1991b): This Year's Model. The Health Service Journal 101, 7/11/91, 26-27.

Fitzgerald,L (1997): Clinical Management as Boundary Management: A Comparative Anaysis of Canadian and UK Healthcare Institutions. International Journal of Public Sector Management 10, No 12, 5-20.

Glennerster,H; Korman,N; Marslen-Wilson,F (1983): Planning for Priority Groups. Martin Robertson, .

Glennerster,H; Matsaganis,M; Owens,P; Hancock,S (1994): Implementing GP FundHolding. Open University Press, Buckingham.

Glennerster,H; Powers,A; Travers,T (1991): A New Era in Social Policy. Journal of Social Policy 20, No 3, 389-414.

Goold,M; Campbell,A (1987): Strategies and Styles: The Role of the Centre in Managing Diversified Corporations. Blackwell, Oxford.

Goold,M; Campbell,A; Alexander,M (1994): Corporate-Level Strategy: Creating Value in the Multibusiness Company. Wiley, Chichester.

Granovetter,M (1985): Economic Action and Social Structure: The Problem of Embeddedness. American Journal of Sociology 91, No 3, 481-510.

Granovetter,M (1992): Economic Institutions as Social Constructions: A Framework for Analysis. Acta Sociologica 35, 3-11.

Grant,R (1991): The Resource-based Theory of Competitive Advantage:Implications for Strategy Formulation. California Management Review 33, No 3, 114-135.

Grant,R (1995): Contemporary Strategic Analysis. Blackwell, Oxford.

Griffiths,R (1983): The NHS Management Enquiry. Department of Health and Social Security, London.

Grinyer,P (1971): The Anatomy of Business Strategic Planning Reconsidered. Journal of Management Studies 8, 199-212.

Gunn,L (1989): A Public Management Approach to the NHS. Health Services Management Research 2, No 1, 10-19.

Hackett, M (1996): Are There Alternatives to Mergers?. Health Manpower Management, 22, No 5, 5-12.

Hakim,C (1987): Research Design: Strategies and Choices in the Design of Social Reseach. Allen and Unwin, London.

Halpern,S (1998): The White Paper: too little, too late for the NHS? British Journal of Health Care Management 4, No 1, 5-6.

Ham,C (1992): Health Policy in Britain: The Politics and Organisation of the National Health Service. 3rd ed. MacMillan, Basingstoke.

Ham,C (1994): Management and Competition in the New NHS. Radcliffe Medical Press, Abingdon.

Ham,C (1997): Management and Competition in the NHS. 2nd ed. Radcliffe Medical, Abingdon.

Hari Das,T (1983): Qualitative Research in Organisational Behaviour. Journal of Management Studies 20, No 3, 301-314.

Harrison,A (1993): From Hierarchy to Contract, Policy Journals. Hermitage, London.

Harrison,S (1988): Managing the NHS - Shifting the Frontier? Chapman and Hall, London.

Harrison,S; Hunter,D; Marnoch,G; Pollitt,C (1992): Just Managing: Power and Culture in the National Health Service. MacMillan, Basingstoke.

Hart, S (1992): An Integrative Framework for Strategy-Making Processes. Academy of Management Review, 17, No 2, 327-351.

Hart, S; Banbury, C (1994): How Strategy-Making Processes Can Make A Difference. Strategic Management Journal, 14, 251-269.

Hax,A; Majluf,N (1985): Strategic Management: An Integrated Perspective. Prentice-Hall, Englewood Cliffs.

Heyssel,R; Gaintner,J; Jones,A; Lipstein,S (1984): Decentralised Management in a Teaching Hospital. New England Journal of Medicine 310, No 22, 1477-1480.

Hirst,D; Clements,R (Eds.) (1995): The Clinical Director's Handbook 1995/96. Churchill Livingston, London. 249 pages.

Hogget,P (1991): A New Management in the Public Sector. Policy and Politics 19, No 4, 143-156.

Hogget,P (1996): New Modes of Control in the Public Sector. Public Administration 74, Spring, 9-32.

Holliday,I (1992): The NHS Transformed. Baseline Books, Manchester.

Hopkins,A (Ed.) (1993): The Role of Hospital Consultants in Clinical Directorates: The Synchromesh Report. Royal College of Physicians of London, London. 103 pages.

Hunter,D; Williamson,P (1991): General Management in the NHS: Comparisons and Contrasts Between Scotland and England. Health Services Management Research August, 166-170.

Institute of Health Services Management (1988): Working Paper No 1: The Search for a System - Establishing the Criteria. Working Party on Alternative Delivery and Funding of Health Services.

Johnson,G (1987): Strategic Change and the Management Process. Blackwell, Oxford.

Johnson,G (1988): Rethinking Incrementalism. Strategic Management Journal, 19, 75-91.

Johnson, G (1990): Managing Strategic Change: The Role of Symbolic Action. British Journal of Management, 1, 183-200.

Johnston,J (1990): Clinical Directorates: Consultants' clinical independence needs to be preserved. British Medical Journal 300, 24/2/90, 300.

Johnston,N (1995): The United Kingdom. In: Private Markets in Health and Welfare. (Ed: Johnston,N) Berg, Oxford, .

Kahn,H; Wiener,A (1967): The Next Thirty Three Years: A Framework for Speculation. American Academy of Arts and Science 96, No3, Summer, 705-732.

Kanter,RM; Stein,B; Jick,T (1992): The Challenge of Organisational Change. The Free Press, New York.

Kay,J (1993): Foundations of Corporate Success. Oxford University Press, Oxford.

Kay,J; Vickers,J (1990): Regulatory Reform. In: Deregulation or Reregulation?: Regulatory Reform in Europe and the United States. (Ed: Majone,G) Pinter, London, .

Klein,R (1989): The Politics of the NHS. 2nd ed. Longman, London.

Laughlin,R (1991): Can the Information Systems for the NHS Internal Market Work? Public Money and Management 11, 37-41.

Lawrence,P; Lorch,J (1967): Organisation and Environment. Harvard University Press, Boston.

Le-Grand,J (1993): Evaluating the NHS Reforms. In: Evaluating the NHS Reforms. (Eds: Robinson,R; Le-Grand,J) Kings Fund Institute, Hermitage, .

Le-Grand,J; Bartlett,W (Eds.) (1993): Quasi-Markets and Social Policy. MacMillan, London.

Levitt,R; Wall,A (1992): The Reorganised National Health Service. 4th ed. Chapman and Hall, London.

Lorange,P (1979): Formal Planning Systems: Their Role in Strategy Formulation and Implementation. In: Strategic Management: A New View of Business Policy and Planning. (Eds: Schendel,D; Hofer,C) Little Brown and Co, Boston, .

Loveridge,R; Starkey,K (1992): Introduction:Innovation and Interest in the Organisation of Health Care Delivery. In: Continuity and Crisis in the NHS. (Eds: Loveridge,R; Starkey,K) Open University Press, Buckingham, .

Macaulay,S (1963): Non-contractual Relations in Business: A Preliminary Study. American Sociological Review 28, No 2, 55-67.

Mahoney,J; Pandian,R (1992): The Resource-Based View Within The Conversation of Strategic Management. Strategic Management Journal 13, 363-380.

Marnoch,G; McKee,L; Dinnie,N (1996): Clinical Directors in Scotland: Roles and Responsibilities 1995/96. Research Project funded by the Economic and Social Research Council.

Mason,J (1996): Qualitative Researching. Sage, London.

Maxwell,R (1993): Clinical Directorates. In: The Role of Hospital Consultants in Clinical Directorates: The Synchromesh Report. (Ed: Hopkins,A) Royal College of Physicians of London, London, 103.

Maynard,A; Williams,A (1984): Privatisation and the National Health Service. In: Privatisation and the Welfare State. (Eds: Le-Grand,J; Robinson,R) Allen and Unwin, London, .

McLauchlin,G; Maynard,A (Eds.) (1992): The Public Private Mix for Health. Nuffield Provincial Hospitals Trust, London.

Mintzberg,H (1979): The Structure of Organizations. Prentice-Hall, Englewood- Cliffs.

Mintzberg,H (1987): Crafting Strategy. Harvard Business Review July-August, 66-75.

Mintzberg,H (1994): The Fall and Rise of Strategic Planning. Harvard Business Review January-February, 107-114.

Mintzberg,H; Quinn,J (Eds.) (1988): The Strategy Process: Concepts, Contexts, and Cases. Prentice-Hall, Englewood Cliffs.

Mintzberg,H; Waters,J (1985): Of Strategies: Deliberate and Emergent. Management Science 24, No 9, 257-272.

Mole,V; Dawson,S (1993): Pole to Pole, Special Report on Clinical Management. The Health Service Journal 102, 11/3/93, 33-34.

Packwood,T; Buxton,M; Keen,J (1990): Resource Management in the National Health Service. Policy and Politics 18, No4, 245-255.

Packwood,T; Keen,J; Buxton,M (1991): Hospitals in Transition: The Resource Management Experiment. Open University Press, Buckingham.

Packwood,T; Keen,J; Buxton,M (1992): Process and Structure: Resource Management and the Development of Sub-unit Organisational Structure. Health Services Management Research 5, No 1, 66-76.

Peel,V (1992): Seven Typologies of Clinical Directorates. University of Manchester HCMU, Manchester.

Penrose,E (1959): The Theory of The Growth of The Firm. Oxford University Press, Oxford.

Perrow,C (1981): Markets, Hierarchies, and Hegemony. In: Perspectives on Organisational Design and Behaviour. (Eds: Van de Ven,A; Joyce,W) Wiley, Chichister, .

Peteraf,M (1993): The Cornerstone of Competitive Advantage: A Resource-based View. Strategic Management Journal 14, 179-192.

Pettigrew, A (1992): The Character and Significance of Strategy Process Research. Strategic Management Journal, 13, 5-16.

Pettigrew,A; Ferlie,E; McKee,L (1992): Shaping Strategic Change. Sage, London.

Porter,M (1980): Competitive Strategy. Free Press, New York.

Porter,M (1985): Competitive Advantage. Free Press, New York.

Prahalad,C; Hamel,G (1990): The Core Competence of the Corporation. Harvard Business Review May-June, 79-91.

Propper,C (1993): Contracts, Competition, and Quasi-markets. In: Qausi-markets and Social Policy. (Eds: Bartlett,W; Le-Grand,J) MacMillan, London, .

Propper,C (1995): Regulatory Reform of the NHS Internal Market. Health Economics 4, 77-84.

Quinn,J (1980): Strategies for Change - Logical Incremenmtalism. Irwin, Homewood ILL.

Ranade,W (1994): The Theory and Practice of Managed Competition in the National Health Service. Public Administration 73, Summer, 241-262.

Rea,C (Ed.) (1993): Managing Clinical Directorates. HCMU, University of Manchester, Manchester.

Rea,C (1995): Clinical Directorates. British Journal of Healthcare Management 1, No 6, 32-33.

Robinson,R; Le-Grand,J (Eds.) (1993): Evaluating the NHS Reforms. Kings Fund Institute, Hermitage.

Rumelt,R (1974): Strategy, Structure, and Economic Performance. Harvard University Press, Boston Mass.

Sako,M (1992): Prices, Quality and Trust: Inter-firm Relations in Britain and Japan. Cambridge University Press, New York.

Saltman,R; Von Otter,C (Eds.) (1995): Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility. Open University Press, Buckingham.

Scottish Home and Health Department (1977): The Share Report. NHS Circular, No 1977 (Gen) 57.

Scottish Home and Health Department (1991): The Function and Structure of Health Boards. NHS Circular No 1991 (GEN) 2.

Scottish Office Department of Health (1996): Priorities and Planning Guidance for the NHS in Scotland: 1996/97. NHS MEL (1997) 51.

Scottish Office Department of Health (1997): Designed to Care, Cmnd 3811. HMSO, Edinburgh.

Schendel, D (1992): Introduction to the Winter 1992 Special Issue: 'Fundamental Themes in Strategy Process Research'. Strategic Management Journal. 13, 1-3.

Schoemaker, P (1993): Strategic Decisions in Organizations: Rational *and* Behavioural Views. Journal of Management Studies, 19, No 1, 107-129.

Scrivens,E (1988): The Management of Clinicians in the NHS. Social Policy and Administration 22, No 1, May, 22-34.

Servers,S (1993): The Role of Hospital Consultants in Clinical Directorates. In: The Synchromesh Report. (Ed: Hopkins,A) The Royal College of Physicians of London, London, .

Shields,R (1996): Commissioning Better Health: Report of the Short Life Working Group On The Roles And Responsibilities of Health Boards. Scottish Office Department of Health, Edinburgh.

Simms,J (1994): Clinical Directors will take the lead. Healthcare Management September, 18-20.

Smith,N; Chantler,C (1987): Partnership for Progress. Public Finance and Accountability 6/11/87, 12-14.

Strauss,A; Corbin,J (1990): The Basics of Qualitative Research. Sage, London.

Strong,P; Robinson,J (1990): The NHS: Under New Management. Open University Press, Buckingham.

Sutherst,J; Glascott,V (1993): The Doctor-Manager. Livingstone, Edinburgh.

(MDG) Management Development Group (The NHS in Scotland); The National Association of Health Authorities and Trusts; The National Health Service Training Directorate (1993): The NHS Guide. Management Development Group, Edinburgh.

Thompson,P (1992): Public Sector Management in a Period of Radical Change: 1979-1992. Public Money and Management, 33-41.

Thomson,J (1967): Organisations in Action. McGraw-Hill, New York.

Tollison,R (1982): Rent Seeking: A Survey. Kyklos 35, 575-602.

Tomlinson,B (1992): Tomlinson Report, Report of Enquiry into London's Health Service, Medical Education and Research. HMSO, London.

Van Der Heijden,K (1996): Scenarios: The Art of Strategic Conversation. Wiley, Chichester.

Von Otter,C (1991): The Application of Market Principles to Healthcare. In: Paradoxes of Competition for Health. (Ed: Hunter,D) Nuffield Institute for Health, Leeds, .

Wack,P (1985): Scenarios: Unchartered Waters Ahead. Harvard Business Review September/October, 72-79.

Walker,A; Craig,N (1994): The Internal Market and Purchasing: Problems and Possibilities. Paper presented at the Health Economics Study Group, London.

Walters, B: Peters, S: Dess, G (1994): Strategic Alliances and Joint Ventures: Making them Work. Business Horizons, 37, No 4, 5-10.

Webster,C (1994): Conservatives and Consensus: The Politics of the National Health Service, 1951-64. In: The Politics of the Welfare State. (Eds: Oakley,A; Williams,S) UCL Press, London, 54-74.

Wernerfelt,B (1984): A Resource-based View of the Firm. Strategic Management Journal 5, No 2, 171-180.

Wernerfelt,B (1989): From Critical Resources to Corporate Strategy. Journal of General Management 14, 4-12.

White,T (1993): Management for Clinicians: A Handbook for Doctors and Nurses. Edward Arnold, London.

Willcocks,S (1992): Managerial Effectiveness and the Public Sector: A Health Service Example. International Journal of Public Sector Management 5, No 5, 4-10.

Willcocks,S (1992): The Role of the Clinical Director in the NHS: Some Observations. Journal of Management in Medicine 6, No 4, 41-46.

Willcocks,S (1994): The Clinical Director in the NHS: Utilising a Role-theory Perspective. Journal of Management 8, No 5, 68-76.

Williamson,O (1975): Markets and Hierarchies: Analysis and Anti Trust Implications. Macmillan, New York.

Williamson,O (1985): The Economic Institutions of Capitalism. Free Press, New York.

Williamson,O (1991): Comparative Economic Organisation: The Analysis of Discrete Structural Alternatives. Administrative Science Quarterly 36, 269-296.

Yin,R (1989): Case Study Research: Design and Methods. Sage, London.