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Tracing Decisions in the NHS

Keith Barnard
Kenneth Lee
Joy Reynolds

Based on working papers of the Royal Commission on the NHS

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EDITORS' INTRODUCTION

During its lifetime the Royal Commission on the NHS commissioned and published six major research studies.[1] A number of other papers were also prepared by outside 'experts' and considered by the Commission along with the findings from the full-scale research projects. The paper reproduced here was undertaken by a team of researchers from the Nuffield Centre for Health Services Studies at Leeds University as part of a study to assess the feasibility of one method of researching the decision-making process in the NHS.

In the evidence to the Royal Commission, a frequent complaint was that the reorganised structure with its principle of consensus management, had led to massive delays in decision-taking. So loud and vigorous was this complaint and so scarce was the existence of any research in this field, that the Royal Commission felt it should explore several avenues of enquiry on the subject. Two of the published research papers, *The Working of the National Health Service* Research Paper Number 1 KOGAN et al, London, HMSO, 1979 and *Management of financial resources in the National Health Service,* Research Paper Number 2 (PERRIN et al, London, HMSO, 1972) studied the process of decision-making, through interviews with a sample of NHS staff. The paper reproduced here explores the feasibility of another method, tracing specific decisions back through records and minutes. The results of this feasibility study demonstrate that this is an effective way of studying the decision-making process, but time-consuming and not without methodological problems. In the event, the Royal Commission decided not to undertake a full-scale study using this approach, mainly because of the limited amount of time available.[2]

The study carried out by the Leeds team however represents a useful contribution both to the understanding of the decision-making process and to the research methods necessary to study it. We are publishing it here in the hope that it will be useful to future researchers in the field and to students of social research.

This paper is the sixteenth in a series of project papers based on the background papers of the Royal Commission on the NHS. The views expressed in the paper do not necessarily reflect either those of the Royal Commission or of the King's Fund.

We are grateful to Kind Edward's Hospital Fund for London for giving us a grant to enable this series to be produced, and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

1 For details of these papers see *Royal Commission on the National Health Service* Report (Chairman Sir Alex Merrison) London HMSO Cmnd 7615 para 1.13

2 For a discussion of the contribution of research to the Royal Commission on the NHS see FARRELL, Christine 'The Royal Commission on the National Health Service' *Policy and Politics* Vol. 8 No. 2 (1980) pp 196-198.

INTRODUCTION

Many of those who submitted evidence to the Royal Commission on the National Health Service questioned the efficiency and responsiveness of NHS management, and criticised its structure. The statement on the Task of the Commission, listed a number of questions to be asked about the management structure and the way decisions were taken:

- how problems were identified?
- who took the decision?
- how long the process was taking

One of the ways suggested for gathering advice to shed light on those questions was a 'retrospective tracer' approach. This implied selecting decisions from a given field - say all decisions taken by a sample of management teams and health authorities, over a given period. The issues upon which the decisions had been taken, would then be traced back through the organisation, to see who had dealt with them, when and by what methods. This approach attempts to reconstruct the decision-making process by such means as reviewing the agenda papers and minutes of committees, file searches and interviews with the participants who dealt with the issue on its path through the organisation.

The Commission's response to this suggestion was to request a study to test both the feasibility of this tracer approach and the value of the information or evidence that could be obtained by these methods. The Commission's own perceptions of the decision-making process were reflected in a series of questions which they posed:

(a) Where (or from whom) did the initial request originate?
(b) How long did it take to reach a decision?
(c) How many, and what type of stages were involved from start to finish?
(d) Were there any apparent delays in the process?
(e) If delays occurred, is it possible to discover from the records, why this was?

(f) Were there any significant changes to the request during the process?

(g) Did the initial request lead to discussions, at any stage, of major policy issues?

It was these questions which shaped the feasibility study, an account of which is presented in this paper. Even though the management structure of the NHS is about to be reorganised again, the issues raised should be of interest to researchers and others concerned with the management of the NHS.

The feasibility study was carried out by a research team (Keith Barnard, Ken Lee, and Joy Reynolds), based at the Nuffield Centre for Health Services Studies at Leeds University. This team was already involved at that time (1977) in a Department of Health and Social Security financed study of the working of the NHS planning system - a key policy and decision making mechanism in the post 1974 reorganised NHS. With the concurrence of one of the NHS authorities acting as host for the planning research, the researchers tested the methodology of tracking decisions, working from the minutes of authority and officer team meetings. It was understood that there would be no commentary on any of the decisions observed.

An obvious limitation of the feasibility study was that it looked at decision making in one area health authority only, whereas if the Royal Commission had decided to commission a full-scale retrospective study on decision making, this presumably could have been carried out across the country. There could be no guarantee that the degree of ease with which this study was carried out, or the nature of the information obtained, would be reflected elsewhere. For instance, the number of districts in an area might well affect the complexity of relationships and information flows in the decision process. Also the study concentrated on the area level (the focus of the planning research), but a full scale study would no doubt have aimed at tracking issues through all three tiers and desirably into the DHSS.

Those were the limitations of the feasibility study. On the other hand,

it will be observed that as researchers carrying out the feasibility study we had advantages which might not exist in a wider study. In the on-going planning research, we had time to build up a good relationship with the officers in the authority. This relationship was founded on a trust that as researchers we would respect the officers' confidences and would handle information in a discreet manner. In a larger study, if researchers spent only a short time in each authority, they might not have found it easy to establish their 'trustworthiness' quickly and therefore, might not have found access to the more sensitive information.

In summary then, the purposes of this study were:

- to put forward possible methods for selecting decisions and identifying steps through which they would be traced back.
- to test out this framework by selecting items, on various subjects and finding out how much information could be uncovered by each step.
- to assess the appropriateness of the various methods adopted, the likely gaps in the information gathered by such methods, possible ways of presenting the material gathered, and the amount of the time and energy spent tracing back issues in one authority.
- to comment on the value of the retrospective tracer approach in shedding light on decision-making in the NHS.

ACKNOWLEDGEMENT

The research team wish to record their warm appreciation of the officers of the host authority without whose cooperation and assistance, this study would not have been possible.

II DECISION-MAKING IN THE NHS

INTRODUCTION

Before presenting the feasibility study it is appropriate to make more explicit the framework within which the study was pursued: ie the model of decision making and management in the NHS specified in the so-called 'Grey Book', *Management Arrangements for the Reorganised National Health Service,* (DHSS, 1972). Furthermore, in order to understand the aims and principles set for the management of the reorganised NHS, it is important to understand the philosophical and political context within which that exercise was conducted.

THE CONTEXT

The segmented administrative structure chosen at the inception of the National Health Service in 1948 represented a compromise between the interests and beliefs of the various groups involved in health care planning and delivery at that time. Over the next twenty years changes in patterns of morbidity and of care, organisational considerations, and the growing magnitude of the resources involved, increased the pressure to reorganise the health services.

In the debate, initiated with the publication of the *Porritt Report* in 1962 the focus was on an administrative unification of the NHS as a precondition for the better organisation and integration of services. In the ensuing sequence of government statements in Green Papers and consultative documents, the complexity of the issues emerged. How centralised did a centrally funded service have to be? What were the nature of links with other social services? How many tiers were needed to secure the necessary linkages between the political tasks of the responsible minister and the professional tasks of clinicians and other health visitors? How was the involvement of staff of all ranks and occupations, of patients and recipients of services to be achieved? Should public representatives be elected or nominated? And what degree of operating autonomy could be

allowed to NHS career bureaucrats, in the interests of effective, efficient management, to secure best value from very substantial resources of manpower, capital and finance? This rehearsal of the major issues indicates the problems of designing a satisfactory structure and the factors precipitating the choice of a complex one.

The solution adopted in the 1973 Reorganisation Act embodied a multi-tier system integrated in a line of command; delegated (rather than developed) authority; separation from, yet linked with, local government (and hence other social services) through a variety of devices; separation of consumer and health workers from management (rejecting a possibility considered earlier) but guaranteeing their right to be consulted and heard; and substantial operating autonomy to multi-disciplinary officer teams in management of the service at each level. It was argued that the arrangements adopted would enchance the opportunities to provide a better quality of patient care.

These proposals reflected the climate of the time when ideology was discounted in favour of 'more rational' decision-making. Within complex, technologically-based organisations, a need was felt to minimise uncertainty. It was considered necessary to find a way of identifying key decisions, whereby the centre could control the general direction and development of the whole organisation while delegating as much operational decision-making as possible to subsidiary units which could act both in the light of centrally-determined general policy and their awareness of local conditions and circumstances. A formal corporate planning and management system was seen as an effective means of achieving this goal. Such thinking infused discussions on how the NHS might best be reorganised.

However, it does seem to be matter of continuing debate how far this approach can be taken in a publicly provided medical care system. Within a large complex service like the NHS, it is to be expected that pressure will be brought to bear on decision makers, by advocates representing or purporting to represent a wide array of interest groups (both providers and recipients of services) and whose efforts will have their effect on the

decision-making process. The increasing specialisation of care has expanded the range of interest groups among the health workers and consumers, while the competition for necessarily limited resources between many justifiable and socially desirable objectives, highlights both the political context of choice and the limitations of conventional corporate planning directed at rationalisation of products and markets.*

Thus it can be seen, at least in retrospect, that the 1974 reorganisation took place against a set of conflicting trends and assumptions. On the one hand, the then current management thinking put forward a picture of professionally trained officials making rational decisions within a well defined corporate structure. On the other, the political reality was a picture of different interest groups, with varying degrees of power, applying pressure on the decision-makers to ensure that their interests were protected, and their point of view heard and heeded. In many cases these political interests were intended to be contained by incorporating them within the formal structure and machinery of consultation and co-operation. Some were soon also to operate extra-constitutionally.

AIMS AND PRINCIPLES OF REORGANISATION

The response, to the situation outlined above, was embodied in the Grey Book on *Management Arrangements for the Reorganised NHS* (1972). The general aims in the reorganisation were that it should ensure a comprehensive and fully integrated health service in which care would be provided locally with due regard to the health needs of the community as a whole. More specific objectives, which the management arrangements were meant to promote, were:

* For an interpretation of the significance of this issue see BARNARD, K. and LEE, K. (eds.) *Conflicts in the National Health Service*. London, Croom Helm, 1977

- coordination of all personal health services with each other and with local government services, and planning services in relation to the 'needs' of the people to be served;
- the more effective working of professional practitioners through the provision of a structure and systems to support them administratively, and the means for them to contribute more effectively to NHS decision making; and
- more uniform national standards of care, but with encouragement to innovation and the rapid implementation of improved approaches to health care at local level.

To give practical effect to these aims the proposed management arrangements were based on certain general organisational principles. For example it was intended that:

- the health care professions should be integrally involved in planning and management at all levels, but without infringing the principle of clinical autonomy;
- individual and collective responsibilities must be clearly defined and allocated as between authorities and officers and as between members of officer teams and
- there should be maximum decentralisation and delegation of decision making, but within policies established at national, regional and area levels. There should be a matching accountability upwards with performance judged against previously agreed plans, and control of expenditure against budgets based on plans.

It will be noted that most of these principles echo those of classic corporate management systems. However, these principles suggest a potential conflict between the management concern for control and order and the professional value of freedom, and yet the viability of the system generally depends on the compliance of all the parties concerned. For instance, in acknowledging clinical autonomy, the Grey Book conceded that the NHS would have to be managed differently from other organisations. In particular, an emphasis would have to be placed on collegiate management and on advisory and consultative machinery. The growth of

specialisation among clinicians and other staff, with the resultant interdependence of different functions both within and outside the organisation, reinforced this need.

The consequences of these particular characteristics were crystalised with the enunciation of **consensus** as a cardinal principle of team management, which implied a trade-off between speed in decision making and commitment to the decision. It does seem that it is the pathology of consensus management - the cluttering of agendas with issues that have no place there and the failure of team members to accept its implications - which has excited as much comment as any other feature of the NHS.

But this debate is paralleled in other major features of the organisational arrangements. In a framework of decentralisation with strategic direction (from above) where can/should decisions be made? What sounds an attractive principle may in practice be ambiguous. What account should be taken in decision making of the obligation to consult and collaborate with other parties?

Thus it emerged that the decision process, which was intended to focus on the most appropriate use of resources, was commonly perceived as being easily frustrated or diverted by political and human factors. And this was despite the fact that many of these factors had apparently been taken into account in the design of the decision-making system.

A FRAMEWORK FOR ANALYSIS

So far this paper has summarised the main features behind the rising concern about the decision-making process which greeted the Royal Commission. From this account, it is possible to generate questions to which answers can be sought by undertaking retrospective or 'prospective' studies of decision making. A possible sequence of questions is set out in Figure 1 and forms the backcloth to the next section.

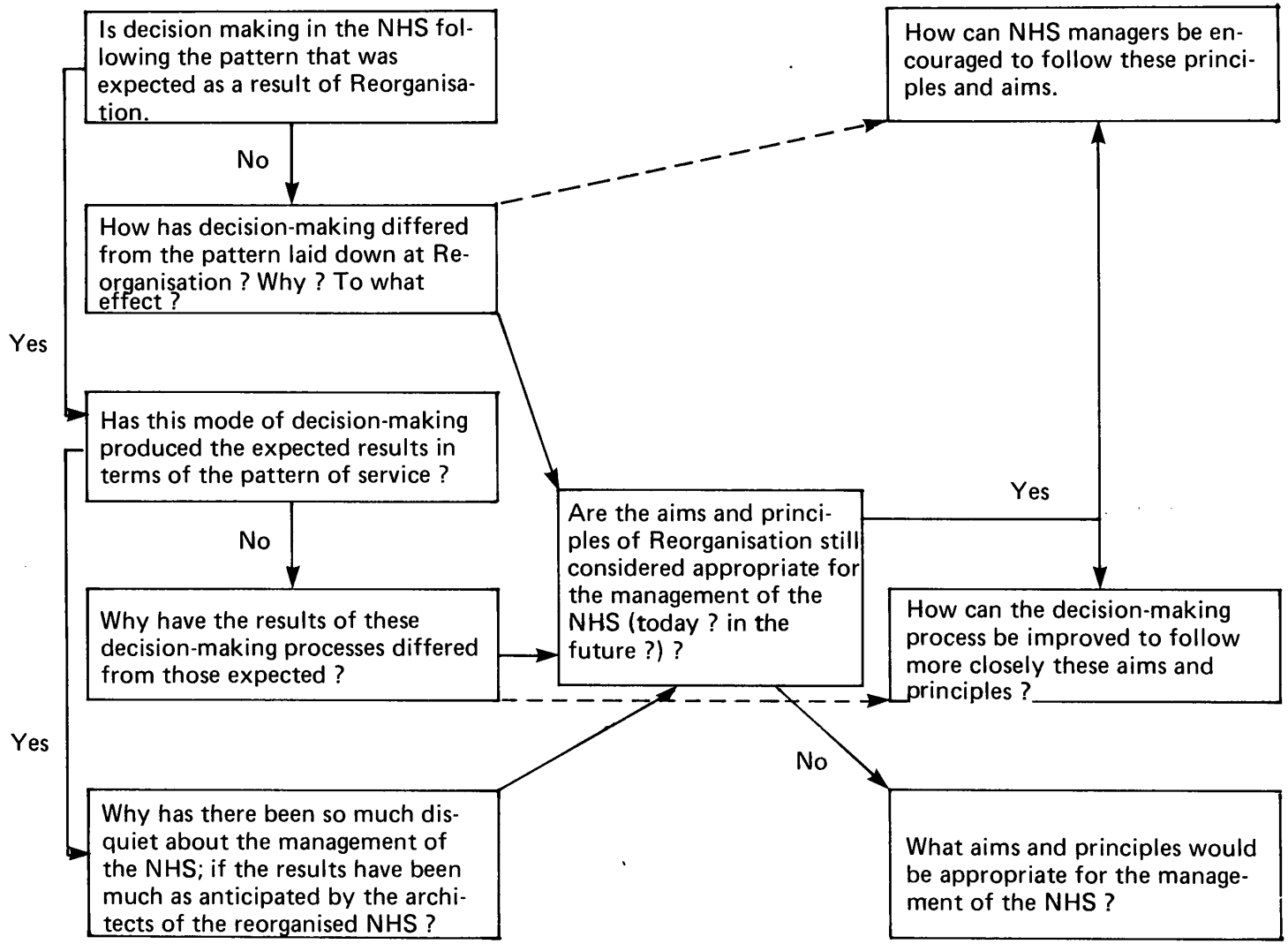


Figure 1 DECISION-MAKING: THE QUESTIONS TO BE ASKED

A RESEARCH FRAMEWORK FOR STUDYING DECISION-MAKING

THE RESEARCH OBJECTIVES

In the previous section we identified certain key features of the management arrangements for the reorganised NHS which seem to bear on the decision process: the concept of consensus management; the delegation of management responsibilities (a) from member to officer and (b) to the most appropriate tier to carry them out; and finally, consultation with community and staff interests.

It was to be hoped that any major study of decision-making in the NHS would throw light on each of these concepts. It would be ingenuous to assume that every authority and management team has implemented the management arrangements precisely as laid down in the national blueprint. Rather one would be looking for situations where particular management concepts were causing operational problems in a large number of cases. This could be pursued by formulating nul-hypotheses against which to test each of these concepts:

Consensus Management

1 Teams of management are taking decisions by a majority vote, rather than by a true system of consensus (where each member personally agrees to the proposal and then takes the responsibility for taking action on that decision on their own occupational network).

2 Multi-disciplinary management teams are taking decision on minor issues which do not require consensus and which should properly be taken by individual department heads.

Delegation of Management Responsibilities

From Members to Officers

1 Authority members are constantly asking questions about detailed management issues.

2 Officers constantly refer detailed management issues to authority members for decision.

From higher to lower levels

1 The higher tiers constantly interfere in the management decisions for which the lower tier feels it has responsibility.

2 The lower tier is constantly referring issues to the higher tier for decision, which should normally have been taken at the lower level.

3 There is no agreement between the tiers about the respective management tasks each tier is to carry out.

Professional Participation in Management

1 The professions (medical, nursing, etc.) in any district feel that they are not adequately involved in the decisions taken at district and area level.

2 The district medical committees and professional advisory committees are not reaching consensus views on priorities and plans.

3 The district medical committees and professional advisory committees are not ensuring that agreed policies and plans are communicated to their respective constituencies. Nor are they persuading them to follow the consensus view.

4 Professional staff who sit on planning teams are not accurately reflecting the views of their colleagues.

Consultation

1 The bodies indentified in the NHS Planning Manual are not being formally consulted.

2 Inadequate consideration is given to the way in which material is presented for consultation.

3 Consultation fails to generate commitment to the policies and decisions that are subsequently made.

4 Consultation fails to generate additional information and insight that would improve the quality and basis of decision.

5 Consultation generates unrealisable expectations and exacerbates any conflicts between decision-makers and affected parties.

It should be noted that these were put forward as nul-hypotheses, to be tested. Undoubtedly, they would have benefitted from further refinement and careful definition of the concepts used, if they were to be tested on a large scale. There are many other nul-hypotheses which could have been added; those cited above were simply suggested as examples of the issues which we believed would need to be addressed in any analysis of decision-making.

COLLECTING THE EVIDENCE - POSSIBLE APPROACHES

1 A 'Grass Roots-up' Approach

One way of collecting data which might elucidate some of these issues would be to study decisions from the grass roots up. The first step would be to select a sample of first line managers and professional personnel working at ground level - unit administrators, senior nursing officers, consultants, GPs, social workers - who could be expected to originate requests which required decisions. The next step would be to find out from each individual in the sample, what requests, for example, he or she had made during the past year, for new members of staff, new items of equipment, improvements to

buildings. The requests would then be sampled and those selected traced up through the structure until a final decision was reached and the request approved, refused or formally deferred for later consideration.

The advantage of this method of approach is that, providing the sample was properly drawn, it would give a good picture of the time it takes to get a decision on a variety of issues, since the study would include those issues which were dealt with quickly, at a local level, as well as those which were referred up. It would also be likely to give a fairly clear idea of the criteria used in deciding which issues are referred up or not and by whom. This would, no doubt, inform the debate on delegation.

On the other hand, it would seem to require a very large sample of issues to ensure that a significant number of issues were indeed referred up to management team level and beyond. Since several of the features identified earlier are only likely to be visible at the higher echelons of management (eg consensus management and consultation), this might be a real drawback. Another problem would be that issues which originate at or near the top of the hierarchy would be missed out. However, the overiding disadvantage is the large amount of time and number of people who would be necessary to conduct a study of this nature.

2 A 'Decision-Backwards' Approach

A second approach - and the one suggested by the Royal Commission- would be to start with the decision and trace the issue back through the organisation. There are also several difficulties associated with this approach.

Perhaps the most important is the difficulty of defining a 'decision' and determining when a decision has taken place. If one takes the example of a request for, say, an item of equipment: the person or team receiving the request, has a choice of several alternative strategies:

(a) acceding to the request and setting the machinery in motion to fulfil the request,

(b) refusing the request and taking no further action on it,

(c) asking for more information on this scheme (and/or possible alternatives),

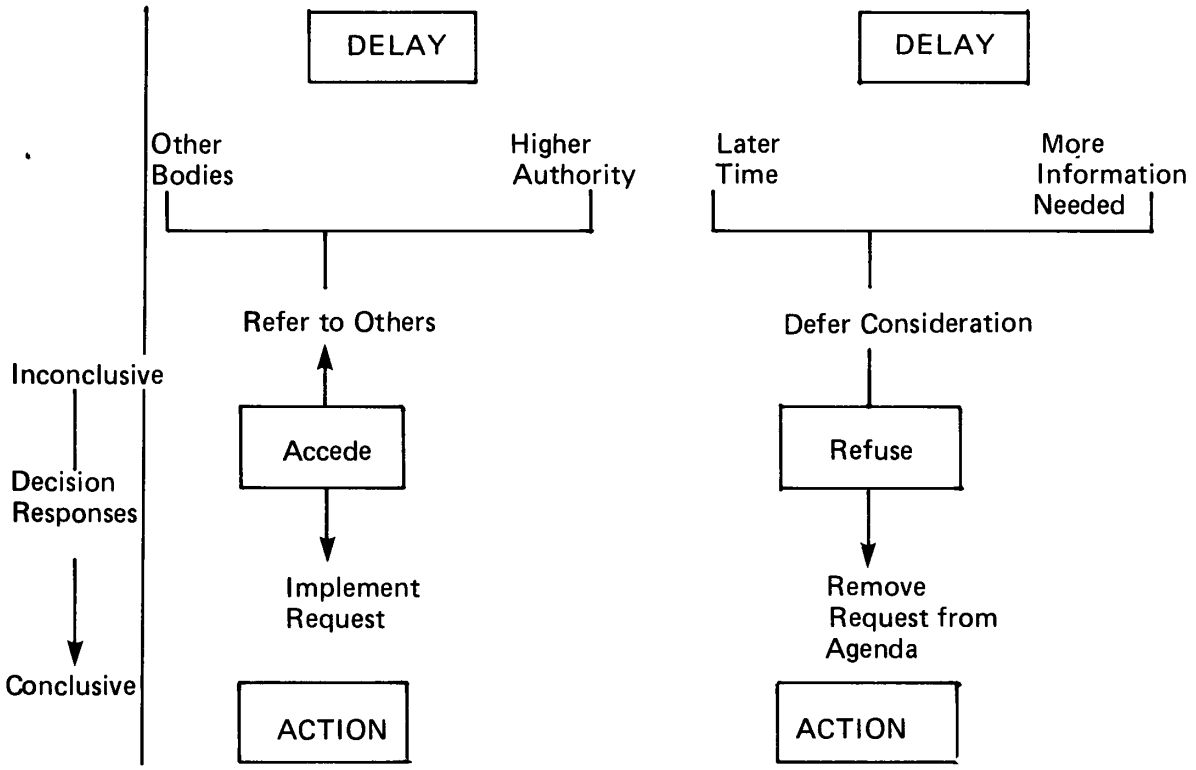
(d) deferring consideration of the request till a later time,

(e) referring the request to a higher authority,

(f) referring the request to other bodies for consultation.

These alternative strategies can be represented in diagrammatic form as follows (Figure 2)

Figure 2 STRATEGIES IN DECISION-MAKING



Any one of these strategies constitues a decision, of a kind, at a point in time but it is only the choice of (1) or (2) which formally marks the end of the decision-making process for the NHS organisation (ie excluding the possibility of the issue being pursued by extra-constitutional action). Note also that this conceptual map does not address itself to questions of whether the decision was correct or whether the delay was justified.

How one defines a decision is clearly of great importance when it comes to selecting a sample of decisions to be traced back through the organisation. It is necessary to identify where issues cluster for decision, so that there is a field which can be sampled. The Royal Commission suggested that many decisions would be recorded in the minutes of management teams and samples could be drawn from this source. This, of course, would leave out all those issues which were resolved before they reached management team level, ie there would be a bias in the sample, perhaps towards the more complex, and time consuming, issues. However, while issues selected from management team minutes would not necessarily provide a comprehensive picture of the way in which decisions are made in the NHS, sampling would probabaly produce sufficient cases to illustrate the complexities of reaching decisions in the service and the wide range of factors that may have to be taken into account.

A further problem concerns the choice of tier from which the decisions are sampled and traced. Intuitively a sample of districts holds the greatest attraction. First, this gives a wider field from which to sample, and would be expected to throw up far more variety in size, environment, facilities, political background and other variables, than there would be at area and regional level. Secondly, one would expect district management teams (DMT) to decide and act on a greater range of issues than area teams of officers because of their specific management responsibilities for service. Thirdly, they would refer certain policy and resource allocation issues arising in district to area and beyond, thus (legitimately or otherwise) inducing delay.

This again raises the question of the definition of a decision. Clearly, if the study did draw its sample of decisions from DMT minutes, it would have to include not only decisions to act conclusively but also decisions which imply delay. Indeed, this suggests a deficiency in the retrospective approach if it is confined to a scrutiny of evidence lodged in the tier of origin. If the whole decision is to be traced through to conclusive action an issue may have to be followed through to area and region, after the DMT has taken its own 'decision'. Likewise if there is further action on an issue within the district itself, after the DMT has taken the 'decision' as selected in the sample, it would be appropriate to include an account of those subsequent events in order to capture the complete process. Quite simply it would not be illuminating if the 'decision' to be traced occurred in the course of resolution of an issue without placing it in the context of the origin and conclusion.

Concern for the total process may be grounds for selecting issues from health authority minutes. First, it might not always be clear from management team minutes whether and when a decision has actually been made, whereas with the health authority minutes there are formal conventions for recording decision. This distinction is readily understandable. Management team minutes are, strictly speaking, confidential accounts of internal discussion, whereas the minutes of health authorities are those of statutory bodies charged with a formal decision-making role and they should be available to the public. Secondly, given these formal decision-making responsibilities, the relationship between members and officers - as manifested in the decisions of the authority - is a significant element in the decision process. Therefore, it would be relevant in a major study to include decisions of both officer teams and authorities, to check whether significant differences exist between the decisions recorded in the two sets of minutes and whether there are strong grounds for using one set of minutes rather than the other, or indeed both.

CRITERIA FOR SELECTING DECISIONS

In enlisting our help to test the retrospective approach, the Royal Commission also suggested that, if possible, six types of issues should be examined:

1 Filling a post

2 Creating a new post

3 Replacing an item of equipment

4 Minor up-grading of a building

5 A Family Practitioner Committee or health centre item

6 A community health service item

It was though that these were *prima facie,* types of issue where, even with the apparent complexity of the organisational structure, the decision process would not be prolonged. Secondly, although a listing of decisions made by a management team/health authority does not of itself illuminate the process by which decisions were made, these categories were regarded as useful in sorting out the decisions which had been made within a given time period.

A sample period of six months was suggested to increase the chance that there would be at least one example in each category. Indeed it was possible that there would then be several decisions in certain categories and some further criteria would be needed to select from these. One approach might be to choose those issues which would provide evidence which could be used to test the nul-hypotheses listed earlier in this section. However, it was not certain that relevant information would be available from the formal minutes to make this feasible. Even in those cases where it was clear that an identified case would illuminate the practice of, say, consensus management or delegation, the fact that it was so self-evident would likely bias the sample. In a full study, therefore, we would argue that it would be wiser to take a random sample from each category from each locality chosen. That is, for each locality selected, all the decisions taken by the management team or health authority, would be sorted into subject categories and a sample of decisions drawn randomly from each subject category.

TRACING THE ISSUE BACK

The selection of decisions is, of course, only the first step in such a study. It is then necessary to trace the issue back through the organisation, and this search involves several stages.

Assuming that these decisions were being selected from DMT minutes, the following stages at least would be included in the search process.

1 Review of DMT minutes as far as the first time the issues was brought to the attention of the DMT, noting the date(s), who referred the issue to the DMT, and what action was taken each time the issue was considered.

2 Review of area health authority (AHA) minutes and agendas. If the issue has been formally discussed by the AHA there is possibly a position paper which sets out the background to the case.

3 After these two steps, it should then be possible to sketch out a rough timetable of events, noting in particular, any delays, substantial changes in the request, or wider discussions on policy arising from this request. This timetable should provide the framework for further investigation and make it possible to identify key features of the process which deserve close attention.

4 Searching through the district files on the matter, for letters, newspaper cuttings, names, which amplify the data already collected could then follow.

5 At this point, it should be possible to identify the people/groups/ organisations who dealt with this issue.

6 If other formally constituted groups were involved, either within the district, in other districts, at other tiers, or outside the NHS, one should consider approaching those groups to seek access to

their documents, recognising that their agreement may not necessarily be forthcoming.

7 Draw up a list of people who need to be interviewed. Clarify the questions to be asked. Contact the individuals formally; explain the purpose of the study and the way it is being carried out and seek their agreement to be interviewed.

8 Interviews. The range of questions to be asked would cover the local formal procedures (if any) for dealing with the type of issue; what actually happened in this case (checking out and amplifying the information already obtained); explanations of delays, changes to the request, and wider policy debates which arose; and the perceptions of the individual on the factors influencing this case and the way it was handled.

9 Ideally, the final product should include a description of the local formal procedure for this sort of request; a specific timetable of events together with a network diagram showing who originated the request, who was subsequently involved, when and how, and the links between the various actors; explanations for delays, changes in the request and wider policy debates; a summary of comments on the case by people involved; and the researchers' conclusions, identifying any information which tests the hypotheses put forward.

These are two major constraints to the diligent pursuit of these stages; one human, one physical. A programme of research, relies heavily on the goodwill of everyone involved. Researchers are outsiders, who have limited time to build up relationships of trust. There is likely to be a certain amount of suspicion and it may be that authorities, teams and individuals who agree to co-operate will still want to place certain restrictions on the research. For instance, the researcher might not be allowed access to confidential files; the availability of officers' time to answer questions might be limited or denied; or there might be a condition that actors outside the immediate office should not be interviewed. Apart from offering the usual safeguards of confidentiality, and

projecting a strong sense of tact and sensitivity, there is little that can be done to avoid these restrictions. Indeed, other experience of a comparable kind suggests that it may be unrealistic to attempt to secure the confidence of all parties when they are, or may see themselves as being in conflict.

Secondly, it is probably that in some cases, many individuals and organisations would be involved in the **process** - as opposed to the **act** - of decision-making. The concept of the **minimum** information to carry out the research task is a valid one, though the criteria for its determination are far from clear-cut. One criterion for selecting people to interview might be the significance of their involvement to the final decision. Yet, 'significance' is not a simple function of attendance at those meetings where the issue was discussed. What can be confidently concluded is that a good deal of research time will likely be dissipated in the 'search' process.

SUMMARY

In this section of the paper suggestions have been made on how the practical application of the decision-making concepts built into the re-organised NHS might be tested through the use of the nul-hypotheses. Alternative ways of searching for evidence on the decision-making process have been discussed. A number of potential constraints and problems have been identified, but judgement should be deferred until the experience of the feasibility study has been examined in the following sections of the report.

[illegible] the process [illegible]

[illegible]

[illegible] product should [illegible] this sort of [illegible]

[illegible] been used or [illegible]

[illegible]

THE FEASIBILITY STUDY : TESTING THE RETROSPECTIVE METHODOLOGY IN ONE PARTICULAR AREA

In this section the research process followed is described, the broad outline of events in each case is charted, and a commentary is offered on how far the research provided an illuminating picture of what had taken place and why.

THE DIFFERENCE BETWEEN THE FEASIBILITY AND FULL-SCALE STUDY

There are certain differences in the way this study was carried out and the way one might expect a full-scale study across the country to be conducted, and these should be made explicit.

The first is that the feasibility study was carried out under the umbrella of a research contract negotiated with the host authority for quite another purpose. In one sense this has restricted the scope for study because that research contract was negotiated with the area level alone, and accepting that we would have to work within an established pattern of relationships with our hosts and others, it was decided not to seek any confidential material at district and regional levels where we had no such 'contracts'. This could well have affected the amount of data collected on features such as delegation of responsibilities. The presumption is that any full-scale study would negotiate a research contract with all tiers involved in decision-making in any one locality.

Secondly, this study was carried out on an intermittent basis, because of other commitments over the period, August to October 1977. The empirical work was necessarily interrupted, whereas it could have been carried out in a more sustained and concentrated fashion, in a full-time study.

Thirdly, the field researcher already had well established contacts in the area and it seems likely that some avenues of information were open to

her which would not immediately be open to a researcher who came in as an outsider. It may also be that officers were readier to go into greater depth about particular cases than would otherwise be the case; although one could possibly argue that they would have felt more confident in openly refusing to disclose information to someone they knew.

A further difference between this study and any full-scale study, is that the **focus** of our attention was somewhat different. In this study more attention was paid to the **sources** of information and to the **form** and **texture** of that information than the **content** of the information obtained about individual cases. Nonetheless, the procedure adopted in the feasibility study followed closely the lines put forward in the previous section and the research methods suggested were all tested on at least one of the decisions traced.

APPROVAL TO CONDUCT THE STUDY

Assent to the feasibility study was given by the hosts after the most careful consideration. First, as they pointed out, the minutes of the area team of officers (ATO) were confidential and circulated to a limited audience. In this instance they agreed that they could be used for this study, although we gave an assurance that the information would be treated as confidential and written up in the most anonymous terms possible. Second, it was pointed out that the task would be made easier by selecting decisions from AHA minutes. These minutes used conventions for recording when a decision had been taken, whereas this was not always the case with ATO decisions in their team minutes. Both ATO and AHA decisions were in the event examined (following the argument developed above).

Once the selection and decisions had been made, it was then 'cleared' locally. In a study of this kind periodic re-affirmation of host support is vital to its successful completion.

SELECTING THE ISSUES

Two lists were drawn up of all those items (within the agreed categories)

in the AHA minutes from January to June 1977, and the ATO minutes for the same period which met certain criteria. Items were included from the AHA minutes where it was clear that:

- a decision had been or was being taken; and
- area officers were involved, at some point, in the decision making process.

Items were taken from the ATO minutes where it was clear that a decision had been or was being taken (and this included decisions to refer an issue to the AHA).

It was not always obvious when a decision should be included. Certainly a wide range of issues may be subsumed under one heading - for instance the category, 'upgrading a building' included both a scheme to resurface some hospital tennis courts and the whole minor capital works programme for 1977/78. It may be that the appropriate issues to trace would be much more evident if one was using DMT minutes, but even here it is likely that the researcher would at times have to take fairly arbitary decisions about what to include in the list to be sampled and what to leave out.

In a larger scale study, where the decisions of many management teams were being studied, it would be sufficient to take a random sample of issues from each category in each locality. With a large sample one would probably find cases which reflected a wide range of characteristics.

In this study it was necessary to make assumptions about the dimensions which might vary significantly and choose examples which could be placed at different points on these various continua. The dimensions taken into account included: the complexity of the issue (ranging from a simple issue where existing procedure was followed, to the very complex issues where no established procedure fitted the situation); and the number of agencies involved (from issues internal to the area office to issue which involved non-NHS bodies, the public etc);

the time scale within which the decision was made (from the issue which simply required the ATOs ratification to those which might drag out over several years); the number of implications of the decision on other services; and also the likely availability of information.

Six issues were finally selected for the following reasons:

	Category	Issue	Reasons for choosing issue
1	Filling a Post	ATO's decision to replace a clerical assistant in the Health Education Department	a seemingly straightforward issue but one which had to be considered in the light of the Management Review on the one hand, and the national policy emphasis on the other.
2	Creating a new post	AHA's endorsement of proposal to adjust staffing levels of student and pupil nurses	a manifestly complex issue - which illustrated the way in which several issues can become entwined and have to be disentangled. Involved negotiations with the districts and with operational staff. Well documented - a large amount of statistical background material prepared to aid decision making.
3	Replacing an item of equipment	ATO's decision to replace a damaged ambulance	an apparently straightforward routine issue, internal to the area administration. Information assumed to be easily available.

	Category	Issue	Reasons for chosing issue
4	Upgrading a building	AHA's decision to convert selected hospitals from use of oil as the main fuel to natural gas	involved a non-NHS agency, and consultations with the districts and region. Potential revenue savings from capital expenditure. Quick decision was required. Well documented.
5	An FPC Item	AHA's decision to take no further action on closure of a GP branch surgery	issue raised because of adverse public reaction to the closure. Illustrated the statutory framework within which the AHA has power to act and especially the relationship between the FPC and the AHA. Information was available at area.
6	A community health item	AHA's approval of proposals for consultation on the fluoridation of water supplies	illustrated the number of agencies who have to be consulted before a decision of this nature could be taken. Also illustrated the type of information that had to be considered. Information was available at area.

TRACING THE ISSUES

Each case was traced back in the ATO and AHA minutes. Where time was available the key officers who dealt with the issue were identified and a standard letter was sent asking for their co-operation in the study. In some cases it was both possible and desirable to seek an interview with the key

officer concerned about the standard procedures and the events of the particular case; in others, it seemed wiser to go through files first.

The seven questions which the Royal Commission had suggested they would like to see investigated, were:

(a) Where (or from whom) did the initial request originate?

(b) Time taken for a decision to be reached?

(c) The number and type of stages involved from start to finish?

(d) The people (or organisations) involved in the process?

(e) If delays occurred, was it possible to discover from the records why this was? If possible, what were the reasons for delay?

(f) Were there any substantial changes to the original request?

(g) Did the initial request lead to discussions at any stage of major policy issues?

When the information had been gathered on each issue, these questions were then posed, and the answers are discussed below.

The conclusions drawn about the usefulness of the procedures adopted for tracing each particular issue and the quality of the information gained, are discussed below.

1 **Filling a Post**

Introduction

The decision - recorded in the ATO minutes - was an agreement reached to advertise the vacancy for a clerical assistant in the health education department. The vacancy arose from the resignation of the previous holder of the post. Although it might be viewed as a fairly 'junior' appointment, it was thought necessary to receive ATO approval because of the stringent review of management costs that was being conducted in the area at that time.

It was decided to trace back this issue from the ATO minutes to locate the origin of the request for a replacement. This involved checking the files, and interviewing the area health education officer, the area personnel officer and the administrative assistant in the personnel department.

Chronicle of events

The chronicle of events, including the sources of information upon which it is based are detailed below (Figure 3) :

FIGURE 3: FILLING A POST

Date	Events in this Case	Source of Information
14 March 1977	1 The F/T clerical assistant in a district's health education department gave a month's notice	Interview with the AHEdO
	2 The area health education officer told her to send a formal letter of resignation to the APO immediately	
	3 The AHEdO informed the area medical officer and the APO of this impending vacancy (as from 11 April 1977)	
15 March 1977	4 The AMO put the item on the ATO agenda	ATO agenda APO - interview

Date	Events in this Case	Sources of Information
	5 'The ATO *agreed* that this post should be advertised in view of the fact that this was a single handed appointment and that if it was not filled the health education service to schools etc would have to cease'	ATO minutes
	6 The advert for the post was placed in the local newspaper. Closing date for applications was 8 April	Area personnel department's file on filling this post
	7 Applications were received	Area personnel department's file on filling this post
Uncertain (late March)	8 APO asked the area health education officer to consider employing an existing member of staff for this post who was to be made redundant. The AHEdO agreed to appoint this person to the post	AHEdO (interview)

Date	Events in this Case	Sources of Information
1 April 1977	9 The administrative assistant in personnel sent out a letter to all the applicants for the post, explaining that it was no longer vacant and that 'The post has in fact been filled by an officer with many years service in another part of the organisation' and that they had been unable to cancel the advertisement before it went to press	Area personnel department's file on filling this post.
13 April 1977	10 The new appointment as clerical assistant was made	AHEdO (interview)

Questions

(a) *From whom did the initial request originate?*
The area health education officer.

(b) *What was the time taken for a decision to be reached?*
The decision to replace the vacancy was made within twenty-four hours of the month's notice being given.

(c) *What were the number and types of stages involved?*
Verbal communications between the AHEdO, APO and AMO resulted in the matter being discussed at short notice (see Figure 3).

(d) *Who (or which organisations) were involved in the process?*
As above (see also Figure 3).

(e) *Were there any delays in the process?*
No.

(f) *Were there any substantial changes during the process to the original requests?*
There were no changes to the request itself - ie to fill the vacancy but the normal progress of events was changed in that a health service employee was both eligble and suitable. It was not therefore necessary to interview.

(g) *Did the initial request lead to discussions, at any stage of major policy?*
No, except for passing observations on the level of management costs baseline.

2 Creating a New Post

Introduction

By way of contrast to the previous example, the issue presented below is complex. In June 1977 a position paper was presented to the AHA indicating the major factors influencing the demands for more nursing staff, and determining the number of new nurses who would have to be employed to meet various criteria. The AHA endorsed these staffing levels and agreed that these should form the basis for discussion between the ATO, DMTs and interested parties. The 'decision' as such is therefore a 'decision' reached by the AHA to agree upon the basis of a 'case', and is not a 'final' decision on what specific action should be adopted.

The background to this debate stems largely from the amalgamation of the district schools of nursing into one area school of nursing and the introduction of two training syllabi - the 1969 General Nurse Training Syllabus, and the 1974 Mental

Nurse Training Syllabus. It was realised in due course that no provision had been made in the plans for 1977/78 for an inevitable increase in nursing staff that these changes would create. To further complicate the picture, visits of inspection by the General Nursing Council during 1976 had led to the recommendation that certain wards should no longer be used for training. The consequence of this would be that these wards would now have to be staffed by qualified nurses. Other factors encroaching upon the decision included the possible misallocation of learners to staff particular wards; the implications of training more registered nurses than enrolled nurses in staffing wards; and the apparent fact that norms for minimum staffing levels in many of the wards were not being met.

For several reasons, it was decided to trace this issue back using only ATO and AHA agenda and minutes. One pragmatic reason was that it would have taken an exceedingly long time to go back through all the files on the issue and interview everyone who was involved. Many of the personnel involved in this issue were not working at the area offices and their office files would only be found at district and unit levels.

Chronicle of Events

Turning now to the chronicle of events, Figure 4 below sets out to record in *summary* form those events which are noted in the agends papers and minutes.

Date	General Nurse Training	Mental Nurse Training
August 1976	An inspector of training schools visited the area school of nursing. There was an informal meeting after the meeting where the inspector outlined her proposals	A second inspector of training schools visited the area school of nursing to review the training schemes for nurses for the care of the mentally subnormal. There was an informal meeting at the end of the inspection where the inspector outlined the proposals he would be including in his report.
	Following this a meeting was held with the district nursing officers (DNOs); divisional nursing officers, senior nursing officers, and some nursing officers from all the hospitals included in the training scheme to discuss the methods by which the recommendations might be implemented.	

Date	General Nurse Training	Mental Nurse Training
21 September 1976	The ATO received a copy of the GNC inspector's report and noted that the ANO was discussing the contents with the director of nurse education.	
Between the end of September and beginning of December 1976	Meetings were held in both districts and some progress was made towards implementing the recommendations of the report.	
November 1976	(Area Plan went to AHA - costings for revenue consequences of probable changes in nurse training not included).	
9 December 1976	ANO made a report to AHA about the inspector's report, discussions on and progress thus far on implementing the recommendations.	
24 December 1976	ANO received a copy of this inspector's report.	

Date	General Nurse Training	Mental Nurse Training
4 January 1977		ATO received a copy of this report and after discussion agreed that various groups should consider the recommendations.
11 March 1977		Meetings of nurses, representatives of the consultant medical staff and area treasurer.
14 April	ANO made a report to the AHA on the progress to date in implementing the recommendations for mental nurse training made by the inspector and informed them that a further report would be submitted as soon as all consultations and discussions had been concluded and the full implications worked out in detail.	
19 April 1977	ANO reported to the ATO that a meeting was being set to discuss staff bids in connection with the new training arrangements.	
26 April 1977		
2 May 1977	Meeting to discuss staffing bids	
3 May 1977	ANOs report to ATO on outcome of previous day's meeting. It was noted that the DNOs and the DFOs would shortly be meeting in an effort to identify costs which were applicable to the change in syllabus and those which might be attributable to the area nurse training school.	

Date

12 May 1977 The AHA discussed and approved the district budget allocation. The point was made by both districts that large sums of money would have to be found from the allocation to meet the unplanned consequences of changes in nursing establishments. It was noted that these costs had still to be refined.

9 June 1977 A position paper was represented to the AHA indicating the major factors influencing the demand for more nursing staff, and determining the number of new nurses who would have to be employed to meet the various criteria.
The AHA **endorsed** these staffing levels and **agreed** that the paper should form the basis for further discussions with DMT's and medical staff.

Questions

(a) *Where (or from whom) did the initial request originate?*
This would be difficult to answer in any case because so many threads became entangled in one web. We knew from the AHA agenda that the inspectors of training schools made two visits of inspection to the area school of nursing in August 1976. However there were no real clues **in the minutes** about when it was **first** realised that the various changes in nurse training would lead to a greater demand for qualified nurses on the wards.

(b) *Time taken for a decision to be reached?*
Since it was not clear when the demands for more nurses arose, it was almost impossible to say how long it took to reach the decision. All that can be said with any certainty was that it was ten months after the visit of inspection that the AHA decided on the appropriate number of extra nurses required to meet their recommendations, along with the other changes which were also being made. However, as mentioned earlier, this 'decision' of the AHA to endorse these staffing levels did not mark an end to the issue and it was not possible to estimate how long it would take to see agreed new staffing patterns implemented.

(c) *The number and type of stages involved from start to finish?*
Only the most outline information was provided from the ATO and AHA agenda and minutes and it would have been necessary to consult other sources before an intelligent response could have been made to this question.

(d) *The people (or organisations) involved in the process?*
We know from the agenda and the minutes that the General Nursing Council and its inspectors set the standards which the area school of nursing was expected to meet. The area nursing officer - and the director of nurse education - figured prominently in the story, and they were supported by an education working group. There was consultation on the proposals put forward by the GNC's inspectors with district nursing officers, divisional nursing officers, senior nursing officers and some nursing officers from all the hospitals included in the training scheme. There were discussions between tutors, clinical teachers, nursing officers and ward sisters on the learning objectives which should be defined for each ward, though we are now aware of the bearing this had on the number of staff required. The medical profession was also closely involved. The area medical advisory committee

was asked to nominate two psychiatrists to the educational working group, dealing with training of mental illness and mental handicap nurses. Clearly the management teams (ATO and DMT) were involved, and particularly the nursing and the finance officers.

In summary, although we knew that representatives of these various groups were involved, we did not know, in most cases, who the representatives were, what viewpoints they represented, whether there was any important division of opinion, because the minutes tended to record the outcome of meetings rather than the discussions that took place and with whom.

(e) *If delays occurred is it possible to discover from the records why this was?*

It was very difficult to say whether or not delays did occur without a more precise timetable. Both visits of inspection took place in August, and whilst the report on **general** training was available by mid-September 1976, the report on **mental** illnesses and handicap training was not available until the very end of that year. A review of the files and/or interviews with those involved might well have revealed the reasons, although the example here does serve to illustrate that occasions arise where the 'delays' lie outside of the authority's control, action resting with other bodies.

(f) *Were there substantial changes during the process of the original request?*

Inevitably, given the nature of this activity, there were changes to the request for more staff since the whole process was one of refining the request - clarifying the objectives, and putting the request in a quantifiable form. However, it was extremely difficult to repond further, given the uncertainty surrounding the nature and timing of the 'original' request.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*
This question is inappropriate in this particular case, since the request was in fact a consequence - at least in part - of a major change in policy ie the introduction of the 1969 and 1974 syllabi. And yet the case did raise, within the area, at least two policy issues: whether or not an outside body (in this case the GNC) should be able largely to determine how an AHA should spend the greater part of its growth money; and also how useful planning is when such a large revenue consequence of a new scheme could arise at the beginning of the financial year, when no provision had been made in that plan to accommodate it. Both these points were aired at AHA meetings and at meetings between ATO and DMT's, but this detail is not apparent from reading the minutes and agenda.

3 **Replacing an item of equipment**

In March 1977, the area team of officers agreed that a replacement ambulance should be obtained to replace a severely damaged vehicle. The background to the case was that during December an on-coming vehicle had collided with a sitting case ambulance causing extensive damage to the ambulance. The decision to be taken was whether the vehicle was so badly damaged that it would have to be replaced, and if so, whether the funds would be forhcoming.

The issue appeared to be straight forward in the sense that the ambulance service was an area based service and that the officers concerned were all area personnel. The issue was traced from the ATO minutes sequence of events, through discussions with the area chief ambulance officer, the assistant chief ambulance officer, and by consulting the accident report file. In this instance, there was a clear procedure for dealing with accidents and the options to be considered when a vehicle was badly damaged.

Where a vehicle was badly damaged (ie the cost of repair was considered greater than the value of the vehicle) the ATO took a decision on whether or not to write it off and replace it. Such a decision, calling for an unplanned replacement, was considered alongside other priorities in the Area.

Chronicle of Events

The sequence of events can be briefly summarised as follows (Figure 5)

FIGURE 5 : REPLACING AN ITEM OF EQUIPMENT

Date	Events in this Case	Source of Information
20 December 1976	Oncoming vehicle collided with a sitting-case ambulance which was carrying two passengers, at a narrow part of the road. The station officer visited the scene of the accident, witnessed the driver's statement to the police and reported the incident to the divisional officer and the chief ambulance officer	Traffic accident report in file and assistant chief ambulance officer memo in file
5 January 1977	Divisional officer sent the estimate for cost of damage to chief ambulance officer	Memo in file
6 January 1977	Chief ambulance officer sent a copy of the accident report to area administrator	Memo in file

Date	Events in this Case	Source of Information
12 January 1977	The ambulance administative assistant sent copies of the accident report and the station officers report to RHA's legal advisor and asked him to deal with the case	Memo in file
21 January 1977	Memo from ambulance administrative assistant to assistant chief ambulance officer, asking if the ambulance vehicle was to be considered a write-off	Memo in file
25 January 1977	Assistant chief ambulance officer's memo to ambulance administrative assistant confirming that the vehicle was to be considered a write-off and authorising ambulance administrative assistant to act accordingly.	
	The assistant chief ambulance officer took this decision himself	assistant chief ambulance officer
31 January 1977	Memo from chief ambulance officer to area administrator explaining the estimate and that the present value was less than the cost of repairs.	Memo in file

Date	Events in this Case	Source of Information
	He asked for permission to count the ambulance as a 'write-off' and obtain a replacement as soon as possible	
15 March 1977	'The ATO agreed that as the present value of the ambulance vehicle was less than the cost of repairs, it should be written-off and a replacement obtained'.	ATO minute

Questions

(a) *Where (or from whom) did the initial request originate?*
The report of the accident and the damage of the vehicle was made to the divisional ambulance officer and then to the chief ambulance officer.

(b) *Time taken for a decision to be reached?*
Three months elapsed from the date of the accident until the ATO took the decision to write-off the vehicle and replace it.

(c) *The number and type of stages involved from start to finish?*
See Figure 5.

(d) *The people (or organisations) involved in the process?*
The driver, the station officer, the divisional officer, the ambulance administrative officer, the assistant chief ambulance officer, the chief ambulance officer, the area administrator, the ATO, the regional legal advisor and the county council's transportation and engineering department.

(e) *If delays occurred is it possible to discover from the records why this was?*
There was a time lapse of about six weeks between the chief ambulance officer asking the administrator for permission to count the ambulance as a 'write-off', and obtain a replacement, and the ATO formally considering this matter (ie 31 January 1977 to 15 March 1977). Without conducting further interviews it was difficult to offer explanations although at the time the ATO was also considering formal consultation on an O and M study report on the ambulance service. The fact that the report recommended a reduction in the size of the fleet could have been a contributory factor in 'delay'.

(f) *Were the substantial changes during the process to the original request?*
None.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*
It is possible that this request was discussed in the context of a major review of ambulance usage and deployment, but this conclusion could not be drawn, for certain, from the sources of information used.

4 Minor up-grading of a building

Introduction

This issue originated from a 'package' offer received from the gas board in January 1977 to install natural gas as the main fuel at three hospitals in the area. This work would have been phased over a two-year period with a start in 1977/78. The gas board, whilst not prepared to offer any understanding over the expected future prices of natural gas was prepared to maintain a differential between the cost of natural gas and oil.

The gas board was also prepared to meet a large proportion of the initial installation costs. A decision was reached by the AHA on the 9th June 1977 to sign a contract with the gas board, having reached agreement in principle to the proposals some three months previously (ie March 1977).

Here again it was decided to use only material in the ATO and AHA minutes and agenda paper. However, there did appear to be more documentation available from these sources from which one could piece together, albeit crudely, an outline of the stages that occurred.

Chronicle of Events

The main events recorded in ATO and AHA minutes and agenda papers are as follows (Figure 6).

FIGURE 6 : MINOR UP-GRADING OF A BUILDING

Date	Events in this Case	Source of Information
18 January 1977	AWO informed ATO of offer from gas board. ATO agreed to support AWO proposals to refer these to DMTs	ATO and AHA minutes and agenda papers
8 February 1977	Report to ATO that capital development group (CDG) had considered proposals and were commending these to districts	
18 February 1977	Letter of intent sent by AHA chairman as an expression of interest (not commitment)	

Date	Events in this Case	Source of Information
22 February 1977	ATO noted comments from DMT. Agreed to seek approval in principle from AHA	ATO and AHA minutes and agenda papers
10 March 1977	AHA agreed in principle to proposals supported chairman's letter of intent to the gas board/ recommended the gas board be asked to recalculate basic price.	
29 March 1977	ATO reviewed scheme in view of reduced allocation - agreed to continue negotiations with gas board/ CDG asked to identify capital projects which could be delayed	
17 May 1977	ATO noted RHA's sympathetic response and that one of the DMTs was already making such provisions for the third hospital	
24 May 1977	ATO noted that RTO was satisfied with scheme - paper to go to AHA	
9 June 1977	AHA agreed that contract with British Gas Corporation should be accepted on terms stated therein	

Questions

(a) *Where (or from whom) did the initial request originate?*
The initial request appeared to have originated with an offer by the gas board to the area through the area works officer to install natural gas at three hospitals in the area at a discount rate. It could be assumed that this offer was made prior to 18 January 1977.

(b) *Time taken for a decision to be reached?*
It appeared to have taken about five months from the date the offer was made until the AHA took the decision to enter into a contract with the British Gas Corporation.

(c) *The number and type of stages involved from start to finish?*
It was difficult to answer this question without access to the files and interviews. Figure 6 is only able to show the stages that were apparent from the ATO and AHA minutes and agenda papers.

(d) *The people (or organisations) involved in the process?*
It was difficult to respond fully to this question. The British Gas Corporation was obviously involved. Within the NHS, both district management teams were asked for comments; the RHA, and particularly, the regional treasurer, were asked for comments on the scheme. Within the area, the area works officer appears to have played a central role in processing this request, taking the matter to both the ATO and the capital developemnts group. This latter group included at that time the area planning and developments officer, the are nurse (planning), the SCM (planning), and the area works officer. But it is , however, likely that this list was not exhaustive.

(e) *If delays occurred is it possible to discover from the records why this was?*
The AHA, in approving this scheme in principle, recommended that the British Gas Corporation be asked to recalculate the basic price, and while this was done with the interests of the Health Service in mind, it may have caused a delay in reaching a decision. Certainly a reduction in the total avenue allocation for 1977/78 compared with the figure that had been expected, meant that the funding of this scheme had to be reviewed. Consultations with the region inevitably lengthened the time period over which the proposal was considered.

(f) *Were there substantial changes during the process to the original request?*
Apparently not.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*
The answer to this question was not apparent from the sources available, although there was some discussion in the arguments advanced for and against the scheme as to the value of spending scarce capital funds now in order to save scarcer capital funds later.

5 **A Family Practitioner Committee Issue (FPC)**

A decision to take no further action on the closure of a GP branch surgery

In this particular case complaints had been expressed, and reported in the local press, concerning the FPC's decision to close a surgery consequent upon the retirement of a general practitioner. The matter was therefore referred to the AHA.

At the April meeting of the AHA, it was reported that complaints had been received from residents and the local community health council about the closure. In the minutes of the authority it was noted that:

(a) The closure was not a planned redistribution of surgery facilities but was the unavoidable consequence of filling a GP vacancy: the doctor who was appointed, having taken over the practice on the understanding that he would not be required to offer sessions at the existing surgery.

(b) The FPC was solely responsible for the filling of vacancies, subject to the approval of the National Medical Practitioner Committee, to advertise the vacancy and subsequently to offer the appointment to the candidate selected by the FPC;

(c) There was no requirement for the FPC to consult anyone else about filling a GP vacancy or about any consequential redistribution of doctors or their surgeries.

Accordingly the AHA made the decision to agree 'that no further action should be taken unless the service proved to be inadequate'.

The decision - not to take the matter further - was recorded in the minutes. What was not recorded was the sequence of events which led up to the decision. Accordingly, it was necessary to interview the FPC administrator concerning the events which took place in this case prior to the AHA meeting, and the formal procedure for filling a GP vacancy. The procedure is well-known, and though the formal process does take time, there is considerable pressure upon the FPC administrator to expedite the issue quickly.

Chronicle of Events

The following information is based upon information supplied by the FPC Administrator.

FIGURE 7 : AN FPC ITEM

Date	Events in this Case	Source of Information
15 November 1976	Resignation received from the single handed practitioner on the ground of ill-health. The date specified for the resignation to become effective was 31 December 1976.	FPC administrator
16 November 1976	Letter was sent to the emergency committee of the family practitioner committee asking whether they agreed that a medical practice vacancy should be declared. The surgery was in an intermediate area which meant that a vacancy could not automatically be declared and that the consent of the medical practices committee must be obtained.	
23 November 1976	Replies received from all members of the emergency committee. Letter to medical practices committee seeking permission to declare a vacancy.	

Date	Events in this Case	Source of Information
29 November 1976	Retiring doctor was approached and agreed to extend his resignation until 31 January 1977. Consent received from medical practices committee to advertise a vacancy. Advertisement sent to the British Medical Journal (A vacancy would normally be advertised in the Lancet also, but the closing date of adverts meant that there would be an unacceptable delay before the advert could appear).	FPC administrator
11 December 1976	Advertisement appeared in the BMJ.	
29 December 1976	Closing date for receipt of applications.	
30 December 1976	Selection of candidates for interview.	
4 January 1977	Interviews conducted. Recommendations submitted to Medical Practices Committee.	

Date	Events in this Case	Source of Information
	The advertised practice had only a small list of patients, which meant that it was not financially very attractive to doctors from outside the area. The committee therefore decided to recommend the partnership of two doctors whose main surgery was about 1½ miles away from the advertised practice and to the closure, therefore, of the advertised practice. The committee established to its satisfaction that there was a reasonable bus service between the two places and that the partnership was prepared to visit patients who suffered undue difficulty in attending their own surgery.	
6 January 1977	Medical Practices Committee decided to confirm the recommendation of the local interviewing committee.	
18 January 1977	Family Practitioner Committee notified by DHSS that no appeals had been received.	
21 January 1977	Letter sent to patients of retiring practitioner	

Date	Events in this Case	Source of Information
1 February 1977	Practitioner retired and successor took over.	FPC administrator

Questions

(a) *Where (or from whom) did the initial request originate?*
From the incumbent GP who handed in his resignation to the FPC.

(b) *Time taken for a decision to be reached?*
The time period that elapsed between the notification of the vacancy (ie 15 November 1976) and the appointment of a successor (ie 1 February 1977) took, in total, 2½ months. The AHA's discussion of this issue took place after the major decision had been reached and implemented and was concluded at its April meeting.

(c) *The number and type of stages involved from start to finish?*
The FPC administrator identified 16 distinct stages (see above) through which the committee - as the responsible authority - processed this decision (in the light of established procedures).

(d) *The people (or organisations) involved in the process?*
In the decision to appoint the GP the following can be identified:

the incumbent GP who returned the FPC administration
the emergency committee of the FPC
the (national) Medical Practices Committee
the joint consultative medical practices committee (interviewing committee of the FPC)
the applicants themselves; and the FPC.

After the decision was made, there were complaints from:

members of the public
a member of parliament; and
a community health council

The area administrator was then obliged to report these complaints received to the area health authority. The above list is not necessarily, comprehensive, as some actors were subsumed under others (eg the FPC and the emergency committee of the FPC)

(e) *If delays occurred is it possible to discover from the records why this was?*
Assuming that the normal procedures as laid down are essentially 'correct', then there were no delays. In this case it could be reasonably concluded that the timetable simply did not permit consultation.

(f) *Were there substantial changes during the process to the original request?*
Yes, the original request was to replace the GP, presumably in the same surgery, but the GP who was appointed practised elsewhere and the existing surgery was therefore closed down.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*
No major policy discussions took place over the decision though discussions took place subsequently about the role of Community Health Councils and consultation with the public on any future proposals to close general practitioner surgeries.

6 A Community Health Issue

Approval of proposals for consultation on the fluoridation of water supplies

Introduction

The final case study included in this feasibility study concerned the issue of fluoridation. In January 1976 the Royal College of Physicians (RCP) produced its report *Fluoride, Teeth and Health*, recommending the fluoridation of water supplies. In June of the same year a DHSS circular (HC (76) 34) was issued, recommending fluoridation of water supplies to health authorities in the light of the RCP Report. In common with other areas this issue has had a long history, certainly stemming from before 1976 and continuing to this day.

For our purpose the 'final' outcome lay immediately outside the six month period for, in July 1977 the area authority made two decisions: in the first place it decided unanimously that 'this Authority does not wish to oppose fluoridation in some form in principle', and second, it decided by a clear majority vote that 'this Authority does not wish to oppose in principle the fluoridation of water supplies'.

This issue was traced back from the authority's decision using the area office file on the topic. Although only a precis is offered below it is relevant to point out that the literature on this topic was contained in two files of letters, pamphlets, memos and the like.

We return to the importance of this correspondence below.

Chronicle of Events

FIGURE 7 : A COMMUNITY HEALTH ISSUE

Date	Possible Key Events
11 December 1975	The file was opened with a letter received in the area office from a district councillor offering his views on fluoridation.

Date	Possible Key Events
6 January 1976	The Royal College of Physicians issued a report *'Fluoride, Teeth and Health'* recommending the fluoridation of water supplies.
7 January 1976	The secretariat administrator (after internal consultation) informed the press that the AHA had not yet considered fluoridation and would not be likely to do so until it had received: 1. the RCP's report; 2, the Court Report on Child Health Services; and 3. any DHSS guidance on the matter. When it did consider the matter the AHA would consult fully with the DMTs, area officers, the professional advisory committees, the JCC, the CHCs and any other interested parties. The best way for the public to put forward its views was through their local councils or preferably the CHCs. (Throughout 1976 many organisations and individuals wrote to the area about fluoridation, but the standard reply was that the area was awaiting DHSS guidance and the Court Report before considering the matter further. It would be true to say that the matter still received active consideration within the area and outside though it is not brought out in this brief chronicle of events).
11 March 1976	The environmental and public health committee of a district council voted in favour of a motion that the council should 'object most strongly to the poisoning of the drinking water by the addition of fluoride'.

Date	Possible Key Events
14 April 1976	This was followed by: a letter from the said district council informing the AHA that the council had passed a resolution on 8 April 1976 that 'the regional water authority and the AHA be asked for assurances that this council will be fully consulted and informed if fluoridation of the public water supplies is ever considered by either authority in time to enable action to be taken'.
20 April 1976	Internal memo setting out the case for and against fluoridation and giving estimated costs of fluoridating water supplies in the area.
June 1976	HC (76) 34 DHSS circular recommending fluoridation of water supplies to health authorities in the light of the recent report of the Royal College of Physicians and setting aside £0.5m pa as a contribution to the initial capital cost of fluoridation schemes. (This circular also made reference to the Minister of State's report and asked AHAs to give urgent consideration to introducing fluoridation as part of their preventive health responsibilities).
23 June 1976	Letter from the honorary secretary of the National Pure Water Association, asking if the AHA had considered fluoridation yet.
10 November 1976	RHA passed a resolution to pursue a policy of fluoridating water supplies in the region.

Date	Possible Key Events
29 November 1976	Letter to area administrator from regional administrator reporting the RHAs decision (with copies of the supporting evidence). The next step was for the RHA to decide how the policy was to be implemented and agree with the AHAs what steps they should take in drawing up a programme of action.
13 January 1977	AHA meeting. A consultative document - prepared by area officers - was presented and discussed, explaining the likely form and content of consultation to be carried out.
26 January 1977	It was agreed to distribute the consultative document asking for comments by 31 March 1977, as follows:
27 January 1977	2 copies and covering letter to chairman of AMAC, 1 copy to chairman of area pharmaceutical committee etc 23 copies to local medical committee (secretary) etc 28 copies to the honorary secretary of the local pharmaceutical committee etc 27 copies to the honorary secretary of the local dental committee etc 50 copies (as requested) to the secretary of one of the CHC's 25 copies (as requested) to the secretary of the other CHC, 1 copy to the chief executive of the county council, + 1 copy for each member of the JCC, 20 copies to the honorary secretary of the association of local councils

Date	Possible Key Events
	30 copies to FPC administrator for FPC distribution, 1 copy to the chief executive of each district council in the area, 1 copy to each member of parliament in the area, 1 copy to each JCC member explaining procedure, copies to members of the AHA, 50 copies to the county librarian for distribution.
2 February 1977	What follows is a highly selective collection of responses to this consultative document (reasons follow).
	Memo from ADO to secretariat administrator re member of parliaments' enquiry: '..... present position - Water Authorities feel that under existing leglislation, they do not have powers to add fluoride to water supplies therefore any promised indemnity will be worthless.' National Water Council is seeking clarification. Both DoE and DHSS have stated that the water undertakings' powers are adequate, but despite this, all water undertakings in the country, save one, have refused to implement AHA's wishes to take action in any new fluoridation schemes. The law officers are looking at the problem and it is understood that the two secretaries of state are meeting next month to discuss it. These doubts recently expressed are being considered by the DHSS and the National Water Council.

Date	Possible Key Events
3 February 1977	Letter from chairman of AHA to the MP explaining that water authorities will not take any action until the matter is clarified but that the decision as to whether water supplies should be fluoridated rests with AHA and it is now undertaking a programme of public consultation.
February 1977	At the February meeting the AHA agreed to defer consideration of the fluoridation issue until July 1977 because a number of local councils would be unable to offer comments before 31 March 1977.
10 February 1977	Letter to AA from secretary of one of the CHCs. The CHC executive committee had considered ways of obtaining representative public views on fluoridation - proposing a press campaign and contacting interested organisations. However, to allow sufficient time to 'obtain sufficient public opinion' matter would not go to CHC until April and so CHCs' views would not be available to AHA until 22 April 1977.
18 February 1977	Letter to area that the APhC 'have no objections to raise and consider the project has great benefits for public health'.
24 February 1977	Letter from chief executive to the county council. Policy and resources committee considered issue on 8 February 1977 but in the light of the uncertain legal position offered no comment and this decision was adopted by the county council (24 February 1977).

Date	Possible Key Events
	Letter from chief executive - borough council. The environmental services committee passed the following recommendation: 'That whilst recognising that fluoride has some beneficial effects on dental health, this committee does not approve of the compulsory fluoridation of drinking water supplies and recommends that the council resist any such proposal'. Council approved this resolution on 22 February 1977.
17 February 1977	Letter from one of the district administrators to AA reporting he has asked both the district medical and dental committees if they wish to be consulted on the fluoridation issue. Both indicated that they are prepared to be represented by their opposite numbers at area (AMAC and ADAC) but they both strongly support the introduction of fluoridation in the water supplies.
4 March 1977	Letter from the district council with the information that the full council voted 20 - 7 positively against fluoridation.
28 February 1977	Letter from district council informing AA that the council are opposed to the addition of fluoride to water supplies.
4 March 1977	Letter from district council informing AA that the council confirmed the recommendation of the environmental health committee that the council should oppose the fluoridation of water supplies on the grounds that

Date	Possible Key Events
	it would not only affect freedom of choice but would prove very costly.
10 March 1977	Letter from local council informing the council's 'strong opposition' to fluoridation.
16 March 1977	Letter noting that a district's dental committee had supported the recommend-ations for fluoridation.
12 March 1977	Letter from LMC reporting that the LMC agreed to recommend to the AHA that the fluoridation proposals be implemented.
15 March 1977	Letter from the secretary to the APhC. Members all agreed that there was no objection to this principle on pharmaceutical or ethical grounds and would be pleased to see it introduced. Letter to AHA from Cllr A protesting in the strongest possible way to the fluoridation of water.
17 March 1977	Letter from borough council reporting that the environmental services committee 'resolved that the AHA be informed that this committee supported the principle of fluoridation of water supplies'.
9 March 1977	Letter from one of the CHCs informing AHA that having considered the consultative document and having conducted a referendum the CHC were opposed to the fluoridation of water supplies in its district.

Date	Possible Key Events
31 March 1977	Letter from the local dental committee reaffirming its unanimous support for fluoridation.
4 April 1977	Letter from FPC administrator. FPC considered issue on 15 March 1977 and expressed their support for fluoridation 'by a very considerable majority'.
20 April 1977	Letter from borough council reporting that the council resolved to advise the AHA that 'they are opposed to fluoridation'.
18 February 1977	Letter from town council reporting that the council did not favour fluoridation of the water supplies.
2 March 1977	Letter from town council reporting that the council objected to the basic principle of fluoridation.
4 March 1977	Letter from town council opposing addition of fluoride.
14 March 1977	Letter from town council which resolved that it was not prepared to give an opinion until the legal position has been clarified nationally.
16 March 1977	Letter from parish council which approved the introduction of fluoridation.
21 March 1977	Letter from town council which was not in favour of fluoridation.

Date	Possible Key Events
18 April 1977	Letter from one of the district councils recording its council's strong opposition to the addition of fluoride.
27 May 1977	Letter from second CHC: 'Following full consultation with the public, comprising a public meeting on 6 April and an opinion poll conducted through the local press, I am instructed by my council who voted on the introduction of fluoride into water supplies on 18 May, that this CHC ..... is opposed to the introduction of fluoride into water supplies'.
14 July 1977	Agenda paper circulated to AHA members on fluoridation. This paper concluded that the authority would be invited to: (1) consider the consultative document on the fluoridation of the public water supplies; (2) receive the comments of organisations formally consulted; and (3) consider and comment upon the ATO's recommendations. The ATO recommends that the authority should agree in principle to the fluoridation of the public water supplies but that a decision on the timing and extent of implementation should be deferred pending the outcome of the deliberations between the DHSS, DoE and the National Water Council; confirmation of the availability of a capital grant from the DHSS and the result of the authority's discussions on the allocation of revenue funds annually in the light of competing demands for the development of other services.

Date	Possible Key Events
	After considering the agenda paper and the expressed views of individual members, the authority:
	(1) **agreed** that two questions of principle existed, viz (a) is fluoridation per se desirable or objectionable, (b) is fluoridation a viable public health measure for the area;
	(2) **agreed** that (1) (b) above should be considered at later date in the light of detailed proposals and costs;
	(3) **noted** the view of the area dental officer that the alternative measures of supplying fluoride were less effective;
	(4) **resolved** unanimously that 'this authority does not wish to oppose fluoridation in some form in principle';
	(5) **resolved** by clear majority vote, that 'this authority does not wish to oppose in principle the fluoridation of water supplies'.

Questions

(a) *Where (or from whom) did the initial request originate?* Essentially the story began with the receipt at Area of a departmental circular, recommending the fluoridation of

water supplies to health authorities and asking authorities to act upon it; however, as the chronicle of events show, this matter had been raised locally before the circular was issued.

(b) *Time taken for a decision to be reached?*
In total, thirteen months elapsed from the receipt of the circular to the point where the AHA decided in principle in favour of fluoridation.

(c) *The number and type of stages involved from start to finish?*
See the above chronicle of events and the commentary which follows.

(d) *The people (or organisations) involved in the process?*
See the above chronicle of events and the commentary which follows.

(e) *If delays occurred is it possible to discover from the records why this was?*
There was a six month gap between the receipt of the DHSS circular and the AHA's decision to go out to consultation. The reason advanced for this delay was that the area was awaiting the report of the Court Committee. There was a further six month gap between the decision to go out to consultation and the AHA's decision not to oppose in principle the fluoridation of water supplies. As the case history reveals it had been expected that the AHA would be in a position to decide on this matter at its May meeting.
In the event, to enable the full consultation process to proceed it was decided to defer a discussion of this issue until July 1977.

(f) *Were there substantial changes during the process to the original request?*
No.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*

This issue was in itself a fairly major policy issue. Certainly there was a lively debate - within and outside of the NHS - about the rights and obligations of health authorities to adopt policies of this nature. Following the AHA's decision in July 1977 there was considerable discussion with, for example, the CHCs about the role and purpose of consultation on policy issues.

THE VALUE OF THE RETROSPECTIVE TRACER APPROACH

There were four basic questions to which this feasibility study was directed.

1 What are the possible documentary and oral sources of information about past decision-making behaviour in the NHS?

2 How accessible are these sources of information likely to be and what factors will influence accessibility?

3 What are these sources of information likely to reveal about decision-making in the NHS?

4 Is it worthwhile mounting a full-scale project using the retrospective tracer approach to examine decision-making.

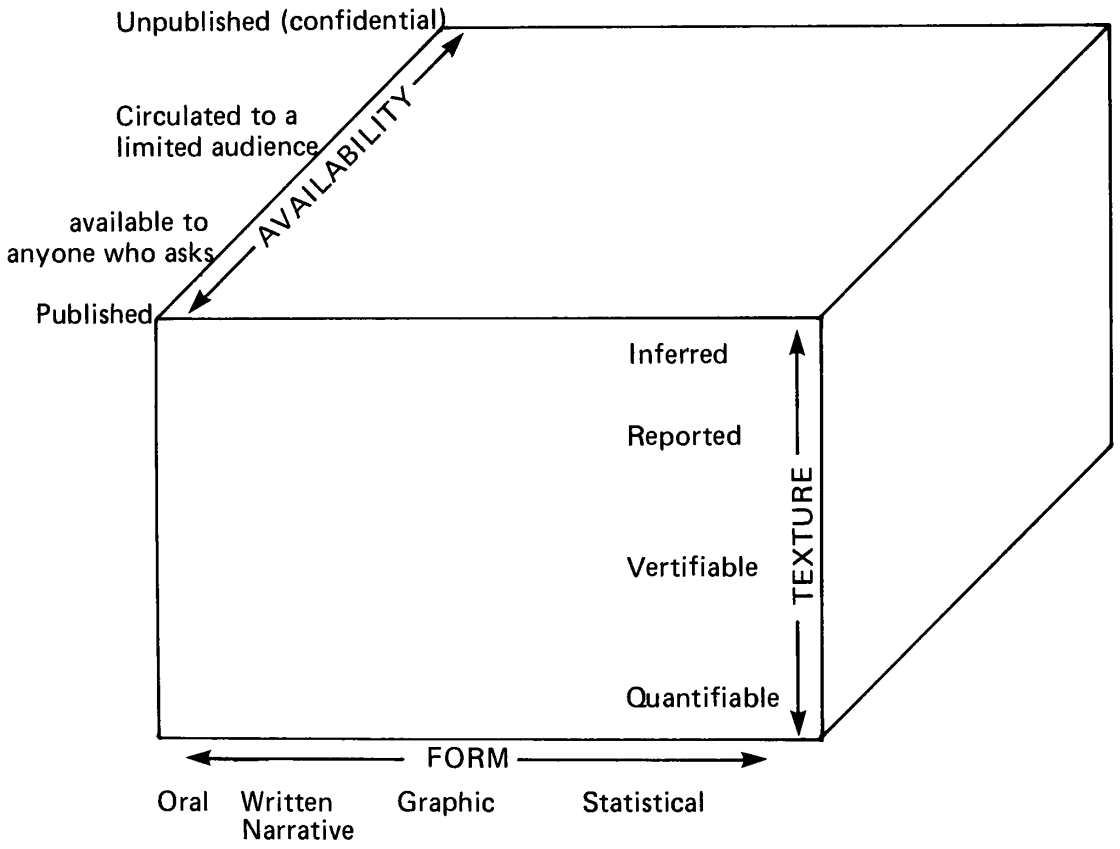
1 WHAT ARE THE POSSIBLE SOURCES OF INFORMATION?

In this type of study, six different types of information are potentially available. These are:

(a) Formal, approved minutes and agenda.
(b) Material on file - letters, memos, etc.
(c) Newspaper reports of events.
(d) Verbal reports - from interviews with participants.
(e) Inference from minutes of letters (eg that a telephone conversation took place).
  . supported by the person concerned.
  . unsupported.
(f) Previous personal observations of the researcher. (In a full-scale study, of course, the researcher would have no such 'independent memory', which highlights the difficulty that may arise of cross checking information in some cases.)

The various types of information are likely to bear different weight and one can characterise different items of information according to availability, form and texture: (Figure 9).

Figure 9 CHARACTERISTICS OF INFORMATION



The formal minutes of a management team, for instance, which are written, verifiable and circulated to a limited audience are less likely to be open to questionable interpretation than a verbal report which is given in confidence during an interview. Yet the verbal report may well provide a far more detailed insight into most events than the often condensed material found in formal minutes.

2 HOW EASILY ACCESSIBLE ARE THESE SOURCES OF INFORMATION LIKELY TO BE?

It is highly likely that any researcher who had been working in an authority for some time and had developed ongoing contacts with the officers there, would find it easier to gain access to confidential material. Certainly none of the officers in this particular authority refused to co-operate in the feasibility study. Rather, as often seemed to be the case, officers welcomed the chance to talk about their work experience and their views to an interested person from outside the organisation. So it is very possible that researchers going into an authority, even for a short period, would be given access to a fairly wide range of information sources, providing they convinced the hosts that individual case histories would be treated in confidence.

To go through each source of information in turn:

- AHA and RHA minutes and agenda are normally available to the public and anybody should be given access to these. The researcher should have no difficulty here.
- Management team minutes and agenda are by contrast confidential but will be circulated widely through the offices of district, area and region. Therefore, if an authority give permission for the research to be carried out, it seems likely that these documents would be made available.
- Office files are more consciously treated as confidential and access to these might well be restricted. For instance, there was one officer in the study who felt that he could not allow the researcher to go through a file which contained job applications and interview evaluations. However, having heard the rationale of the study, he prepared for the researcher a precis of the main stages in that particular case. In the case quoted the precis proved helpful; but the use of the material was dependent on the researchers confidence that a full and accurate precis had been provided. A greater difficulty is that it may not always be easy to know in advance in which file the relevant information

is stored. Where there are several potential pertinent files, care should be taken that none is overlooked.

Interviews of participants. Again, if the authority has granted permission for the research to take place, it is likely that the researcher will be allowed to interview officers. Certainly none of the officers interviewed in this study raised any objections. Of course, individual officers may vary in their readiness to give detailed and open accounts of events in which they took part. They may well be reticent if the issue or their own role in it is a matter of controversy. But conversely if, say, participants from different tiers (or organisations) were also being interviewed, they may be eager to put into the record their own account of the decision process.

3 WHAT ARE THESE SOURCES OF INFORMATION LIKELY TO REVEAL ABOUT DECISION-MAKING IN THE NHS.

Before responding to such a question, we should first differentiate between two aspects of decision making:

(a) the events or stages in arriving at a decision; and
(b) the processes adopted to reach a decision.

'Events/Stages'

There may be some confusion over what actually constitutes a 'stage' in decision making. In the simplest model the steps that a person/group/organisation might perform in arriving at a decision would be:

receipt of request
demanding information on the issue
receiving information on the issue
harnessing information already at hand
formulating alternatives
reviewing the alternatives
making a choice between alternatives
instituting appropriate action.

In an organisation, dealing with one issue these stages may be repeated several times at different levels. Of course, the number of 'events' which relate to a particular issue may be considerable. What is required for a study is an account of **significant** events/stages which having weighed the evidence, is necessarily a matter for the researcher's judgement.

Processes

In a complex multi-professional, multi-tier and multi-location enterprise, the decision-making processes of particular importance might be summarised in these terms:

the form of debate by which a multi-professional management team reaches a consensus view

the criteria adopted in delegating responsibility for decisions

the degree to which those working at ground level actually influence and shape decisions

the extent to which consultation with outside interests influence the final decision taken

the extent to which the accumulated previous experience of the organisation is taken into account when making a given decision.

What then, judging from the feasibility study, are the various sources of information likely to reveal about these two aspects of decision making, ie the stages and the processes?

Authority minutes rarely reveal much of the flavour and substance of the debate on any issue. They normally record the final decision taken and summarise the argument made in favour of that decision. If, however, a formal vote is taken, the minutes will record the names of those members who voted for and against a proposal and this would be a fairly clear indication that the issue was disputed and that there were various options put forward.

Authority agenda papers on the other hand can provide a very useful historical outline of a case. It will be observed, though, that normally it is only a limited number of major or sensitive issues which go to the health authority, so this source of information could not be regarded as comprehensive.

Management team minutes — Again these minutes tend to present the conclusion rather than the content of a debate. So although they provide a useful record of 'events' they say little about the way in which a decision is taken. For instance it is not likely that one could tell if there was equal commitment to a decision from all members of a team of whether certain memebrs may have abstained or grudgingly given in to the majority view. In short they do not illuminate the working of consensus management.

Office files. These are usually a useful source of more detailed information on the events that took place and they are also likely to reveal major differences of opinion. Inter-office memos and notes scribbled on letters/circulars are often an indication of the informal views held by key actors and which may well have shaped their formally given opinion.

On the other hand it is very likely that the recording of events on paper will vary from officer to officer and also from one occasion to another, depending on the pressure of business or the willingness to put views on paper. It therefore seems reasonable to assume that a file cannot give a complete chronicle of events, still less that it will necessarily make clear the reason why actors acted in the way they did. Often it is also extremely difficult to tell where gaps in information exist. For instance, it may appear from the written information available that an inexplicable delay took place in dealing with a particular issue. Was there in fact a delay or was it that the events which took place in that period went unrecorded for whatever reason? One obvious way of trying to rectify this difficulty is to carry out key witness interviews after the file search, and ask questions about the apparent gaps in the information gathered thus far.

Interviews with key witnesses are the most direct way of obtaining a perspective on the human (personal) interrelationships which influenced the way in which a decision was made. They are also a means of getting quickly a broad view of the sequence of events and important factors which influenced a decision.

Unfortunately, individual key witness accounts even where there is good recall will be partial. This is not to imply criticism of the witness. It is almost inevitable that any occupant of a particular role within an organisation will view an issue from the perspective of that role, and is likely to remember only those events which had personal significance. The difficulty for the researcher comes in separating out those views which can be attributed to a person's present role and those which have been shaped by that individual's background and personality.

Thus the researcher has to accept that different key witness accounts will possibly generate conflicting evidence. Ideally one would hope to interview a range of people involved to build up the most accurate feasible reconstruction. But memories are often hazy in the absence of written records to prompt recollection. In particular it is difficult to put dates on events. So this is not a reliable method of estimating the time taken to process an issue.

Probably the best one can hope for is to use a combination of all these research methods and thus reach a story of events and influences which represents the most plausible account against the general background and climate, as known, within the locality and the NHS generally at the time.

When commissioning the feasibility study, the Royal Commission listed a number of questions about decision-making in the NHS. (See Introduction) How far did the information sources, listed above, offer answers to these questions?

(a) *Where (or from whom) did the initial request originate?*
This may be mentioned in authority or management team minutes; it is possible that an agenda paper to the authority will state this. If the researcher has access to files, at least it can be established when and by

whom the first entry was made in the file. Key witnesses may be less clear about where a request originated unless they were personally involved at the beginning or had collected information to elucidate the issue. However, none of the sources will capture the origin of a request that was the subject of informal exchanges between parties, some time before arriving on the organisation's agenda in print.

(b) *Time taken for a decision to be reached?*

Since we are selecting the issue from the point of a decision as recorded in the minutes, if we have the answer to (a) and a date attached, the answer to (b) should be straightforward. But those who complain about delay may unconsciously have in mind also the time lapsing before the issue is placed on the agenda.

(c) *The number and type of stages involved from start to finish?*

This is problematic because it first depends on what definition of 'stages' is adopted. However, by using a combination of different sources and types of information one can draw up a chronical of significant events, showing: the main people (or organisations) involved in the process (d); if there were any apparent delays and if there were any significant changes to the request (f)

(e) *If delays occurred is it possible to discover from the records why was this?*

It may well be possible to discover from the records why an apparent delay took place. However, it is equally likely that the only way of explaining a delay will be by interviewing particular key witnesses. If the delays were due to problems which had been kept confidential it might not be possible to answer this question at all.

(g) *Did the initial request lead to discussions, at any stage of major policy issues?*

If there were informal discussions about the policy implications of a decision these might well not be recorded in minutes or files.

Key witnesses might make reference to such policy discussions, but if, as might conceivable happen, the policy implications had been discussed and then discounted (say, in the interests of reaching a quick decision) then those who had been involved in such discussions might well not readily recall them.

4 THE VALUE OF A FULLSCALE RETROSPECTIVE STUDY TO EXAMINE DECISION MAKING IN THE NHS

The experience of the feasibility study suggested that a study which drew on all four types of information (minutes, agenda papers, files and key witness interviews) could well produce illuminating information on the factors that influence the way decisions are made in the NHS. Such a study would begin to answer the initial questions posed in the flow chart, Figure 1 on page 15, although the answers to questions about the processes of decision making (eg consensus management) would come mainly from structured interviews with key witnesses. There would be real advantages in interviewing about specific retrospective cases, because this would help to focus attention on actions and feelings in a concrete situation.

It must be stressed, however, that it would be necessary to use all four sources of information. If the researcher is not allowed access to all sources, the outcome will be very partial and form an incomplete picture of the way in which decisions have been made. This means that little would be gained by going into an authority to carry out this kind of research, unless the research team could negotiate a 'contract' with the hosts which permitted free and open access to all four types of information. There might have to be some exceptions in practice, but the principle would have to be accepted by the host in the negotiations which precede the study. Only those authorities prepared to accept researchers on those conditions could be included in the sample. The bias that this produces is an inevitable consequence in an empirical study of this kind. In terms of resource requirements, we judged that, extrapolating from the feasibility study, a full scale investigation would probably have required at least six full person-weeks in each district/ authority to draw a sample of six issues - on the topics suggested by the Royal Commission, from the management team minutes - and to

follow each issue through minutes, agenda, files and interviews. One clear lesson from the feasibility study was that what seemed to be a relatively simple issue could, in fact, take much longer to trace than expected.

THE QUALITY AND EFFICIENCY OF DECISION-MAKING

Our studies suggest that the retrospective tracer approach - though not without its pitfalls and handicaps - is potentially a useful contribution to the illumination of the decision process. A number of caveats have been entered as to the likely access to sources, to establish the sequence of events and the ability to infer what in fact happened in particular cases. These have been documented in the text. The limitations of the method have been highlighted to guard against more weight being put on the evidence than it can bear. Finally, some general comments on the study of decision-making can be made, some of which were implicit in the earlier observations.

The Commission, reflecting the submissions made to it, focused on the notion of 'delay' in the decision process. 'Delay' suggests that attempts are made, either consciously or otherwise, to postpone, defer or put off. And yet, the passage of time may well be essential if considered views from all parties who must contribute to a given decision are to emerge. Again, delay may prevent a course of action being followed which if taken would have soon been seen as misguided. There appears to be no agreed benchmark against which to judge whether the passage of time is desirable *or* undesirable, an aid *or* an hindrance to a better quality of decision. What constitutes unwarranted delay?

It may well be desirable to sample historically, to see whether 'delays' now are greater than, less than, or equal to the 'delays' experienced in the transition period after 'reorganisation' or, further back, in the separated structures of the unreformed NHS before 1974. Whether it would be possible to collect evidence on this longitudinal basis is debatable, and further assumptions would have to be made in interpreting findings, eg, are the issues 'bigger' now, necessarily taking longer to be made; and have the quality and attitudes of decision-makers changed over time such that changes in the decision process can be satisfactorily explained only in terms of changing structures.

Alternatively, by sampling a number of authorities and taking 'similar' issues, it may be possible to identify what factors seem to be important in extending or contracting the period of time that elapses between the request and the 'final' decision, ie, that prompts action. Again, however, this cross-sectional approach would not necessarily address the **quality** of the decisions taken.

But to focus on 'delay' also suggests that the complete decision process should be studied. It is not enough to trace through to the point of decision as the exercise of choice between alternatives. Tracing must continue through implementation to the point where the will of the decision-maker has been completed. 'Delay' in implementing the decision may be as considerable, significant, or costly as delay preceding the exercise of choice.

Only sampling requests from the 'bottom up' to the point of a decision to act or delay would have a further distorting effect. This would miss those issues which are identified and determined by management, as instanced in the policy review process or in interpreting guidance from higher authority.

This leads into our second concern over the decision process. Are decisions being made at the most appropriate point in the structure? By concentrating on the decision making activity of management teams and authorities, an *a priori* judgement is being made that the study should concentrate on 'significant' decisions which 'ought' to be settled at that level. Such decisions might be defined as those involving resources (other than routine consumables), those from which manifestly serious consequences flow, and those which specifically involve changes in patterns of work, referral processes, coordinating arrangements and job descriptions. (These criteria are not intended to be mutually exclusive). Of course it may be how the 'non-significant' decisions are processed, such as a request for a porter to attend to an immediate task, which would be a better indicator of a quality of management and organisational performance - that which is administered least, is administered best.

It follows that one would not expect to see issues which are not 'significant' (by the above criteria) to be on management team/authority agendas. In the absence of any contradictory evidence, it would then be inferred that, in one respect at least, the decision process was efficient. Conversely, the presence of non-significant issues on those agendas would be revealing about the application of 'reorganisation' concepts. Sampling therefore should not be constructed to deliberately exclude the study of 'non significant' decisions being made at that level.

Finally, but crucially, as a study of the literature on decision making would show, the 'tracer' issue approach only covers those issues which have been allowed onto the management/authority agenda and are the subject of record. Issues which key actors have the power to keep off the agenda will not be picked up. This assumes great significance, signalling the need for a different direction to the research effort if other evidence suggests that this frustration of the will and aspirations of other groups is a major cause of the perceived discontent and disquiet over the National Health Service.

POSTSCRIPT

The original draft from which this text has been prepared was sent to the area administrator for his comments. A number of his comments concerned the specifics of the issues traced, and for reasons of confidentiality are not included here. However, his observations on the general phenomonon of NHS decision-making were most illuminating and extracts are included below:

(a) I would entirely agree that all four sources of information must be used and would stress that selection of key witnesses is as important as the selection of appropriate files.

(b) I do not agree that none of the sources will capture the origin of a request which was the subject of informal exchanges over a period of time.

It may be that there is a need for account to be taken here of 'power' and I know you will understand that I am not suffering from the 'Speakman syndrome'* in referring to the administrator who is able to influence (because of his position of advantage in this respect):

1 when an issue is brought into the formal decision-making arena
2 the processes to be adopted
3 what is put to the AHA and what is minuted.

* Mr Speakman was invited by the Secretary of State in 1976 to undertake through the Whitley Council machinery a review of top NHS salaries to determine the relative salaries of members of officer teams in the light of the management concept operating since 'reorganisation' of teams with members of equal status.

Five of the issues you selected were referred to or were identified as matters for decision by the administrator **in the first instance.** Interviews and cross-check with other key witnesses would identify this activity in most instances.

(c) I agree that it is difficult to judge what constitutes inordinate delay but **comparative** studies would at least show an average for the present service and would give some indications about delegation of appropriate decision-making.

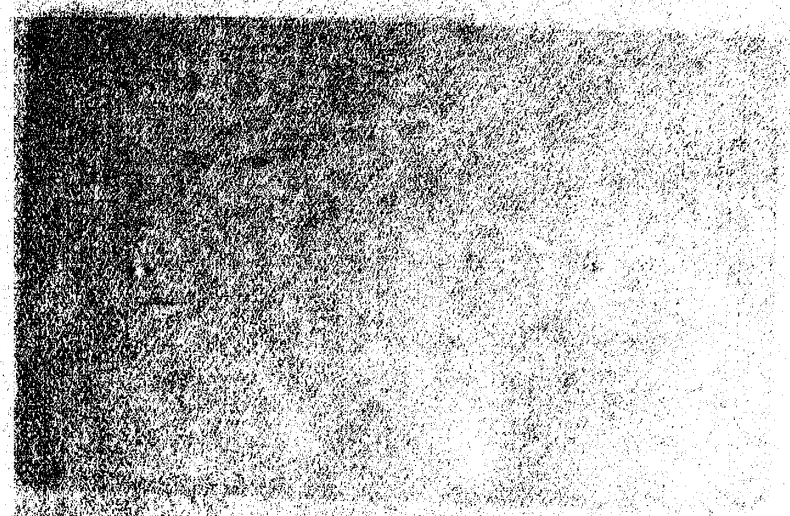
(d) the researcher will find it easier working in an efficient organisation with:

1 well documented agendas and minutes, eg divided to illustrate whether items are for policy decision; proposals for action or matters of reports
2 a good filing system with action notes in each file
3 clear lines of responsibility.

(e) One final general comment. If it can be assumed that delays in decision making will help to demonstrate that there are:

- too many tiers
- too many meetings and not enough action
- insufficient delegation
- too many administrators
- unclear roles and processes

then the way in which 'insignificant' decisions are dealt with becomes important in what it tells us about the organisation. For example, the fact that requests did not lead to discussion of major policy issues and continued to be dealt with on an *ad hoc* basis represents a failure to identify the need for a policy decision and subsequent delegation within that policy framework. Again, a comparative study will bring this out.



decision making
efficiency

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From 1976 to 1979, the three authors were working on a DHSS funded study of planning in the National Health Service, which focussed particularly at the role of areas in the NHS planning system.

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