Evaluation of Management Advisory Service and Performance Review Trials in the NHS

A REPORT PREPARED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON
BY A TEAM FROM THE FACULTY OF SOCIAL SCIENCES, BRUNEL UNIVERSITY

HIBcB:HB
Kog

King Edward's Hospital Fund for London

£5.00

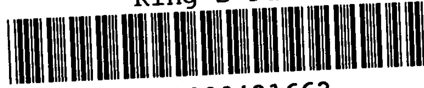
KING'S FUND COLLEGE LIBRARY
2 PALACE COURT LONDON W2 4HS

ACCESSION No.	CLASS MARK
10702	HIBCB: HB ~~HB~~ 302
DATE OF RECEIPT	PRICE
12/12/85	£5.00

KING'S FUND COLLEGE

LIBRARY

King's Fund



54001000421662

27 JUN 1995

EVALUATION OF MANAGEMENT ADVISORY SERVICE AND PERFORMANCE REVIEW TRIALS IN THE NHS

A Report Prepared for

King Edward's Hospital Fund for London

by a Team From

The Faculty of Social Sciences

Brunel University

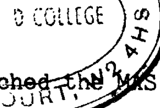
December 1984

© King Edward's Hospital Fund for London 1985

King's Fund Publishing Office
126 Albert Street
London NW1 7NF

FOREWORD

This report, by a Brunel team led by Professor Maurice Kogan, was commissioned by the King's Fund at the request of the Department of Health, and financed by the Department. It describes the Management Advisory Service in the Oxford and South Western Regions, and Performance Review in Wessex, in the period from 1982 to 1984. These activities, known collectively as the MAS Trials, were launched by Patrick Jenkin as Secretary of State, in connection with Patients First. They were intended to help reconcile increased delegation to the new district health authorities (and to units of management within them) with continuing accountability to central government. After a two year period (later extended to three years), the trials were to be reviewed in order to decide whether to establish a national Management Advisory Service. Although the initiative may currently look to have been a policy backwater, out of the political and managerial mainstream of the last five years, its story is well worth reading, and its implications are relevant to the management of the National Health Service post-Griffiths. Apart from anything else, the topics with which these experiments mainly dealt, namely how to transfer experience from one district health authority to another, how to promote organisational learning and how to improve managerial performance, have certainly not gone away. Professor Kogan's report suggests that the experiments have not been wholly successful. That should not prevent our learning from them. Moreover, the fact that both the experiments are currently continuing in some form, funded by the customers rather than the Department of Health, is interesting. Those close to the experiments seem prepared to go on from them towards something else, rather than viewing them simply as blind alleys.



Quite why Patrick Jenkin, as Secretary of State, launched the MAS is unclear. At least three different lines of thinking seem to have merged. One stemmed from Frank Pethybridge, Regional

Administrator in Manchester, who had argued to the Royal Commission for an NHS Advisory Authority - a type of health service inspectorate, based in part on the model of the Health Advisory Service. His proposal appears to have grown from frustration at the weakness of what Roy Griffiths later called the general management function in the NHS. Central or regional policy initiatives frequently dissipated in the sand, frustrated (it sometimes seemed) by the ingenuity of area and district authorities in evading action. Thus Frank Pethybridge's proposal was in a sense authoritarian, aimed at strengthening the general management line in the National Health Service, with an emphasis on tighter accountability.

A second strand, representing a strong contrast to the Pethybridge view, stemmed from the Outer Circle Policy Unit (which flourished briefly in the late 1970s in the Outer Circle of Regent's Park) via the Royal Institute of Public Administration. David Hunter, now at the University of Aberdeen, provided the focus for a small group of NHS administrators and academics who formulated a proposal for a network of NHS development agencies. They envisaged the eventual development of a small number of regional development agencies, each serving a group of regions, backed by, and interlocking with, a national development agency. The initial emphasis would be on an experimental regional development agency. Its purpose and style would be markedly different from the Pethybridge model, for it would be less concerned with strengthening the line of command, and more with stimulating innovation in the management of services at the local level, and with the transfer of innovation among authorities.

The third strand, possibly originating more directly from the Secretary of State himself, was closely linked to doubts about

the future role of regional health authorities and to criticisms from the Social Services Committee of the Department's lack of knowledge about the impact of its own policies. With the abolition of area health authorities, there was thought to be a danger that RHAs would move into the vacuum, thus negating the thrust to take management decisions as close to the patient as possible. Paragraphs 37 to 40 of Patients First argue for a different model in which 'The regional authority must stand back from the operational activities of the districts'. In time, the composition of RHAs might be changed towards a federal model, in which the DHA chairmen would provide the majority of the RHA membership. The RHA would still retain responsibility for financial control and for monitoring the implementation of district plans, and would provide agreed services on an agency basis. But it would withdraw from the broader monitoring of the quality and efficiency of services, this role passing to 'an advisory group of experienced NHS officers, who would report to the district health authority, with copies to the RHA'. Such a dramatic change of regional role must also affect the Department, itself beginning to come under fire from parliament in a campaign to strengthen central accountability.

From these varied and contrasting strands of thinking the MAS trials evolved in 1980 and 1981. Mentions in ministerial speeches and DHSS publications provide some pointers to the development of government thinking during this period. At a key meeting with regional chairmen in November 1980, the Secretary of State asked for volunteers willing to undertake regionally-based trials of a Management Advisory Service, stressing particularly the inspectoral Pethybridge model. The North West RHA, where Frank Pethybridge was Regional Administrator, was a natural volunteer. Others were less willing and their motives more mixed. The Chairman of the Wessex RHA, for example, seems to have volunteered the Wessex Region in a sense as a preemptive strike.

The idea of a weak, federal region did not appeal to the Wessex RHA, which has long had a tight and distinctive regional management style. Wessex was therefore a natural opponent of the MAS as a stalking horse for devising a change of RHA role. On the other hand, Wessex RHA had already been experimenting with detailed monitoring of performance within the region. Could it pursue this interest as part of the MAS trials, thus at once carrying forward an initiative of its own and forestalling a potential threat? The third trial was to be a collaboration between the Oxford and South Western RHA, with a supervisory board external to both. The thinking behind it was less clear than for the North West or Wessex, but it appeared to lie conceptually somewhere between them. Following the untimely death of Alan Brooking, Regional Administrator in the South West, Bob Nicholls became a shaping force in this particular trial. He and Derek Mowbray, who became the Director of the MAS, moved it substantially towards the Outer Circle Policy Unit/RIPA model of a development agency, although it would be a mistake to underestimate the variety of views about the proper role of the MAS that continued to exist within its Supervisory Board and within the two regions concerned.

The three trials (in four regions) began at different dates in 1981 and 1982. Two factors further complicated the picture during this period. One was the collapse of the trial in the North Western Region, thus eliminating what was conceptually the clearest version of a Management Advisory Service. The trial ran into severe difficulties following a brief, unpopular pilot survey in the Oldham District in December 1981 and January 1982. There were difficulties in recruiting people of calibre to man the MAS (which was envisaged as an experienced multidisciplinary team on the Health Advisory Service model) in the run-up to the 1982 reorganisation of the National Health Service. These

difficulties might have been overcome, had not Frank Pethybridge fallen sick, and after a lengthy period of absence, retired from the Service. Others would probably have carried his idea forward, if it had not run into major obstacles. A change of regional chairman and regional administrator also meant a change in thinking. No doubt some of what was envisaged in the North West has been pursued in other ways, but not through an MAS trial.

The second new influence at this stage was an increasing central government emphasis on efficiency and tighter accountability in the NHS. As the Department of Health came under criticism from the Public Accounts Committee and the Social Services Committee, it tended to emphasise the new role that the MAS would play as a 'roving eye' and 'an important instrument to help meet the requirements of Parliamentary accountability without undue involvement in district affairs by RHAs and the DHSS' (see paragraph 2.8, page 8). The MAS had quickly become a secret weapon to confound critics of government policy and of Departmental performance.

Meanwhile in late 1981 the King's Fund was approached by the Department with a request to help undertake an evaluation of the trials, which were due to begin officially in March 1982. Our initial response was that the Fund did not have the expertise required, which was far more likely to be found in the universities, particularly in departments of social sciences or government with a tradition of evaluative research. Nevertheless we were persuaded to help identify who could undertake an evaluation of this kind, and also to play a part in developing its terms of reference and in explaining the idea to those directly concerned with the trials in the National Health

Service. In due course this led to our commissioning Professor Maurice Kogan and his team, who have prepared this report, based on an evaluation of the surviving trials in the Oxford and South Western Regions and in Wessex, carried out between Spring 1982 and Summer 1984.

Their report documents two detailed case studies of agencies attempting to bring about change for the better in the management of the National Health Service. We knew in advance that an evaluation of the MAS trials would not provide answers to many questions that we would all like to ask. It could not show whether the trials had themselves improved the running of the service to the direct benefit of patients. Too many other variables were at work for that to be feasible, even if the evaluation had been started sooner and continued longer. Moreover it was inevitable (and probably beneficial) that the evaluation should itself influence the trials, by feeding back information and encouraging reflection. Rightly or wrongly we decided at the start that the inclusion of other regions as controls would not actually prove anything, while adding greatly to the complications and costs of the study.

What we hoped for, and have received from the Brunel team, was a careful and vivid account of the trials as they happened, and an assessment based (for example) on their consistency with their stated objectives, their internal logic, their efficiency and their usefulness as judged by those they were designed to help (Chapter 3). I for one believe that was well worth doing. It is also worth remembering that when the research study was commissioned a prime concern of senior NHS managers in the regions involved was that the Brunel team would be a heavy, added complication. In the event the members of the team observed, questioned and commented with great tact and sensitivity throughout the period of their work.

What conclusions can in the end be drawn from the trials and their evaluation? Any answers must be personal. These for what they are worth are my own:

1. <u>Whatever the failings of the MAS initiatives, it was an unusual and brave step for a Secretary of State to launch them</u>. It was also imaginative to seek to evaluate them. There are few, if any, other examples of any minister in any department deliberately encouraging different authorities to try varying approaches to the running of services and to compare the results.

2. <u>The period of the trials and of the evaluation was much too short</u>. As between the trials, this was a bigger problem for MAS (Oxford and South West) than for Performance Review (Wessex) because the latter was an ongoing commitment of the Region while the former required the creation of a wholly new and unknown institution. There is always a tension between the wish for quick answers and the time taken to provide answers that are worth having. The tension is extreme in public services, such as health, where ministers have short lives (an average of 2½ year terms since the Ministry of Health was first established) and services are highly complex. The irony is that for all the rush with which trials (or commissions) are conducted, ministers have virtually always changed and lost interest by the time the results are available. As A P Herbert once remarked 'A Government department appointing a Royal Commission is like a dog burying a bone, except that a dog does eventually return to the bone'. Before the end of the MAS trials and the evaluation we were left in no doubt that ministers had turned against the whole idea. That is of course their privilege. The lesson is, I think, to recognise at the

beginning that experiments of this kind must not be hurried. In the long run it will be more valuable (as with any other form of research) to take adequate time to try to find valid evidence that will one day illuminate policy and management, without worrying too much about short-term political relevance.

3. With hindsight, the timing of the trials could hardly have been less fortunate. The official start date was that of the 1982 reorganisation of the NHS when district health authorities were born and most of the senior managers in the Service were changing jobs. During the period of their lives one iniative after another was launched by central government to promote efficiency and tighten accountability. In the early stages, the MAS trials were presented to parliamentary committees as a key instrument for this purpose. By the end of the period, there were so many other, perhaps sharper, tools available to ministers that MAS (which had been devised by their predecessors) had lost all appeal for them. Yet uncertainty and turbulence are endemic in public services in the 1980s. We therefore have to recognise that any managerial experiment is likely to be carried out against a tempestuous background.

4. While the objectives of the whole MAS initiative were somewhat unclear, diffuse and even conceptually muddled, the topics of organisational learning and managerial innovation remain crucially important for the future of the National Health Service. That does not necessarily mean that external agencies are the best way to stimulate and support processes of assessment and improvement in the way services are run. Indeed Performance Review was not an external agency. But the greatest dangers of the next decade in

managing the NHS will be of resources remaining locked into inherited patterns of service, a falling quality of care and a growing disillusion among staff about the gap between what the NHS is supposed to be providing (the best care for all, on the basis of need) and what they know it to be doing. One element of a positive response to these problems must be to give people elbow-room and encouragement to find better ways of managing and to try new approaches. Fundamentally that is what the MAS trials were trying to do.

5. The problems of evaluation are formidable. This applies not only to particular experiments in management development but to management itself. Since no two situations are identical, many independent variables are at work, and the context changes rapidly, it is difficult (if not impossible) to prove that a particular management action or approach has changed an organisation's performance. This is not an argument against evaluation - far from it. It does, however, affect the form of evaluation that is likely to prove useful, the skills required, and the answers that we can expect to obtain. For example it perhaps argues for being very selective and specific about the key evaluation questions, and for a counselling style, with relatively rapid feedback into further managerial action.

6. The MAS and Performance Review experiments, whatever their weaknesses, contain some important lessons about managerial innovation and improvement. For example, the question of 'ownership'. Any initiative of this kind will raise questions about who stands to benefit and who controls it. Both trials ran into difficulty on this front. My hunch is that the future does not lie with a national initiative, as originally envisaged by Frank Pethybridge, but with

something negotiated between a region and its districts, with a jointly agreed remit. The trials also raised questions that will recur about adequacy of data, and the pros and cons of generating new data; about recruitment and training; about the breadth of functions and services to be covered; about the balance between external review ('this is how you should be doing it') and developmental activity ('let us work with you to find better ways'); about the form of presentation of results; about timescales and the mix of work to be tackled; about funding for activities of this kind and value for money in them; and about need to develop a distinctive managerial style ('this is the way we do things around here'), with a competitive edge to it.

* * * * *

Overall this report contains an account of serious and significant attempts to do something difficult and worthwhile, both within the trials and in the evaluation. These attempts have flaws. But they also contain pointers for future managerial learning and improved managerial performance in the National Health Service.

Robert J. Maxwell
Secretary
King Edward's Hospital Fund for London

TABLE OF CONTENTS

PREFACE	1
CHAPTER 1: TERMS OF REFERENCE OF OUR EVALUATION	2
Access to the Field	4
CHAPTER 2: INSTITUTIONAL CONTEXT AND POLITICAL BACKGROUND	5
Intervention in the NHS	5
Political Background to the MAS Trials	7
REFERENCES TO CHAPTER 2	12
CHAPTER 3: FRAMEWORKS FOR THE STUDY	13
I - EVALUATIVE METHODS	13
The Approach of the Brunel Evaluative Team	14
Components of Evaluation	14
Evaluative Framework Used in the Trials	18
II - ASSUMPTIONS ABOUT INTERVENTION	21
REFERENCES TO CHAPTER 3	25
CHAPTER 4: OXFORD AND SOUTH WESTERN REGIONS - MAS PROJECT	26
The Brunel Research Team's Approach	26
PART I - AN OUTLINE OF THE MAS PROJECT	28
Objectives	28
Organisation	29
Staffing	30
Mode of Working	30
Range of Work	31
Authority	35
Costs	36

PART II - THE MAIN EMPIRICAL COMPONENTS OF THE STUDY 37

STAGE ONE - INITIAL PERCEPTIONS OF THE ROLE AND VALUE OF MAS 38

History and Objectives 39
Model 40
Supervisory Board 42

STAGE TWO - PERCEPTIONS OF THE FIRST FOUR STUDIES UNDERTAKEN BY MAS 44

Management of Inpatient Waiting Lists 44
Utilisation of Resources Allocated to Trauma and Orthopaedic Services 44
Allocation of Units of Medical Time 45
Process and Arrangements for Preparing Planning Briefs for Capital Schemes 45

Distribution of the Reports 46
Value of Reports 47
Promotion of Change 50

STAGE THREE - EVALUATION OF SELECTED STUDIES 51

(A) DISTRICT STRATEGIC PLANNING 52

Stimulus 53
Initial Doubts 54
Collaboration 54
Results 55

(B) REGIONAL STRATEGIC PLAN 57

Stimulus 60
Initial Doubts 60
Collaboration 61
Results 62

(C) FIVE DAY WARDS 64

Stimulus 65
Collaboration 65
Results 66

(D) REVIEW OF SELECTED SERVICES FOR THE ELDERLY 67

The Origins and Nature of the Report 69
The Reactions to the Study 70
Consideration of Policies and Strategies 71
Follow Up 71
Collaboration 72

STAGE FOUR - LATER PERCEPTIONS OF THE ROLE OF MAS 73

Contacts with MAS 74

The Value of MAS 77

(1) To Districts 77
(2) To Regions 78
(3) To the Supervisory Board 80
(4) In Undertaking District Studies 82
(5) In Undertaking Regional Studies 83

Promotion of Change 84

(1) District Views 84
(2) Regional Views 86
(3) Supervisory Board Views 87
(4) Compared with Other Mechanisms 88
(5) MAS Views 89

Role of MAS 89

(1) District Views 89
(2) Regional Views 91
(3) Supervisory Board Views 93
(4) MAS Views 94

Expectations of MAS 95
The Role of the Supervisory Board 96

PART III - EVALUATION 98

OBJECTIVES 98

CONCEPTUALISATION AND DESIGN 100

(1) Objectives 100
(2) The Model 100
(3) Structural Arrangements 101
(4) Models of Change Underlying MAS 101

Change or Intervention Processes 101
Evaluative Approach 102
Criteria and Methods 103
Scope of the Scheme 104

(5) Feedback and Follow Up 105

IMPLEMENTATION AND COHERENCE BETWEEN OBJECTIVES AND RESULTS 105

(1) The Model 105
(2) Institutional Arrangements 106
(3) Change or Intervention Processes 106
(4) Evaluative Approach 109
(5) Criteria and Methods 109
(6) Scope of the Scheme 111

UTILITY OF PROCESS 112

(1) Costs 112
(2) Use of Resources 112
(3) Commitment to Evaluation 113
(4) Needs for Change Identified 114
(5) Establishment of Criteria 115
(6) Capacity for Adaptation 117

UTILITY OF OUTCOME 118

(1) Data 118
(2) Changes in Planning 119
(3) Changes in Operational Efficiency and Effectiveness 120
(4) Dissemination of Good Practice 121
(5) Changes in Industrial or Professional Relationships 122
(6) Changes in Consumer Expectations 123
(7) Influence of Context 123

REFERENCES TO CHAPTER 4 125

CHAPTER 5: WESSEX PERFORMANCE REVIEW 126

The Brunel Research Team's Approach 126

PART I - AN OUTLINE OF PERFORMANCE REVIEW 128

Objectives 128
Organisation 129
Staffing 130
Mode of Working 131
Range of Work 131

PART II - THE MAIN EMPIRICAL COMPONENTS OF THE STUDY 133

INITIAL PERCEPTIONS OF THE ROLE AND VALUE OF PR 135

The Region 135
The Districts 136

THREE REVIEWS EXAMINED 140

(1) Catering Performance Review 140

Expectations Entertained of the PR 141
The Roles and Structures Implicit In It 142
Methodologies 143
Perceived Benefits 144
Implementation and Dissemination 146

(2) Services for the Elderly Performance Review 150

(A) Consultants' Review 150

The Organisation and Methodology of the Consultant Element of the Performance Review of Services for the Elderly 151

The Expectations and Perceptions of the Review 153
The Perceived Benefits and Costs 154
A Self-Contained Exercise 156

(B) Nursing Services Review 158

Our Evaluation 158
Expectations and Objectives 158
Structures and Roles 160
Organisation and Methodology 161
Perceived Benefits of the Review 163
Implementation and Dissemination, Including Institution Building 164

(C) The Minor Elements of the Overall Review 166

(3) Accident and Emergency Performance Review 168

The Organisation and Methodologies of the Accident and Emergency Review 168
Expectations and Perceptions of the Accident and Emergency Review 171
Perceived Benefits and Costs of the Accident and Emergency Review 172
Perceptions of the Concept of Performance Review 174

IMPACT, IMPLEMENTATION AND COMMITMENT ACROSS THE PRs 177

The Levels of Knowledge and Understanding Of and About PR 177
Concepts Held About PR 179
Modes of Implementation 180
Results of PR 181
Commitment Gained for PR 182

PART III - THE TEAM'S COMMENTS 183

Changing Objectives 183
Conceptualisation and Design 184
Process or Product 185
Structural Arrangements 186
Models of Change Underlying Performance Review 188
Evaluative Theories and Methods Underlying Performance Review 189
Data Needs 191
Feedback 192
Implementation and Coherence Between Objectives and Results 192
Efficiency of Process: Costs 193
Did it Establish Usable Criteria, Standards and Measurements of Performance? 194
Utility: Efficiency and Effectiveness of Outcome 194

REFERENCES TO CHAPTER 5 195

CHAPTER 6: SUMMARY, COMPARISONS ACROSS THE PROJECTS AND CONCLUSIONS 196

Summary of the Two Evaluations 196

The Oxford and South Western Management Advisory Service Trial 196

Objectives 196
The Model: Conceptual Coherence 197
Model: Thinking About Change 197
Model: Structures 198
Implementation of the Scheme 198
Results 199
Costs 199
Impact of Concept 199

The Wessex Performance Review Trial 200

Objectives 200
The Model: Conceptual Coherence 200
Model: Thinking About Change 201
Model: Structures 201
Implementation of the Scheme 201
Results 202
Costs 202
Impact of Concept 202

Comparisons Between the Two Trials 204

Comments on the Comparisons 205
Models of Intervention 206
Structures 207
Time Scales 208
Knowledge and Technical Content 209
Generalisability 210
Some Conclusions 211

More General Reflections on the Evaluation 212

National Context 212
Can Pilot Schemes Help? 214
Can Pilots be Evaluated? 215
Time Spans 216
Incentives to Change 217

REFERENCES TO CHAPTER 6 219

APPENDIX A: 'THE PROCESSION' OF MANAGEMENT INTERVENTIONS IN THE NHS 220

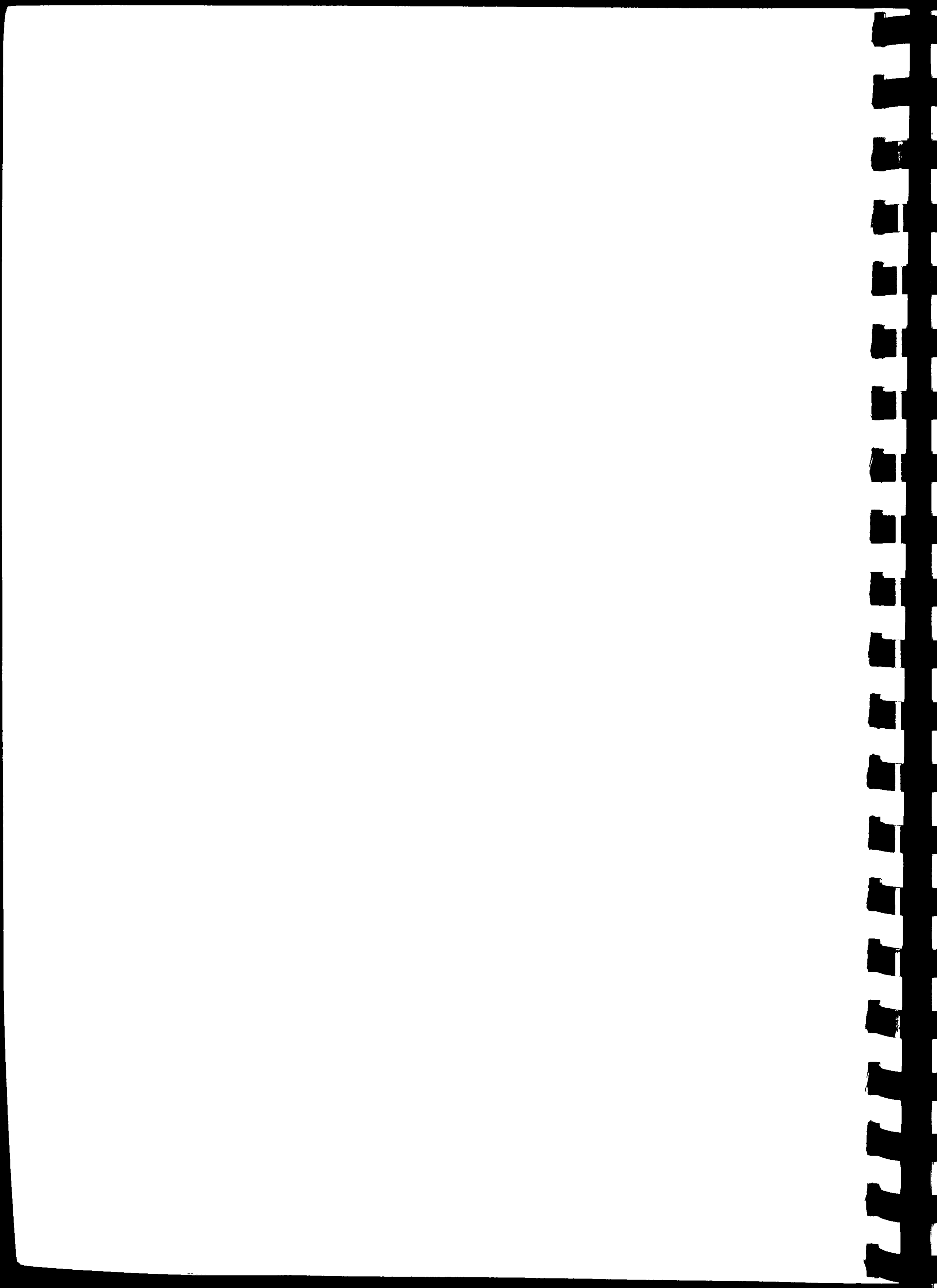
(1) HEALTH ADVISORY SERVICE 220
(2) MONITORING 222
(3) PLANNING 223
(4) NATIONAL DEVELOPMENT TEAM FOR THE MENTALLY HANDICAPPED 224
(5) REGIONAL REVIEWS 226
(6) INDICATORS 228
(7) THE ENGLISH HEALTH SERVICES INFORMATION GROUP 229

REFERENCES TO APPENDIX A 230

APPENDIX B: EVALUATION AND INTERVENTION APPROACHES 231

REFERENCES TO APPENDIX B 239

APPENDIX C: EVALUATIVE FRAMEWORK (Version 1) 240



PREFACE

In the course of our work within the Oxford, South Western and Wessex Regions we generated many obligations to those who co-operated with us. We particularly express our indebtedness to the Supervisory Board and the Director of the MAS Team, Derek Mowbray, in the Oxford and South Western Region and to John Hoare, Regional Administrator, and Vincent Criscuolo and Athene Houston, the full time members of the Wessex Performance Review Group. Other officers at regional level were also accessible and helpful to us at meetings and in interviews. Very many people in the districts and units gave time and thought to our enquiries.

We are also indebted to Robert Maxwell for his steerage and chairmanship of the project and to Bryan Rayner and Alan Bacon of the DHSS for their help and support in the earlier stages of the project.

The project was steered by a National Advisory Group and we express our gratitude to its members for monitoring and advising on our work.

Sally Harris, Department of Government, Brunel University underook much of the administration of the project and provided expert typing of field notes and of the successive drafts of the project report.

Maurice Kogan
Martin Buxton
Mary Henkel
Tim Packwood
Lisanne Radice
Ellie Scrivens

December 1984

CHAPTER 1

TERMS OF REFERENCE OF OUR EVALUATION

1.1 In March 1982, a research team based in the Department of Government, Brunel University, was invited by the King Edward's Hospital Fund for London, acting on the invitation of the Department of Health and Social Security, to make an evaluation of the trials being undertaken of Management Services for the NHS.

1.2 No specific terms of reference were drafted for the evaluation but a letter from the DHSS to the Secretary to the King's Fund contained the following general directions:

> '..... we believe that the evaluation should be carried out by one research team. By design, each trial has been developed in different ways, with rather different objectives or emphases, and although each stands to be looked at in its own right, at the end of the exercise we would very much like to see a comparison of the three trials to enable us (and of course the NHS) to judge the strengths and weaknesses of each. At the moment, we do not know whether at the end of the exercise we shall want to develop something like a single system for the whole of the Service, or allow each Region to produce something tailor-made to its own circumstances, or indeed whether or not to abandon the whole idea altogether. A single, coherent analysis and assessment by one research team would, in our view, be very helpful to enabling us and the Service to reach conclusions.'

1.3 The DHSS mandate, in commenting that the evaluation of the trials should not attempt too much, also remarked:

> 'What people involved in the process, whether as the givers or the receivers of advice or those otherwise affected by it, think about the way the system has operated may - together with the observation of independent assessors - be considerably more important than any attempt to assess the outcome in any precise terms. Obviously, we do not want to limit the scope of the evaluation to something that is unduly restricted, but at the same time we would not want to attempt what might turn out to be unrealistic.'

1.4 The King's Fund set up a National MAS Advisory Group; its members and the members of the Brunel Research Team were as follows:

National MAS Advisory Group

Mr. A. Bacon, Department of Health and Social Security

Mr. P. Cooke, Regional Administrator, Oxford Regional Health Authority

Mr. T. Evans, King Edward's Hospital Fund for London

Mr. J. Hoare, Regional Administrator, Wessex Regional Health Authority

Prof. R. Klein, Professor of Social Policy, University of Bath

Mr. R. J. Maxwell, Secretary, King Edward's Hospital Fund for London

Mr. R. Nicholls, Regional Administrator, Oxford and South Western Regional Health Authority

Mr. W. Plowden, Director General, Royal Institute of Public Administration

Mr. B. Rayner, Department of Health and Social Security

In Attendance at Meetings

Mr. V. Criscuolo, Co-ordinator, Performance Review Group, Wessex Regional Health Authority

Mr. D. Mowbray, Director, MAS Team, Oxford and South West Regions

Brunel Research Team

Prof. M. Kogan, Professor of Government and Social Administration, Brunel University

Mr. M. Buxton, Senior Research Fellow, Health Economics Research Unit, Brunel University

Miss M. Henkel, Lecturer, Department of Government, Brunel University

Mr. T. Packwood, Lecturer, Department of Government, Brunel University

Dr. L. Radice, Lecturer, Department of Government, Brunel University

Dr. E. Scrivens, Research Fellow, Department of Social Policy, University of Bath

Access to the Field

1.5 Agreement was reached with the Oxford and South Western Region Supervisory Board and the Wessex Regional Health Authority that work might proceed in those three regions and arrangements were made to enable the team to secure the agreement of districts to access. By the time the evaluation began, proposals for an MAS trial in the North Western Region had been abandoned and after preliminary discussions it was agreed that the team would not attempt to extend its evaluation to cognate activities in the region.

1.6 In the event, therefore, the team evaluated an MAS trial piloted jointly in Oxford and South Western Regions and the Performance Review experiment established on a somewhat different basis by the Wessex Region. Both of these initiatives took place, however, within broader national political and historical developments and it is to these that we now turn.

CHAPTER 2

INSTITUTIONAL CONTEXT AND POLITICAL BACKGROUND

Intervention in the National Health Service

2.1 The Management Advisory Service trial must be seen against a procession of interventions over the last 15 years each of which was intended to improve the management and performance of the NHS. One kind of intervention attempted to introduce various forms of systematic enquiry and analysis and included the Health Advisory Service (originally the Hospital Advisory Service) first established in 1969; the elaboration of the concept of monitoring (1972); the creation of formal planning systems (1976); the National Development Team for the Mentally Handicapped (1976); the Management Advisory Service (MAS) Projects (first announced 1980); and the Regional Review System (1982). There have been attempts recently to improve the routine data-base, and to identify more positive ways in which it can contribute to monitoring and evaluation: these include work on performance indicators and the Steering Group on Health Services Information.

2.2 Attempts to apply different forms of systematic enquiry were interwoven with political and administrative attempts to solve the inherent problems of health service organisation. A massive reorganisation had taken place in 1974 when the services maintained by hospital authorities and groups were amalgamated with those maintained by local authorities as well as the arrangements for family practitioners. The three tier unitary system (of regions, areas and districts) hardly had time to establish itself when a further reorganisation, in 1982, eliminated the areas and created appointed district authorities. Then, and at the same time as the MAS trials were getting underway, the Secretary of State initiated the NHS Management Enquiry under the leadership of Mr. Roy Griffiths which proposed yet further far reaching changes. The Griffiths Report (1)

proposed management under a single General Manager at each level of the NHS. To this end there would be a Health Services Supervisory Board and a full time NHS Management Board. The general manager would be held responsible for achieving the objectives set by the authority. There would be a review and reduction of functional management structures at all levels. Clinicians would be involved more closely in the management process in a manner 'consistent with clinical freedom'. There would be Units of Management to control budgets. The Griffiths team were brought in 'because of our business experience' and their recommendations reflected their expertise: they did not perceive the NHS to be far different from business as an enterprise. They emphasised the importance of precise management objectives, of control of expenditure, of the measurement of health output, and of meeting the needs and expectations of people the NHS served. Implementation of the report was announced on 4 June 1984.

2.3 At the same time as the Griffiths inquiry was being absorbed by the NHS, instructions from the DHSS required health authorities to analyse their constituent services to see which might be offered to private contract. In particular, they were required to obtain commercial tenders for catering, laundry and domestic services to compare with in-house tenders. This involved consideration of service objectives, detailed specifications of required service levels and standards, and the analysis of working arrangements. Managers were required to observe manpower limits and efficiency saving schemes specified by the DHSS. 'Efficiency savings' were to pay for increases in priority services. Health service managers had to find money for new developments by savings on old.

2.4 These varied initiatives incorporated conflicting goals: the use of authority as against professional and occupational discretion; central authority as against local autonomy; the use of systematic disciplined enquiry in a setting created by political action and affected by wider social movements. In

Appendix A we summarise the main characteristics of different forms of disciplined enquiry which have been applied to or contemplated for the NHS and identify these variations within a common framework.

Political Background to the MAS Trials

2.5 The idea of a Management Advisory Service adumbrated in Patients First in 1979 (2) contained more than one strand of thought. In 1978, Frank Pethybridge, Regional Administrator, North Western Regional Health Authority, proposed (3) a National Health Services Advisory Authority to replace the Health Advisory Service and 'to provide an efficient mechanism for the development of comprehensive national standards; impartial assessment of practices within the service; the dissemination of good practices; and the reinforcement of public accountability'. In effect, this would create a national health inspectorate. With the change of government in 1979, the new Secretary of State, Patrick Jenkin, took up a similar theme with, however, an emphasis on devolutoin of authority to the districts. At the same time other groups such as the Outer Circle Policy Group and the Royal Institute for Public Administration were considering means of promoting cross fertilisation and innovation in the health authorities. A RIPA working group proposed the creation of an experimental free standing Regional Development Agency, that would complement the MAS trials. (4)

2.6 More specific proposals for a MAS expressed the government's belief that the decentralisedhealth authorities proposed in the 1982 reorganisation of the NHS would benefit from 'the challenge and stimulus of independent scrutiny and check'. (5) It was felt that the proposed local reviews of performance by health service managers needed to be reinforced by independent reviews.

2.7 This new form of monitoring was first announced in 1980. (6) The DHSS was considering possible pilot schemes to be run by a service which might be entitled, 'A Management

Advisory Group.' The trials were launched following a meeting of the Chairmen of Regional Health Authorities with the then Secretary of State, Patrick Jenkin, in November 1980. At this time, the government was preoccupied with the need to strengthen the District Health Authorities in the reorganised service, whilst, at the same time, ensuring accountability to central government.

2.8 In the session 1980/81 both the Committee of Public Accounts (PAC) and the Social Services Committee discussed the proposals for the setting up of the MAS. The DHSS, in a memo to the PAC on accountability in the NHS, elaborated on their earlier proposals.

> 'The MAS will complement the monitoring role of RHAs: it will introduce a "roving eye" approach at the national or regional level in which intervention is more selective, either on a regular basis or in response to specific causes for concern. The MAS should also help to strengthen local accountability by giving district chairmen and members an independent assessment of the services for which they are responsible. Thus the Department sees the possible development of an independent "monitoring" service as an important instrument to help meet the requirements of Parliamentary accountability without undue involvement in district affairs by RHAs and the DHSS.'

The statement then went on to outline the launching of three regional trial schemes, and to indicate that the future scope of the MAS would finally be determined in the light of these trials. (7)

2.9 When evidence was taken by the PAC on 25 March 1981, Sir Patrick Nairne, the Permanent Secretary, made it clear that he saw the MAS as an effective monitoring service, assisting in the promotion of good practice and providing an external inspectorial eye at the local level. MAS would identify a range of performance indicators against which

performance could be assessed. (8) However, he thought it probable that it would remain a regional rather than a national service, though at the same time it would have to be provided with some means of passing information from one region to another. (9)

2.10 The PAC endorsed the ideas behind the setting up of MAS. The Committee hoped that it would 'be effective in spreading good practice more widely, and that if necessary the DHSS will ensure that its recommendations are implemented.' (10)

2.11 In May 1981 the DHSS spelled out more fully the details of the proposed MAS trials to the Social Services Committee. In the North Western Region the object of the reviews would be to look at the quality, efficiency and effectiveness of the service provided by the authority within whatever constraints affected it. The Oxford and South Western MAS team would aim to examine selected operational services, compare performances, identify differences and deficiencies, and alert authorities to the need for change. It would disseminate information on the development of good practice. Finally, in Wessex, the RHA proposed to mount a series of performance reviews of selected services, looking at both the efficiency and effectiveness of those services and achieving changes as a result. All the authorities in the region would participate and their reviews would be conducted by the management staff of the district health authority concerned. Explicit standards of performance would be agreed by the authority concerned which they would attempt to achieve. At the end of the programme, the methods and results of the work would be reviewed objectively. (11)

2.12 In its report, the Social Services Committee stated that it was encouraged, in the context of the need to increase overall efficiency and planning in the NHS, by the government's long term objective to develop an independent national MAS. The Committee proposed that those charged with monitoring - 'whether at the regional or national level - should report back to the committee their findings about the adequacy and quality of the health services being provided.' (12)

2.13 The Social Services Committee returned to the question of the role of the MAS in the following sessions when discussing the Government's 1982 White Paper on Public Expenditure. (13) In reply, the Department stated that all three pilot schemes were in an advanced state of preparation and that the three separate approaches would provide a wider view so as to enable a decision to be reached on the practicability of a national MAS scheme at the end of the two year pilot schemes. The Department went on to say that the King's Fund had been approached to undertake a central role in evaluation and that the MAS would maintain close contacts during the pilot scheme with the HAS and the Mental Handicap Development Team. (14) MAS was to be seen as only one of the initiatives in which health authorities would stimulate better performance. Others were to include regional reviews, performance indicators and the Steering Group on Health Services Information.

2.14 The Committee, while congratulating the Department on the progress made so far, nevertheless sounded a note of caution about the apparent lack of criteria for evaluating the project and a possible latent ambiguity in its goals. The Committee went on to remind the government that it had recommended, and the government had accepted, that the DHSS should continue to seek to develop ways of assessing quality independent of the input of resources, and that this could usefully become the responsibility of the new MAS. However, it now noted that the emphasis in the latest White Paper (15) was on the important part that MAS would have to play in identifying ways of saving money and carrying them into effect at a local level. The Committee recommended that 'in setting up a national MAS scheme the Department keep the parallels of the HAS and Mental Handicap Development Team in mind rather than seeing MAS solely as an agency for cutting costs.' (16)

2.15 By the end of the 1982 session, therefore, the role of the MAS remained somewhat ambiguous. The government had initially seen it as a means of encouraging good practice and strengthening the role of the district authorities in reviewing their services. The 1982 White Paper on Public Expenditure, however, appeared to

assume other functions; issues of accountability and control of expenditure and policies were now at the centre of government initiatives in the NHS. Even without these changes in emphasis, MAS was overtaken by Norman Fowler's decision to inaugurate regional reviews and performance indicators. The region which had initiated the concept of MAS, North Western, withdrew from the trials before they began. And the DHSS' own interest in them evaporated before they could be evaluated.

REFERENCES TO CHAPTER 2

(1) NHS Management Inquiry (Griffiths Report), DHSS, October 1983 (Mimeod).

(2) DHSS, Patients First, 1979.

(3) F. Pethybridge, A National Health Service Advisory Authority, North Western Regional Health Authority Paper, 1978.

(4) D. Hunter et al, Development Agencies in the NHS in England: The Promotion of Innovation, RIPA, 1981.

(5) The Government's White Paper on Public Expenditure in the Social Services. Reply by the Government to the 3rd Report of the Social Services Committee 1979-80, Cmnd 8086, HMSO, p 7.

(6) DHSS, Health Service Development Structure and Management, HC(80)8.

(7) Committee of Public Accounts, 17th Report, Session 1980/81, Financial Control and Accountability in the NHS.

(8) Ibid, pp 54-55.

(9) Ibid, pp 59.

(10) Ibid, xviii.

(11) Social Services Committee, 1980/81, Third Report, Public Expenditure on the Social Services, Vol. I, Para 5, HMSO, 1981.

(12) Ibid, xii.

(13) White Paper on Public Expenditure, Cmnd 8494, HMSO, 1982.

(14) Social Services Committee 1981/82, Second Report, 1982 White Paper, Public Expenditure on the Social Services, Vol. 2, pp 31.

(15) 1982 White Paper, op.cit.

(16) Social Services Committee, 1981/82 Second Report, White Paper, Public Expenditure on the Social Services, Vol. I, HMSO, 1982.

CHAPTER 3

FRAMEWORKS FOR THE STUDY

I EVALUATIVE METHODS

3.1 In deciding our modes of working, the Brunel team faced some theoretical issues. A choice had to be made among the range of evaluative modes available to a research team. This choice had also to be related to the nature of the trials which we were to evaluate.

3.2 There is a large range of evaluative approaches and techniques which are available, at least in the theoretical literature if not always in empirically tested forms. Our own survey of these methods is briefly summarised in Appendix B. Our attention was directed to this range for two reasons. First, it was necessary to select our own evaluative stance in relationship to the two projects. Secondly, both MAS and PR themselves seemed likely to entail varying degrees of evaluative work and it was, therefore, necessary to locate them, too, in the range of evaluative approaches and techniques available. A further and related concern is that PR and MAS incorporated assumptions about interventions in organisation, practice and policy making; we therefore go on to consider relevant theories of intervention.

3.3 Evaluations can be placed on a continuum, at one extreme of which is the classic, experimental, 'scientific', approach, depending upon strict controls against which comparative observations can be made. This mode of evaluation has dominated thinking about what constitutes 'rigorous' evaluation in the NHS. Economists and others have followed the 'scientific' ideal of randomised control tests (RCTs - see Appendix B). At the other extreme there is no control that can be applied and no testable hypothesis rigorously established.

3.4 In the study of organisational change, it is rarely realistic to produce a scientific input-output description. For this reason, Cope (1) distinguishes between experimental and quasi-experimental research designs (which in fact vary in terms of the degree of control that can be established) and proposes a non-experimental design. In his view, it is possible to determine whether a process of change exists after an intervention and whether the direction of change is towards the achievement of the objectives of the intervention. The method involves collecting data and watching for a pattern to emerge. Some explanations will be supported, and others eliminated, and patterns may show themselves.

The Approach of the Brunel Evaluative Team

3.5 The research team's evaluation was constrained by the circumstances in which the trials were to be held. We were to evaluate two very different projects, with unresolved possibilities of tackling a third, after they had been already inaugurated. The period of our evaluation, from April 1982 until July 1984, was not coterminous with that of the trials. We could make no assessment before the trials began against which changes could be judged. Our evaluation could therefore at best be fed back for the benefit of the experiment before completion rather than lead to judgements at the end of an experiment. We could not attempt to compare equivalent states over time. The evaluation would rather have to be concerned with the quality of the processes adopted and their impacts as perceived by those involved.

Components of Evaluation

3.6 The main issues determining our evaluative framework, therefore, were as follows:

1. Who sets the criteria for evaluation?
2. What are the criteria?
3. Who is intended to benefit from the evaluation?
4. What is its focus: input; process; output; impact?
5. Is the evaluation made over a time series?
   And does it start before any intervention?

6. Are there formal controls?
   (For example, randomised, double-blind?)

7. What sources of information and data are employed?

8. Is change measured quantitatively?

9. Are there predefined hypotheses?

10. Is either replicability or generalisability an objective?

11. Is the evaluation intended to be:-

    (a) objective-summative-instrumental (that is, making an external appraisal, deriving authority from objectivity);

    (b) expressive (that is, expressing the aims and activities of those evaluated in such a way that they can learn from it. Authority is here derived from sensitivity and powers of communication, as well as critical analysis);

    (c) participative-formative in intention (that is, activity helping those evaluated to achieve change)?

3.7 On the basis of the issues raised in paragraph 3.6, the Brunel team selected approaches to be pursued, as in the following paragraphs.

Who Sets the Criteria for Evaluation?

3.8 The criteria by which MAS and PR were evaluated derived from the DHSS and its various statements of objectives for the MAS trial; from the regional health authorities which instigated the trials and the teams responsible for carrying them out; and from the Brunel evaluative team.

What Are the Criteria?

3.9 The criteria were based on the wide range of regional and national statements of objectives for MAS and the proposed evaluation criteria internal to the MAS and PR projects (see Chapters 4 and 5). From these we distilled a basic set of evaluative criteria to be applied throughout the study under the four headings identified by Rossi and Freeman. (2)

Planning

Relevance of the projects to the regional and national statements of objectives.

Conceptualisation and Design

Internal logic and coherence in the conception of the projects.

Implementation

Internal consistency between values, objectives and actual processes, methods and outcomes of work.

Utility

(a) efficiency of process;

(b) efficiency and effectiveness of outcome.

3.10 The basic criteria were overlaid by the different emphases on, for example, participation and involvement that derive from particular local philosophies. The evaluation was to be sensitive to such local emphases, and take account of any changes in emphasis over time and differences of perspective within the participant authorities.

Who Benefits From the Evaluation?

3.11 In determining the framework set out in paragraph 3.20, the team assumed that those benefitting from the evaluation would be:

(a) the DHSS - the Department saw use in developing systematic monitoring and evaluation of interventions in and by health authorities;

(b) Parliamentary Committees such as the Public Accounts Committee, the Social Services Committee, as well as non-Parliamentary bodies and individuals concerned with public policy;

(c) non-participating health authorities who would hope to learn from the experiences of the regions, providing MAS or PR projects;

(d) those participating in the projects.

What is the Focus of the Evaluation?

3.12 Our evaluation has been focussed on Inputs, Processes and Outcomes of MAS/PR rather than on their Outcomes. Some evaluations of impact on the participant authorities have been made but the time span of the evaluation made a comprehensive evaluation of outcome impracticable.

Is the Evaluation Made Over a Time Series?

3.13 The evaluation could not be undertaken before the intervention began nor after it was completed. Nor could it be a full time series study. Where possible observations were made at the beginning of specific exercises and at later stages. For the most, part, however, the interval between the team's observations was insufficient to incorporate the full sequence of change.

Are There Formal Controls?

3.14 The evaluation was not concerned with experiments or trials subject to controls.

What Sources of Data Are Employed?

3.15 The principal sources of data were documents supplied by the DHSS, regions, districts and the MAS and PR teams; interviews semi-structured on the basis of the evaluative framework; observation of selected meetings; quantitative data supplied by the health authorities, including some of the costings of MAS/PR interventions. No surveys were undertaken.

Has Change Been Measured Quantitatively?

3.16 Change was measured quantitatively only in some limited specific cases. For the most part it was evaluated qualitatively.

Are There Predefined Hypotheses?

3.17 While limited or middle range hypotheses might emerge from the evaluation it was not possible in a non-experimental project to predefine hypotheses other than the most general proposition that MAS and PR initiatives would or would not lead to desirable change.

Is Either Replicability or Generalisability an Objective?

3.18 The projects were not experimental in the rigorous sense of the word, so that replication was not a relevant objective. However, it was hoped that generalisable concepts and propositions about, for example, prerequisites and processes of change would emerge.

Mode of Evaluation

3.19 The sponsors might have wanted the evaluation to aim at being summative, that is, producing a definite and instrumentally useful statement of 'results'. But for the reasons given earlier, at most it could prove to be only 'formative', that is to say capable of being taken into account in latter stages of the trial. Demands from some of the participants involved the evaluators in taking up a participative and formative role; they were asked to feed back evaluations and impressions in the course of the evaluation so that the progress of the project might be affected.

Evaluative Framework Used in the Trials

3.20 Our first attempt at elaborating the basic criteria set out in paragraph 3.9 was our Evaluative Framework (Version 1) (May 1982). (Appendix C). The final version was based upon that document:

Planning: Relevance to Objectives

(a) What objectives have emerged in the national development of MAS? Have they been consistent over time and are they mutually compatible?

(b) What objectives have emerged in the regional developments of MAS/PR? Have they been consistent over time and are they compatible with the national objectives?

(c) From what institutional problems have national and regional objectives derived?

(d) What priorities are derived from the stated objectives and problems?

Conceptualisation and Design: Internal Logic and Coherence in the Conception of the Schemes Participating in the Trial

(a) Are the objectives of the scheme explicit? Have they changed over time? Are they mutually compatible?

(b) Do the authors of the scheme have a distinct model?

(c) If so, is it an advisory scheme or itself concerned with the implementation of change? Is it concerned with creating a product or initiating a process?

(d) Do the institutional arrangements for the scheme reflect a clear conception of its objectives and of the structural, functional and authority relationships with the health authorities and within the scheme itself?

(e) Is the scheme underpinned by explicit thinking about change or intervention processes, evaluative theories, criteria and methods? Have the scope of the scheme, the data needs and criteria for selecting subjects of the scheme been worked out?

Implementation: Internal Consistency Between Values, Objectives, Actual Processes, Methods and Outcomes of Work

(a) Was the scheme implemented as intended? If not, what prevented it? What was not implemented?

(b) These questions needed to be considered by reference to: institutional arrangements; scope of the scheme; selection of subjects; evaluative theories; criteria and methods; data collection and use; feedback and follow up.

Utility: Efficiency of Process

(a) Costs: What were the costs of providing a MAS/PR:-
- to those who were the subject of advice/review;
- to RTOs, DMTs, RHA/DHA members;
- to members of the advisory service itself?

(b) Costs might be calculated in terms of resources used (money, time, manpower, use of plant - for example, computer resources). Were there costs in industrial/professional relationships (for example, man hours, etc.) and/or translated fully into financial costings?

(c) Could the exercise have been carried out with better use of resources?

(d) What commitment did it achieve to evaluation/performance review and to the objectives as specified by the region?

(e) What needs for change in management, practice, planning processes did it identify?

(f) Did it establish usable criteria, standards and measurements of performance? If so, what were they, how were they determined, and to what use have they been/could they be put?

(g) Has the system been capable of adaptations/response in the face of problems encountered?

Utility: Efficiency and Effectiveness of Outcome

(a) Has MAS/PR produced more or better data, or improved information systems?

(b) Has MAS/PR led to changes in planning systems and/or processes?

(c) Has MAS/PR led to changes in operational efficiency and effectiveness, i.e. more economic use of resources; improved response rate in delivery of services; changed working methods of existing institutions; new advisory or administrative structures and/or communication systems?

(d) Has MAS/PR led to dissemination of good practice within and/or across professional boundaries?

(e) Has MAS/PR led to changes in industrial and/or professional relationships (behavioural and expressive)?

(f) Has MAS/PR led to changes in the expectations about services by consumer or pressure groups?

(g) in relation to all of these factors, what other events during the period of the pilot scheme might have had an influence on the identified changes (reinforcing MAS/PR, negating it, pre-empting it)?

II ASSUMPTIONS ABOUT INTERVENTION

3.21 The MAS/PR trials were intended to cause change. The two trials, however, demonstrated a wide range of assumptions about ways in which change might be formulated and implemented. As briefly explained in Chapter 2, the trials took place within a changing political environment in which different views of the relationships between the DHSS, the regions and the districts became evident over relatively short periods of time. This indicates the impact of theories such as those of Rein (3) who regards the implementation of organisational change as the continuation of the political process in another arena.

3.22 Others (e.g. Wolman (4)) consider implementation to be primarily a rational process divided into two phases, formulation and carrying out. Wolman maintains that it is too often assumed that where failures occur they result from imperfect carrying out. Formulation, conceptualisation or other elements such as the creation of control structures are, in his view, as or more important. The programme design may not be adequate for analysing the causes to be tackled or for accommodating political problems or for tackling the issues of technical feasibility and the unintended consequences of change. A similar kind of point is made by Elmore. (5) His set of formulations centres on the extent to which implementation is analysed as 'backward mapping' or 'forward mapping'. Forward mapping is the traditional implementation process. It assumes that objectives are set by policy makers at the top of the organisation and that implementation is achieved through the phased application of specific techniques. Backward mapping starts from the point of service delivery. The point of analysis is where practitioners meet their clients. It then works sequentially through the various organisational actors until the traditional top of the policy process is reached.

3.23 Once granted, however, that a change programme takes place within a broader political and environmental context, there are several typologies of contrasting change models which are relevant to our concerns. As they emerge from the literature there are the contrasts between 'top-down' and 'bottom-up' (6) and/or between centre-periphery or periphery-centre or periphery-periphery. (7) Contrasts are drawn between the managerial and the collaborative modes (8) and change caused by external as opposed to internal agents. Coercively administered forms of change, embodying the use of sanctions, are contrasted with collaborative modes which depend upon incentives.

3.24 The assumed conflict between top-down and bottom-up, and centre-periphery and periphery-centre models is discussed by Hunter. (9) He observes that the opposing typologies derive from the paradox of health administration (and probably of administration generally) that there is a dual search for certainty, which demands control, and flexibility, which is a prerequisite of innovation. The top-down model assumes that only the centre is in a position to take sound allocative decisions. Recent attempts to enforce accountability such as the programme of annual review meetings between ministers, civil servants, RHA Chairmen and officers, the creation of performance indicators and the earlier apparent intentions underlying the creation of a national MAS fit comfortably with this model. By contrast a bottom up model would rely on the belief that service innovation requires collaboration by groups within their authorities and good informal inter-authority relationships at operational-management levels. In this model the centre has a facilitating rather than a control function. Top-down approaches are assumed to inhibit rather than promote innovation at the periphery because policy making and implementation are interactive processes. A bottom-up model may assume pluralism and aim for consensus through learning, rather than compliance and control.

3.25 A further set of considerations concerns ways in which individuals or groups can be persuaded or induced to change. According to Chin and Benn 'Normative re-educative approaches to effecting change bring direct interventions by change agents, interventions based on a consciously worked out theory of change and of changing, into the life of a client system, be that system a person, small group, an organisation or a community.' Such approaches (10) emphasise the involvement of clients in programme change and the bringing of the client and his problem into 'dialogic' relationship with the way in which he and his problem are seen by the change agent. On the face of it, such educative change models start at the periphery or with the individual and take account of his or her psychological and other resources and needs. They are, nevertheless, compatible with managerial structure and hierarchy which might be seeking normative re-educational methods to further organisational goals. Thus whilst individuals are given the opportunity to internalise and work out organisational goals, this would be a different process from that implied by Hunter in which the knowledge and power of individual practitioners at the periphery are the primary motive force in securing change throughout a larger system.

3.26 In essence, attempts to model seem to address two interlocking sets of questions. The first concerns the organisational or institutional structures through which action is legitimated and control is exercised. Such models are concerned with the issues of authority, accountability, power and use of sanctions and organisational rewards. But, secondly, such discussions carry with them assumptions about what constitute the best ways of inducing organisational change and learning both among individuals and in larger groups. Some models might start from this second set of issues but they inevitably travel through the same terrain. There is a continuing connection between questions of authority and questions of how to implement change.

3.27 It may be helpful to summarise some of the typologies of change models or theories which are relevant to our concerns and which are embodied in the discussions in previous paragraphs.

1. Rational Organisational - Political Bargaining
2. Forward-Mapping - Backward-Mapping
3. 'Top-Down' - 'Bottom-Up'
4. Centre - Periphery
5. Managerial - Collaborative
6. External - Internal
7.

Coercive..........	.......Sanctions
Collaborative.....	......Incentives

8. (a) Rational - Empirical
   (b) Normative - Re-educational
   (c) Power - Coercive

3.28 The above chart indicates the wide range of dimensions within which change can be conceptualised. It is also set out in a form which draws attention to conflicts and tensions in assumptions about organisational change: between change as an administrative and political process, between alternative locations of change initiatives and between modes of inducing change. The identification of such conflicts and tensions is a central feature of the analysis and evaluation of the MAS/PR trials in the Oxford and South Western and Wessex regions which now follows.

REFERENCES TO CHAPTER 3

(1) D. Cope, Organisation and Development Action Research in Hospitals, Gower, 1981.

(2) P. Rossi and H. Freeman, Evaluation: A Systematic Approach, Sage Publications, 1982.

(3) M. Rein, From Policy to Practice, Chapter 7, Implementation: A Theoretical Perspective, Macmillan Press Ltd., 1983.

(4) H. Wolman, 'The Determinants of Program Success and Failure', Journal of Public Policy, Vol. I, Part IV, October 1984, pp 433-464.

(5) R. F. Elmore, 'Backward Mapping: Implementation Research and Policy Decisions', in W. Williams (ed), Studying Implementation: Methodological and Administrative Issues, Chatham House Publishers Inc, 1982.

(6) D. J. Hunter, 'Centre-Periphery Relations in the NHS: Facilitators or Inhibitors of Innovation', in K. Young (ed), National Interests and Local Government, Heinemann Educational Books Ltd., 1983.

(7) D. Schon, Beyond the Stable State, Temple Smith, 1971.

(8) T. Burns, referred to in D. J. Hunter, op.cit., 1983.

(9) Hunter, op.cit. and Schon, op.cit.

(10) R. Chin and K. Benn, 'The Roots of Planned Change', in W. Bennis, K. Benn and R. Chinn, The Planning of Change, Holt, Reinhart and Winston, 1969 (2nd edition).

CHAPTER 4

OXFORD AND SOUTH WESTERN REGIONS - MAS PROJECT

The Brunel Research Team's Approach

4.1 The work and impact of MAS were evaluated over a two year period - Spring 1982 to Spring 1984. Over this period the researchers interpreted their task as being to:

(a) monitor the progress of the experiment, principally through contacts with the MAS team and observation of some of the Supervisory Board meetings;

(b) learn the perceptions of the role and value of MAS held by staff in the field, both in connection with particular studies and in general terms;

(c) make their own assessment of the logic and value of the approaches adopted by MAS in the light of their knowledge of its work and of other change strategies and interventions as discussed in Chapter 3.

4.2 Evaluation, however, posed a number of problems. First, there were the limited research resources available for the work. These limitations had to be set against the number of studies undertaken by MAS, their extensive subject area and the range of methodologies they employed. Second, the studies were applied across 19 districts in two regions, which although territorially contiguous, had different histories and traditions, different forms of organisation, different ways of working and different emphases and needs. Third, there was the dynamic nature of MAS itself, and the way in which its own methods and emphases were planned to evolve over the period of the experiment. Finally, there was the problem of the right time to seek an evaluation of MAS's work. Results in terms of local change would probably not be evident until long after the

relevant study had been completed. The initial phases of MAS work also corresponded with the period when the health service was preoccupied with reorganisation. The evaluation was submitted in draft form to the Supervisory Board and its officers, and note taken of their comments in producing this chapter for the report.

4.3 The evaluation is presented in three parts:-

PART I - AN OUTLINE OF THE MAS PROJECT
Provides the context, describing the structure and work of MAS throughout the period of study (Paragraphs 4.4 to 4.19).

PART II - MAIN EMPIRICAL COMPONENTS OF THE STUDY
Reports a number of studies undertaken by the researchers to gain service opinions of the experiment (Paragraphs 4.20 to 4.163).

PART III - EVALUATION
Assesses MAS within the evaluative framework developed in Chapter 3 (Paragraphs 4.163 to 4.236).

PART I

AN OUTLINE OF THE MAS PROJECT

4.4 MAS in Oxford and SW Regions was set up as a two year experiment. It formally began in October 1982, although the Director had been in post from the Spring. A six month extension was later negotiated, making the closing date the end of March 1985.

Objectives

4.5 The objective of all the MAS experiments was defined by the Secretary of State as being 'to explore the value of establishing an independent source of advice to the district and regional health authorities on the efficiency of their services.' However, as mentioned in Chapter 2, there were other national objectives concerned with monitoring the implementation of policy, with improving quality of performance and securing greater accountability. MAS in Oxford and SW formulated its own specific objectives. These were:

> to identify, examine, make recommendations (and influence implementation) on significant management issues;
>
> to contribute to the development of planning within the NHS;
>
> to support districts in monitoring their own performance;
>
> to encourage the use of research resources and disseminate good management practice.

MAS would meet these objectives by employing data that were largely routinely available, although on occasion it might need to collect additional information, and by alerting authorities to the need for change.

4.6 While these objectives were clearly inter-related and could all provide routes to efficiency, they were general and capable of wide interpretation. They also carried different emphases in the service and called for different forms of relationship. Would the stated approach of MAS, 'to review selected services using routinely collected data and to disseminate good management practice', prove efficacious in meeting these objectives, individually or collectively?

Organisation

4.7 In its work MAS was to be independent of the regions and districts, working to the Supervisory Board. The Board comprised:

the two RHA Chairmen, or their nominated deputies;
two RTO members, one from each region;
two DHA chairmen, one from each region;
one independent member.

Board meetings were also attended by the two Regional Administrators and the MAS Director.

4.8 The terms of reference of the Board were:

'To establish and operate for a two year period starting on 1st October 1982 a structure to assist Health Authorities to monitor subjects concerned with management practice and performance within the Oxford and South Western Regions. The Supervisory Board and its supporting team, whilst part of the NHS, will act independently of Health Service Authorities. Its activities will be complementary to the normal and proper monitoring responsibilities of the Authorities within the two Regions. The Supervisory Board will agree a number of subjects for study and, if possible, use systematically collected informationfor this purpose. The exercise will set out to compare performance and highlight deviations with the intention of promoting good practice and stimulating change if and when inefficient practice is identified.'

The Board met quarterly. Its NHS membership exhibited considerable change over the period of the study.

Staffing

4.9 For most of the period of evaluation the MAS team had three senior members: the Director, who carried chief officer rank, and two Management Associates, Administration and Finance. All three were appointed in the spring or summer of 1982 and, together with the Administrative Secretary, who was also appointed in summer 1982, made up the core of the team. A fourth core member, a nursing specialist, was recruited in autumn 1983. Others, junior members or seniors with specialist knowledge, were recruited later; seconded for varying lengths of time or serving in a part time or temporary capacity. A statistical assistant was based in the SW regional offices from December 1982. MAS did not perceive the need for a similar appointment in the Oxford Region although it offered to provide support to the Oxford Health Service Library.

4.10 Apart, then, from its senior core members, the team had a fluid membership. This was deliberate. The Director saw the work as requiring staff with an understanding of policy and management and capable of applying analytical skills. Specialist knowledge of particular aspects of the NHS might be useful for particular studies or groups of studies but could be brought in on a temporary basis. However, the team encountered difficulties with recruitment. Posts with MAS were treated as part of the staff protection arrangements associated with reorganisation. Vacancies thus had to be first advertised separately in the two regions and only if this proved unsuccessful could they then be placed nationally. This proved time consuming in the context of a project with limited life that required to attract high calibre staff.

Mode of Working

4.11 The mode of working adopted by the Director put a premium upon flexibility which would enable a high output. Senior members of the team were given responsibility for the different studies according to their experience and their workloads. Junior and senior members alike participated on the different studies as the work dictated. Thus all members of the MAS team might be involved with one study when it reached a demanding phase. The Director saw it as part of his role to allocate the work of the team and to ensure that junior members received appropriate guidance and experience. Clearly the

senior members of the team were heavily committed in terms of providing leadership for the various studies and undertaking much of the data collection and analysis.

Range of Work

4.12 MAS was concerned with improving the management of NHS services. This included clinical as well as supporting services. It was also concerned with exploring innovations in management to stimulate good practice.

4.13 In an Interim Report, issued in autumn 1983 (1), MAS categorised their studies as follows:

I - Studies reviewing services by the use of resources or other activity measures.

II - Studies reviewing services by policy fulfilment.

III - Studies developing models enabling authorities to review their services.

IV - Studies developing management processes.

V - Studies dealing with specific district problems.

4.14 By the spring of 1984 the team had undertaken or were in the course of undertaking the following studies:

Subject	Category
Review of the Allocation of Units of Medical Time	I
Review of Trauma and Orthopaedic Services	I
Review of Inpatient Waiting Lists	II
Review of Capital Planning Processes	III
Review of Management of Transport Services	III
Review of Joint Planning Processes	III
Review of Selected Services for Children	II
Review of Selected Services for the Elderly	II
Review of Hip and Knee Replacement Programme in SW Region	I

Review of Selected Community Services	II
Development and Application to a District of Nurse Manpower Level Indicators	IV
The Costs of New and Replacement Consultants	I
Abstract of Efficiency Measures	I
Assisting in the Development of Regional Strategic Planning in South Western Region	IV
Development and Application of Resource Allocation Model to District Decision Making	IV
Implications of 5 Day Wards	V
The Relationship Between Senior Hospital Doctors and Health Authority Members in South Western Region	III
Emergency Duty Payments	I
Methods of Curbing Requests for Diagnostic Investigations	III
Review of Services for the Mentally Handicapped	II
Development of District Strategic Planning Intentions	IV
Impact of Staff Holidays on Patient Services in a DHA	V
Impact of Holiday Season on A & E Services in a DHA	V
Methods of Manpower Planning in a DHA	V
Services for the Elderly in two DHAs	V
Organisation of Out Patients Clinics	III
Development of Mental Illness Strategy for a DHA	V
Development of a District Profile Undertaken for Two DHAs	V
Review of District Services for Children	V
Review of Secretarial Services for a DHA	V
Methods of Monitoring the Performance of Units in Three DHAs	V
Alternative Methods of Servicing Medical Equipment for a DHA	V
Review of District Acute Services	V

4.15 Although the different studies could all be seen as promoting efficiency, they required different methodologies and relationships with the field. Thus I and II could be undertaken at a distance, through the collection of information and routine or specific quantitative data. The results could be expressed in comparative form which allowed the identification of standards for judging district performance. The studies in III involved a closer relationship with the field and a reliance on qualitative as well as quantitative data in formulating models for service review. These models could then be tested by the service. The studies in IV involved collaboration with the field in developing new processes and thus the assimilation of quantitative and qualitative data. Studies in Category V varied according to the problem being studied. They were likely, however, to involve the provision of quantitative and qualitative data to the district concerned and a consideration of its application in the light of local circumstances. MAS believed in the virtue of producing quick results and was constrained by its own time-scale. Generally its studies lasted between three and six months, although Category V dealing with district problems had to be reasonably well contained and not likely to require more than 10 days of MAS time. For all of its studies, MAS found it essential to commence by agreeing a protocol defining the methodology and time scale with relevant service interests.

4.16 Categorisation of the studies should not obscure the fact that they contained common approaches. Studies of management process or of district problems required the collection of routine data and possibly the provision of comparative information, allowing the authority in question to see itself in comparison with its neighbours. However, categorisation was useful in that the studies exhibited different foci of attention and, as stated, applied different methodologies and relationships. This added to the complexity of evaluation. The research team deliberately attempted to include examples of the different categories in their evaluation of MAS and these are reported in Part II.

4.17 In addition to undertaking the analytical studies listed above, MAS was engaged in a range of other activities:

(a) publicising its results. When approved by the Supervisory Board, studies were published and distributed in the two regions. Originally different procedures for circulation applied in the two regions. In the SW, studies were distributed directly to districts by MAS, whereas in Oxford, studies were distributed through the Region. Following representations by MAS, the former procedure was adopted in both regions. Reports in the first four categories tended to be lengthy and since only a limited number could be distributed, MAS produced digests summarising the main findings for wider circulation. Results were also publicised through seminars, conferences and other educational events. Although initially slow to 'get off the ground', these devices appeared to be gathering momentum by 1984;

(b) publicising its existence. MAS issued regular six monthly bulletins reporting its activities which were distributed across the two regions. An initial pamphlet announcing the existence and role of MAS was issued by the two regions early in 1982. Considerable time was given to development and maintenance of contacts with district and regional staff. When MAS began, the Director systematically made contact with all 19 districts and with senior regional staff, and in the winter and spring of 1984 he again visited each DMT. Such contacts, often in connection with particular studies, took up the time of the senior members of MAS. They were given high priority by the Director, since he believed that personal contacts would prove more influential in securing change than written reports.

One of the most helpful developments in this connection was seen as the nomination of liaison officers to link with MAS by the districts in the SW region;

(c) collection of information. MAS provided a source of information for the service, largely using routinely available data and bibliographical detail. The information available was to assist authorities in drawing up Profiles or in applying particular management processes;

(d) MAS engaged in two research projects with academic institutions: with the University of Bath in an ESRC funded project examining methods of change in health authorities, and with the University of Leeds in developing a model for Strategic Planning;

(e) the MAS team were involved in a number of educational events both within and outside the NHS;

(f) the Director had a part time commitment to the Inquiry into NHS Management (Griffiths Inquiry) and the MAS team undertook one of the studies for this Inquiry. MAS was also invited to undertake work on policy intentions and measurement for the Joint NHS/DHSS Working Party on Performance and participated in the DHSS (Rayner) scrutiny on Transport.

Authority

4.18 The authority of MAS in the two regions was never explicitly stated. However, a study of the documentation suggests that implicitly the team had authority to:

seek information from the service, the expectation being that this would normally be data that were routinely available to the service;

report its findings to NHS management, although, as mentioned above, it was not always clear whether this should be direct or through the region.

Costs

4.19 The MAS trial in Oxford and SW was financed by the DHSS. As a new institution it had to start from nothing. Details of the direct expenditure which includes staffing, travel, accommodation and equipment, are given below.

Year	Budget (£000)	Expenditure (£000)	Variance (£000)
1981/82	20	7	- 13.0
1982/83	180	106.5	- 73.5
1983/84	183.5	144.8	- 38.7
1984/85	183.5		

Underspending was partly attributed to the delays and difficulties in making approved appointments, but also to the lack of any need to 'pump prime' studies and to the Director's policy of allowing the progress of the project to dictate expenditure.

PART II

THE MAIN EMPIRICAL COMPONENTS OF THE STUDY

4.20 The intention was to seek the opinions of those who had experienced MAS work. In selecting areas for investigation the researchers attempted to:

(a) gain a general view of the role of MAS both at the outset and at the conclusion of the evaluation;

(b) select a range of MAS work for examination according to the type of study and its location within the service. Here, where possible, the researchers attempted to gain a 'before and after' perspective by seeking initial opinions of objectives, processes, gains and losses likely to be involved in working with MAS and then examining how these were borne out by experience.

4.21 This aspect of the evaluation was undertaken in four stages:-

STAGE ONE - Initial perceptions of the role and value of MAS - researched in summer 1982. (Paragraphs 4.23 to 4.38).

STAGE TWO - Perceptions of the first four studies undertaken by MAS - researched in the autumn, winter and spring 1982/83. (Paragraphs 4.39 to 4.50).

STAGE THREE - Evaluation of four selected studies, selected by category and territorial application - researched in later 1982, 1983 and early 1984. (Paragraphs 4.51 to 4.102).

STAGE FOUR - Later perceptions of the role and value of MAS - researched in autumn and winter 1983/84. (Paragraphs 4.103 to 4.163).

4.22 The results of these evaluations are briefly summarised in the following paragraphs. The range of those interviewed is indicated for each study, although the district authorities are anonymised and the individual views of NHS respondents are not attributed.

STAGE ONE - INITIAL PERCEPTIONS OF THE ROLE AND VALUE OF MAS

4.23 This evaluation is based upon separate semi-structured interviews held in the summer of 1982 with:

- the Director of MAS;
- the Management Associate (Administration) of MAS;
- the Management Associate (Finance) of MAS;
- the Regional Chairman, Oxford Region;*
- the Regional Administrator, Oxford Region;
- a Specialist in Community Medicine, Oxford Region;*
- one DHA Chairman from the Oxford Region;*
- one DHA Member from the Oxford Region;*
- one District Administrator and District Treasurer from a District in the Oxford Region;
- the Regional Chairman, SW Region;*
- the Regional Administrator, SW Region;
- the Regional Treasurer, SW Region;*
- the Deputy Regional Administrator, SW Region;
- one DHA Chairman from the SW Region;*
- one District Administrator, Deputy District Treasurer and SNO (Personnel and Training) from a district in the SW Region.

4.24 The results of this particular evaluation were presented to the Advisory Group at their meeting in December 1982 and to the MAS Supervisory Board in the same month. The summary that follows takes account of points made at both meetings.

* Membership of the MAS Supervisory Board.

History and Objectives

4.25 In general terms, MAS was seen by our respondents as a reaction to the need for tighter resource control in the health service, to the consequent need for changes in managerial behaviour, and to the problems of accommodating management with professional freedoms.

4.26 More specifically, the MAS trials were seen as having been initiated at a meeting of regional chairmen with the then Secretary of State, Patrick Jenkin, in November 1980. The Minister and the DHSS appeared to see MAS as a way of improving monitoring in the NHS, and thus strengthening public accountability. The independence of MAS would also respect the principle of devolution of authority to districts and provide the means, hitherto absent in the NHS, whereby different parts of the service could learn from each other. The Pethybridge proposals, at the inspectorial end of possible approaches, were mentioned as an important influence; not so the more developmentally orientated proposals of the RIPA.

4.27 However, regional chairmen were thought to have played a leading partin arguing the case for a regionally based experiment. They, and some of their chief officers, had believed that MAS could assist the regions in their role of promoting efficient management in the NHS in the context of greater devolution of authority to the districts.

4.28 Districts, too, recognised the need for more efficient management and for help in achieving it. However, it was felt that the balance of power within the NHS had shifted since MAS was first initiated. In 1980 the regional role was uncertain; by 1982 there had been a change in Minister and a stronger role for the regions. This did not dislodge the value of MAS as a means of achieving better performance, but:

> from the regional perspective MAS became complentary to other strategies such as regional reviews and performance indicators;
>
> from the district perspective, MAS was only one element in the larger issue of regional and district relationships and was likely to be seen as an instrument of regional purpose.

Model

4.29 The status of MAS as defined in the terms of reference of the Supervisory Board (see Part I above) was somewhat ambiguous, in that while part of the NHS, it would act independently from Health Service Authorities. Was it therefore a health service inspectorate or, at the other extreme, a consultancy service? MAS saw its role as distinct from either; its relationship to the field should be continuous and it rejected both the idea of providing authoritative prescriptions or the alternative of providing a service only when, and if, asked. MAS saw itself as a motivator; continuously encouraging and assisting authorities to make the most efficient use of their delegated powers. However, this role posed two difficulties.

4.30 Although by **definition** MAS was an advisory service, the MAS team and members of the Supervisory Board felt that there was an expectation that its work should produce change. What was the role of the team in this? It was willing to engage in the process of changing managerial behaviour if given a mandate to do so, and saw the possibility of including collaborative and seminar work with the districts in its programme as a way of promoting change. However, this would take time to develop, for the service had first to settle down from reorganisation and gain an appreciation of what MAS had to offer. The Supervisory Board was sure that the implementation of any changes would have to come through normal management processes; processes which were likely to occur at different speeds within the two regions.

4.31 This, however, led into the second issue; how would the regions use MAS findings? If MAS findings were to be automatically taken up by regional management, the team was likely to be seen as an arm of the region. MAS might thus become a means of promoting uniformity and be performing a 'policing' activity. Alternatively, the regions might respect district autonomy; 'holding off' and seeing if districts changed their practices as a result of MAS findings. The answer was likely to be crucial in defining how districts saw MAS. Without necessarily agreeing

that the regions should always 'hold off', the Supervisory Board were closer to the latter view. MAS was an independent service, not a regional agency, with a region-wide role.

4.32 MAS was concerned to evaluate activities against regional, national or professional standards, models of excellence and regional or national averages. Policy statements were not seen as easily providing suitable criteria for evaluators although some of those interviewed on the team and Supervisory Board felt that they should be borne in mind. The district viewpoint suggested that it would be profitable to evaluate longitudinally, thereby identifying trends, as well as comparatively across the two regions. It was also suggested that MAS needed to consider performance in the field as well as that recorded in statistics. Many significant deviations could be explained by local practices. The expertise of the MAS team was also seen as crucial in evaluation. To be credible it had to be capable of supplying insights that had eluded local managers.

4.33 The general framework to be adopted by MAS in its work was seen as:

determining the nature of the problem;

seeking information, identifying policy, good practice and forms of measurement;

analysing information, selecting relevant criteria/ models. (MAS was seen to have an important role in showing how information could be more usefully applied than hitherto);

comparing regional and district performance against the criteria/model. Wherever possible MAS would make use of data that were already available. However, it had the authority to ask for specific information to be collected;

reporting results, analysing results of comparisons in terms of range of performance;

promulgating good practice.

4.34 This framework was being adopted by the team in its initial studies. However, team members were aware that if they developed other approaches, such as collaborative work with the districts, new frameworks could be required.

4.35 In its scope, MAS was excluded from undertaking clinical audit but it was not excluded from studying clinical organisation. Many of those interviewed at all levels felt that this was the area of the service that offered most scope for achieving greater efficiency. The independence and expertise of MAS gave it an advantage in this field. MAS would also need to extend its activities outside the NHS if it was to adequately consider such topics as planning.

Supervisory Board

4.36 This initial evaluation also included the role of the Supervisory Board. The role was defined as:

appointing the team Director and helping him to appoint staff;

helping the Director construct the MAS programme. The Board was seen to have a clear role in approving subjects for study and initially had made most of the running in suggesting suitable topics for study. Through their knowledge of the NHS, members were well placed to advise the Director of pitfalls;

helping, if necessary, MAS to gain access. Here members with senior NHS roles carried considerable weight;

commenting on reports. Here there were two views of the Board's role. One view was that it was no part of their role to censor, screen or sanction results. Rather, their advice was on presentation, distribution and format: matters which might be crucial in determining NHS reactions. The other view was that the Board should have an eye to the substance of MAS recommendations and, given its members' expertise and knowledge of policy and political considerations, was well equipped for this. Members received draft reports of completed studies and oral or written reports from the Director on those in progress. Whichever of the two above views of the role were taken, responses reflected members' individual perspectives and it was largely up to the Director to aggregate the collective will.

4.37 A further uncertainty concerned the degree to which the Board members could act as representatives. RTO views were well provided for through the membership of two officers plus the attendance of the administrators. The two regional chairmen were in a position to present the views of their respective authorities. It was impossible, however, for the Board to reflect a collective district viewpoint. The two district chairmen lacked the means to link with a constituency of district members, let alone district officers. This, then, carried a second implication in that the Board appeared to be weighted towards regional rather than district interests. As the experiment proceeded it was likely that the MAS Director, through his own network of contacts, might be better placed than the Board to express district views of MAS work. Whether or not Board members were representatives, it was agreed that the NHS members could not divorce their role on the Board from their role as senior members of the NHS. Indeed, the latter was seen as a strength. The Board members remained aware that they would have to deal with MAS recommendations in their NHS capacity.

4.38 To summarise, although the role of the Board was not felt to be fully defined and would evolve with experience, it was seen as primarily supportive to the MAS. The team and particularly the Director were given freedom to create their own working methods. Members of the Board believed that the employment of high calibre individuals carried the corollary that they would have their own ideas as to how they wished to work.

STAGE TWO - PERCEPTIONS OF THE FIRST FOUR STUDIES UNDERTAKEN BY MAS

4.39 The purpose of this evaluation was to examine how the service responded to the initial, and therefore unfamiliar, work of MAS and the nature of the relationship that began to develop. The studies involved were:

Management of Inpatient Waiting Lists.
Utilisation of Resources Allocated to Trauma and Orthopaedic Services.
Allocation of Units of Medical Time.
The Process and Arrangements for Preparing Planning Briefs for Capital Schemes.

These reports entailed different methodologies and intentions. However, the Brunel research deliberately focussed upon the overall impression of the service regarding the value of MAS rather than specific reactions to individual reports.

4.40 Management of Inpatient Waiting Lists was an example of a Category II study. It reviewed and compared district inpatient lists for general surgery, ENT, plastic surgery and gynaecology across the two regions against standards set by the DHSS. The study drew on data that were routinely available and concluded that regional policies on waiting lists should be formulated and monitored and that all authorities needed to formulate and monitor their own standards along the lines suggested in the report.

4.41 Utilisation of Resources Allocated to Trauma and Orthopaedic Services was an example of a Category I study. Using routinely available data, it reviewed and compared district performance across the two regions in terms of a number of resource and activity measures. It also indicated some of the factors influencing activity and provided financial comparisons between the districts. The study highlighted wide variation in both resources and levels of activity and the absence of guiding policies and standards of performance. It urged authorities to establish the latter and

suggested that some districts should examine the way in which their services were currently being utilised.

4.42 Allocation of Units of Medical Time was also an example of a Category I study. It required the districts to provide information as a special exercise and compared their allocation of UMTs against the standards derived from the criteria laid down for allocation. The study was seen as particularly appropriate as the DHSS was in the process of introducing new procedures for allocating UMTs. The results indicated, as had been expected, that there was variation in the allocation of UMTs between staff undertaking similar commitments. Further, excess UMTs were being allocated with the associated financial consequences. MAS recommended that all junior medical staff contracts be reviewed.

4.43 Process and Arrangements for Preparing Planning Briefs for Capital Schemes was an example of a Category III study, developing a framework or model which managers could then apply for themselves. This study, which required specific information from the two regions, was felt to be timely in view of the re-examination of capital planning procedures initiated by the DHSS. In their report, MAS made a number of suggestions for clarifying the information required, for preparing planning briefs and urged a closer relationship between regions and districts.

4.44 The topics were all suggested to the Supervisory Board by the two Regional Teams of Officers. They also shared the characteristics of being considered capable of study from the MAS headquarters with a minimum of staffing resources, MAS at the time consisting of the Director and a secretary, and of completion within a short period of time.

4.45 The information in this evaluation is based upon consideration of the content of the four reports and separate semi-structured interviews held during late 1982 and early 1983 with:

the Director of MAS (two interviews);
the Regional Medical Officer, SW Region;
the Regional Administrator, SW Region;
the Forward Services Planning Officer, SW Region;
a District Administrator, Associate District Administrator and District Medical Officer from a District in the SW Region;
a District Administrator and a District Medical Officer from a second District in the SW Region;
a District Administrator from a third District in the SW Region;
an Assistant District Administrator from the same third District;
the Regional Medical Officer, Oxford Region;
the Regional Planning Officer, Oxford Region;
a District Administrator and District Medical Officer from a District in the Oxford Region;
a District Nursing Officer from the same District;
a District Administrator and District Treasurer from a second District in the Oxford Region.

District reactions to the first four studies were also gained from observation of a seminar for District Liaison Officers in the SW Region, held at Taunton in summer 1983. Reactions of members of the Supervisory Board were gained from observation of their meetings.

Distribution of the Reports

4.46 The reports were circulated to the regions and to the districts who were asked by MAS how many copies they required. Different authorities adopted different procedures:

(a) in the regions the reports went to the RTO and other relevant officers; for example, regional planning officers received the report on Capital Planning. In the Oxford Region the RTO designated a nominated officer to study each report and advise on further action. This could include circulating the reports to the district, further consideration within the region or circulation to professional bodies. The SW Region was in the process of deciding how best to deal with the reports, although they had agreed that they could all be circulated direct to the districts;

(b) at district, the reports went to the DMT and in two cases to the authority chairmen. One district noted that the number of reports distributed was insufficient. The processing of MAS reports was seen to fall on the District Administrator, although two districts in the SW Region had nominated second-in-line officers to co-ordinate their circulation and to advise the DMT as to further action. In the Oxford Region the DMTs determined the appropriate distribution, sending reports to those likely to be interested;

(c) at both regional and district levels it was realised that procedures would have to be devised to process MAS reports and this led to some apprehension that the necessary support was not available, the service being in the throes of reorganisation, and that it would inevitably result in extra work for senior management. Even where second line liaison officers were designated to handle MAS business, decisions on action would still rest with senior management teams.

Value of Reports

4.47 Here there appeared to be some polarisation of view by region:

(a) the general Oxford view was that the reports failed to provide fresh insights; they were too long and some were based upon inadequate data. Both districts in the Region felt that some of the reports were misleading because their use of data was superficial. They were largely based upon routinely available information which failed to take local circumstances into account and thus gave an inaccurate impression. Further, the need to collate special data for two of the studies had given the districts additional work. Certainly the reports were useful in indicating trends and providing 'pointers' for consideration but the NHS could do this kind of

monitoring itself, the work did not require an independent body. MAS would be more useful if it brought research together to develop models of good practice, models that had practical application in that they were focussed on district problems. The NHS lacked the time and breadth of vision to formulate such models itself;

(b) the SW view was more positive. The reports were not particularly innovative, some of the districts had already done this kind of study for themselves,, but they provided reminders of problems and would prove useful enabling documents to management. They were the first step in producing change. They also gave districts a wider perspective. It was suggested that the reports could not be ignored, but the reaction depended upon the district's position in 'the league'. If the district was identified as an outlier, the report would receive greater attention;

(c) the SW liaison officers, with the benefit of some hindsight, felt that these studies had proved a means of getting districts to consider the possibility of change and had given them information to use. However, the data were open to a variety of interpretations and perhaps the topics were too general to be of much help to the districts. There was a danger of making too much of district comparisons in that those districts in the middle positions could well be those with the most serious management problems;

(d) the MAS Director agreed that the data could be criticised as superficial although new data had only been collected for two of the reports, but felt that the information could still help districts to consider change. The provision of comparative information related to objectives across the two regions represented an innovation which was not currently being undertaken by authorities and which did not seek to emphasise one district's position vis a vis another. It

was the willingness to consider change that was important, not the data. The ciruclation of the studies highlighted the issue of whether MAS had a role in promoting change once it had provided information and recommendations.

4.48 The observations of the Director to the Supervisory Board in October 1982 took up each study in turn.

The Management of Inpatient Waiting Lists had been flawed by poor data. The study did not merit a major effort on implementation but it did demonstrate the need for the regions to formulate policies.

The Utilisation of Resources Allocated to Trauma and Orthopaedic Services also suffered from constraints of data. The study identified districts that would merit a local examination. It was hoped that they would seek assistance from MAS in this respect.

The Allocation of Units of Medical Time had required a special survey. MAS only received a 50% response in the stated time. The study provided districts with information that could aid management processes and was timely in that it coincided with a DHSS review of the subject.

The Process and Arrangements for Preparing Planning Briefs for Capital Schemes had required a survey and documentary review. It had concentrated on a particular aspect of the capital planning process and the initiative for implementing the recommendations in the report lay with the regions. MAS could help by providing a seminar to explain their recommendations.

4.49 In general, the Director stressed that MAS was not seeking to be directional. It would assist in implementation where this was wanted by authorities. It was up to the regions to take the lead in implementation through such means as District Reviews.

Promotion of Change

4.50 The various viewpoints were as follows:

(a) the Oxford regional view was that the studies provided the Region with a management tool and strengthened its monitoring ability. The Region needed to follow up MAS findings within both its own organisation and the districts. The form of the follow up would be governed by the subject and the findings; in some cases managerial action would be appropriate, in others reference to the professional networks. If the Region was to use MAS in this way it followed that the subjects for future study had to be chosen with care so that they met regional needs;

(b) the SW regional view also saw MAS as contributing to the Region's monitoring function, but felt that the regional reaction should be one of interest and encouragement rather than imposition;

(c) the district view of the ability of the studies to promote change was that it proved difficult to pin-point precisely the causes of change. The MAS studies might contribute, but along with other local factors. There was still some feeling that MAS was the creature of government - national and regional - and that the districts were the subject of study. It was unclear, then, how the regions would treat MAS findings but they were likely to follow them up. The districts, however, might wish to use the studies as a lever on the regions for more resources. Not surprisingly, the greatest potential for MAS in promoting change was felt to come from studying specific district problems. It was also suggested that MAS might have most influence in new districts where relationships and management procedures were uncertain. However, the job of managing the service rested with the districts, not MAS. The recommendations were not edicts;

(d) the liaison officers, viewing the studies at a later date, felt that MAS could only hope to promote change if its work helped the districts to plan and monitor their activities. To this end it would have been helpful if these first studies had been more practical and less abstract. Again the argument was reiterated that studies focussing on specific district concerns are most likely to produce change;

(e) regional and district views alike stressed that it was a bad time to be setting up as a change agent. The service was still coping with reorganisation and had a plethora of monitoring institutions. In this climate change took time. Regions and districts had different priorities and different time scales from MAS which had to make its mark quickly;

(f) the Director felt that experience with these first studies was as expected. It underlined the need for the authorities to take up MAS recommendations, and the need for MAS itself to be involved in promoting their recommendations after they had been published. Regions and districts had to develop processes for handling MAS reports. It was apparent that MAS was not yet well known in the districts and was seen as one monitoring device among many. The service was not sufficiently aware of MAS objectives and the range of help that it could offer. However, comments received from the service suggested that the studies had been found helpful and there was a role for independent advice. They had emphasised the need for the regions to develop policy guidelines for the various services.

STAGE THREE - EVALUATION OF SELECTED STUDIES

4.51 Four studies were chosen for evaluation. These were selected by:

category of study;
location within the two regions;
level of authority within the NHS.

(A) District Strategic Planning (Paragraphs 4.52 to 4.64).

(B) Regional Strategic Planning (Paragraphs 4.65 to 4.77).

(C) Five Day Wards (Paragraphs 4.78 to 4.85).

(D) Review of Selected Services for the Elderly (Paragraphs 4.86 to 4.102).

(A) DISTRICT STRATEGIC PLANNING

4.52 This study was undertaken by MAS in a district in the SW Region from November 1982 to May 1983. It represents a Category IV type study, concerned with developing and testing a new process for district strategic planning. The subject thus satisfied one of the specific objectives of MAS - to contribute to the development of planning within the NHS. The MAS approach to planning was based upon the assumptions that:

as wide sources of advice as possible should be made available to the planners;

wide participation is desirable since it engenders consensus and commitment to plans;

it is productive to identify and concentrate attention upon 'key issues' facing the district.

The study occupied a considerable proportion of MAS resources. At different times all the team members were involved and the Director and Management Associate (Administration) were particularly heavily involved with the study.

4.53 The period of the study fell into two phases. Phase 1 was a four weeks preparatory stage, where MAS gathered together the necessary information to provide a district profile and determined those issues that warranted further study. The second phase, which was supposed to extend for six weeks, involved consideration of the issues by multidisciplinary district teams. The whole cycle would conclude with a planning workshop where the key issues would be presented for discussion and debate to an audience drawn from different health disciplines and including Authority members, officers from the neighbouring districts, regional officers, local authority officers and members and the Secretary of the CHC.

4.54 The study was to be directed by a Steering Group of senior officers and clinicians. Administration of the process would be undertaken by a Support Group drawn from MAS and the district.

4.55 This evaluation of the district planning study involved the following:

Separate interviews at the beginning of the study in the autumn of 1982 with:

the Director of MAS;
the District Administrator;
the Assistant District Administrator.* **

Interviews as the study proceeded with:-

the Director of MAS.

Separate interviews at the conclusion of the study in spring 1983 with:

the Director of MAS;
the District Administrator and District Treasurer;
the Assistant District Administrator;* **
the Secretary of the Community Health Council;*
a specialist in community medicine.* **

The final planning workshop in May 1983 was also observed.

Stimulus

4.56 Respondents identified four motives for the study:

(a) collaboration with the district made logistical sense for MAS, since its offices were based in the same district and initially shared the same premises;

(b) the district was near the regional average in terms of population and budget. Any model developed there would therefore be likely to have wider application elsewhere;

(c) the district was perceived to need help with its planning. It had been newly created in 1982 and

---

* Membership of the Support Group.

** Membership of the Steering Group.

had not inherited a strong planning capability;

(d) MAS wished to develop and test a model for district strategic planning.

Initial Doubts

4.57 There were few, but from the service included fears of the additional work that might be involved, particularly since the district had not completed recruiting the administrative staff for its new management structure. It seemed likely, then, that the MAS would have to provide most of the information groundwork for Phase I. Although the MAS protocol for the study had been accepted there was some doubt in the district as to the value of the final multidisciplinary forum. This would be an expensive event and it was felt that it might prove counter-productive in terms of engendering participation and commitment to planning.

Collaboration

4.58 This was felt to work well by both the service and MAS. Indeed, members of the former drew attention to the value gained from having access to independent advice and advice as competent and experienced as that provided by MAS. However, aspects of the methodology were criticised. The timetable had been perceived as too tight and ten weeks were subsequently extended to 20. It had proved difficult for the district to provide the necessary resources and it was felt that:

the DMT;
the DHA;
and senior clinicians

had failed to participate at the level hoped. The DMT for example, had declined to act as the Steering Group for the study. This was thought to have implications for the fate of any proposals that emerged, since the support of senior managers, senior professionals and authority members was seen as vital. Another criticism was that the exercise produced costs in terms of fractured personal relationships; costs that would have to be carried by the district when MAS had departed. Some individuals felt threatened by the presence of MAS and not all were comfortable with participative working. On the

the credit side, however, the presence of MAS was seen as helping newly appointed staff to clarify their relationships and responsibilities in the planning process. Some thought that initial fears regarding additional work had proved all too prophetic, although others argued that this degree of effort would have been involved in any strategic planning exercise and that the district was fortunate in having MAS to do much of the basic fact finding.

4.59 From the MAS standpoint the study imposed heavy demands. The team had had to gather most of the information that went into the District Profile. Their programme had to be amended to take account of a longer time scale and of the decision not to cascade the multidisciplinary teams or involve them in a delphic survey. Collaboration was generally felt to be good although it was accepted that the study imposed a heavy burden of work on district staff. This was partly unavoidable given the weak planning facility. The method may also have carried a cost in fractured personal relationships and some district staff undoubtedly felt threatened. Nonetheless the process of participation succeeded in drawing in the views of the local authority, the Region and the CHC. DMT participation was not as great as MAS had hoped for and that by the Authority was almost non-existent.

Results

4.60 The service view was that the exercise had provided the district with a planning method. However, the contents of the final plan had still to be determined by the DMT and authority. A positive view was that the approach had gained wide commitment. It had demonstrated that planning could both be undertaken as a rational activity and be open; drawing in fresh thinking and wider viewpoints to allow a fuller realisation and examination of health needs.

4.61 The planning workshop provided a microcosm for these intentions. It would bring together Authority members, staff from different disciplines, including senior clinicians, local authority officers, staff from Region and neighbouring districts and members of the CHC. The event was to be structured around the discussion

of five key strategic issues for the districts:

self sufficiency;
the pattern of hospital provision;
care of the elderly;
promotion of health;
management and professional advice.

It was hoped that the day would demonstrate a degree of agreement for various strategic options and secure commitment to this consensus. Some staff doubted, however, whether there was much room for participation at this stage of the process and feared that it might raise false hopes. Would Authority members feel that it was pre-empting their role? Would the expense, considerable since it necessitated half a day's removal from normal duties for some 110 staff plus the cost of hiring accommodation, be justified? On the day, both the Authority Chairman and District Administrator stressed that it was the role of the Authority and DMT to determine the final plan. The workshop certainly brought out different viewpoints but it was felt to be more in the nature of an educative or even a public relations event than productive of consensus.

4.62 MAS accepted many of these qualifications. There were questions regarding the commitment felt by the DMT and the Authority to the consensus that had emerged from the process, since both had remained distanced. Like all organisational processes, the approach developed by MAS needed committed supporters within the system. However, it was noted that by July 1983 the Authority had felt sufficiently committed to agree the production of a booklet - The Ten Year Plan - giving an account of the planning workshop for wider circulation.

4:63 NHS staff also expressed doubts regarding the wider application of the model. Most districts would not have the resource for gathering and analysing information that, in this case, was provided by MAS. Without this resource what would be the incentive for districts to adopt the model? Much would depend upon

the approach to strategic planning adopted by regions and the DHSS. It was also likely that, unlike this district, others would have their own well developed planning processes and would therefore be less eager to experiment with new approaches.

4.64 Again MAS accepted many of these qualifications. Their model might well be less viable if districts had their own established procedures. The team intended to develop and test their approach through a study at regional level and in other district settings. However, it was felt that the exercise had shown that planning does benefit from drawing information from well beyond the NHS and that such information can be obtained and shown to be relevant to NHS needs. More significantly, it was held to have demonstrated that an open approach to planning is possible in the health service. By July 1983 MAS had written up the study in a report - Random Reflections of a Strategic Planning Process - which was intended to publicise the approach to other districts. The Supervisory Board appeared unsure whether the report had any wider value beyond describing one district's planning experience but stressed their belief in the importance and value of planning in the NHS.

(B) REGIONAL STRATEGIC PLAN

4.65 This study was undertaken by MAS with one of the two regions from April to February 1984. It also represents a Category IV type of study, concerned with developing and testing the framework for planning that had been applied in the district study reported above. It was based upon the same assumptions, namely that:

as wide sources of advice as possible should be made available to the planners;

wide participation, in this case with the districts and the field, is desirable in engendering consensus and commitment to plans;

it is productive to identify and concentrate attention upon 'key issues' facing the region.

4.66 Like the district study this study also made heavy demands upon MAS resources. However, the region possessed its own service planning facility and it was not envisaged that MAS would need to be much involved in seeking and preparing information. Indeed, in agreeing the study, the RTO had stressed that it was impossible to start with a clean sheet and apply the MAS model in its entirety. Particularly in the initial stages of the planning process the standard regional procedures would be followed, although advantage would be taken of the MAS presence in getting it to review these procedures. As in the district study, the members of MAS most heavily involved were the Director and Management Associate (Administration).

4.67 The study was planned in a number of stages. The Initial Stage, which lasted until early August, was to comprise the production and issue to the districts of an Outline Strategy, the role of MAS being a source of advice and process review. Concurrently with this, in Stage One, MAS would be agreeing the procedures and processes for the new approach with the RTO. In Stage Two, which was to take place in August, a Regional Profile would be prepared, followed in Stage Three by the identification of major strategic issues. Finally in Stage Four, which was scheduled for September and October, these issues would be debated by working groups drawn from region and district staff.

4.68 Although the framework was similar to that applied in the district study, there were differences. These reflected the need to follow regional processes mentioned above, the fact that the region had its own planners and that MAS could not provide as heavy a commitment because of other demands upon its time and, lastly, a feeling that some elements in the district approach, such as the planning workshop, could not readily be translated to the region.

4.69 The Steering Group for the study was to comprise the RTO, together with some members of the Services Planning Group. Great stress was laid on the involvement of the RTO, which was seen as a reflection of the centrality of the planning task to regional work. Detailed support and administration of the process would be provided by a Core Group drawn from the Regional Services Planning

Group. The Core Group needed to remain small and cohesive. It was considered that its membership should reflect expertise in financial resources, manpower resources, service planning and estate management but it would have the authority to draw in staff from other areas. MAS would participate in meetings of the Steering Group and assist the Core Group.

4.70 Because of time and resource constraints the evaluation of the Regional Planning Study could only include the Initial Stage, when the Region was preparing the Outline Strategy, which was not the main focus of MAS involvement. The Outline Strategy was to comprise policy proposals grouped under subject headings by client groups, for example, children, or services, for example trauma and orthopaedics. The evaluation included the following:

Separate interviews at the beginning of the study in spring 1982 with:

the Director of MAS;
the Management Associate (Administration) of MAS;
the Regional Administrator;**
the Senior Assistant Treasurer;*
a Specialist in Community Medicine;* **
the Regional Medical Officer;**
the Regional ForwardServices Planning Officer; * **
the Assistant Regional Forward Services Planning Officer. *

Separate interviews at the conclusion of the Initial Stage in summer 1983, with:

the Director of MAS;
the Management Associate (Administration), of MAS;
the Senior Assistant Treasurer;*
a Specialist in Community Medicine;* **
the Regional Medical Officer;**
the Regional Forward Services Planning Officer;* **
the Assistant Regional Forward Services Planning Officer.*

In addition, a number of the policy proposals within the Outline Strategy were consulted.

---

* Membership of the Core Group.

** Membership of the Steering Group.

Stimulus

4.71 There was wide agreement from service respondents that in the past the planning system had been too mechanistic. If plans were to generate commitment and produce change, the way in which they were created had to be more open and participative. MAS was seen as possessing expertise in planning and particularly in developing participative planning. The region could thus learn from MAS. It was also suggested that left to itself, the Region would find it hard to create participative working with the districts because of the authority relationship. As an independent body, MAS would be able to bring region and districts together. Another, more practical, viewpoint was that the Region was the starting point for strategic planning. If MAS wished to influence the planning process it had to make an impact at Region as well as with the districts. MAS had already been working at district level. It was empowered to work with the regions, so it was logical for it to be involved in the current strategic planning exercise. Another view saw MAS involvement as tied to the RTO's, and particularly the Regional Administrator's desire to rethink the role of the RTO. In this context it was significant that the RTO was acting as the Steering Group for the study. Finally, there was the view that MAS offered a source of direct help in collecting and presenting information.

Initial Doubts

4.72 The Region had its own planning staff and there was some feeling that they would see MAS involvement both as a threat to their own competence and as a source of additional work at a particularly busy time. Certainly not all the planning staff agreed that they needed help in developing a participative approach in the field. The region was already working in this way, so MAS would only be duplicating what was already done. There was some doubt as to whether MAS could contribute sufficient resources to the study to be of much practical help. The view was also expressed that the full blown participative approach MAS were seen to be advocating would not be appropriate at Region, which was tied to a tight timetable and would need to be selective in gaining access to the best ideas. Not all felt that the

collaboration meant additional work. It might mean different work but planning would have to be done whether or not MAS were involved. It was recognised that as well as collaborating with the Region in the development of a new approach, MAS would be observing and reviewing regional processes. It was assumed that the basis for its review would be rationality and efficient use of resources, but regional processes would also be tested against MAS's own model of planning. The planners' knowledge that they were being studied added to the sense of threat. For their part, MAS were aware of the need for sensitivity in working with the regional planners. Although the team wished to test and develop their own model, they would be constrained by the Region's own programme and existing procedures. As in the district study, it was suggested that the results of the study might prove abortive if Authority members were not involved.

Collaboration

4.73 The sense of threat was felt to have dissipated as the planning staff became accustomed to MAS. Certainly in this initial stage of the study the presence of MAS was not seen as adding to the costs. The planners would have had to prepare an Outline Strategy whether or not MAS was involved. Indeed, one estimate was that MAS had contributed some 10% of the work through their advice, provision of information and production of some of the proposals within the Outline Strategy. However, one of the respondents who, despite the terms set out in the protocol, had seen MAS as a source of direct help in data collection was disappointed. MAS had made little input to data collection and its chief concern had been with how the planning process was administered. Others also drew attention to this emphasis in the collaboration. It was suggested that the tight timetable had so occupied the planners' attention, as to leave a vacuum in the administration of the process which MAS had filled. From MAS's perspective, the initial phase had proved demanding, involving two senior members of the team for the equivalent of one day each week. However, MAS had found it helpful to work with the planners. Both the team members concerned had a background in planning and found that they and the planners 'spoke the same language'. The structure for the study was felt to have worked well enough,

although the Core Group proved to be too narrowly drawn and needed enlarging to include members with expertise in statistics and information collection.

Results

4.74 MAS was critical of the processes involved in preparing the Outline Strategy. Papers were too long and their distribution on the day meant that there was insufficient time for consideration. The planners had reached the same conclusion, but felt that they had been constrained by the tight timetable. MAS were also critical of the content in the Outline Strategy. Their criticisms were made explicit through their observations on draft policies and in the way in which those policies which they, themselves, drafted were formulated. Basically their criticism was of imprecision. Policy issues were left unclear, were written at too great a length and were too descriptive. The format advocated by MAS consisted of:

- a brief description of the scope of the services;
- policy aims, preferably quantified;
- strategic intentions, indicating priorities, norms and relevant data;
- issues for further consideration.

4.75 At the end of the initial stage, MAS made these points in a critique of the Outline Strategy. This device allowed them to raise points in a way that was impossible as members of a collaborative working group. The preparation of an Outline Strategy had no place within the MAS planning model and observation of, and involvement in, its preparation did not convince the team of its utility. Again, the planners were aware that the Outline Strategy could have benefitted from greater precision but felt constrained by the timetable. It was also argued that since MAS had been involved in formulating the Outline Strategy they could hardly criticise it from a completely objective standpoint.

4.76 Another feature of the study, and one upon which MAS laid great store, was the involvement of the RTO as the Steering Group; an involvement which would draw the RTO into planning activity. At the end of the Initial Stage, MAS felt that there had been a measure of RTO involvement both as a Steering Group and as a result of an RTO member regularly attending meetings of the Core Group, and this had succeeded in bringing the RTO into closer touch with planning activity. An RTO member confirmed this, although he felt that it was impossible for the RTO to be involved with more than key issues.

4.77 In this initial stage of the Strategic Planning Study, MAS had felt that it could contribute to improved planning by promoting clarity. MAS had made such a contribution and the majority of planners believed that its presence had influenced the content and presentation of the Outline Strategy, although one participant said that it would not have been noticeable if MAS had been absent. However, MAS involvement in the Initial Stage was regarded as a precursor to the greater changes it would wish to promote through developing participative planning in later stages. At the end of the Initial Stage, the value of this was still unknown. The collaboration of MAS and the planners had helped mutual familiarisation, gained some acceptance of MAS ideas and approaches and some acclimatisation of MAS into the regional planning environment. Whether participation could occur and whether, if it did, it would lead to better and more strongly supported plans, still remained to be seen. If the MAS approach was successful in the region there was no surety that it would be valid elsewhere. Participants felt that this particular region was distinctive in the degree of freedom that was allowed and encouraged to the districts. Some felt that this must produce a climate favourable for participation that would be absent in regions where the relationship with the districts was more authoritative and prescribed. Others, however, felt that the freedom in the redgional district relationship meant that participation could be harder to promote than elsewhere. Participation could not be commanded and would only arise if it was seen to be of use.

(C) FIVE DAY WARDS

4.78 This study was undertaken by MAS at the request of a district in the Oxford Region. It represented a Category V type study in that it dealt with a specific district problem, although it was envisaged that the topic would be of wider relevance in the two regions. The intention was to investigate the implications of five day/short stay wards, identifying:

patient groups which could be accommodated;
operational difficulties;
manpower implications;
ambulance and community service implications;
financial consequences.

4.79 The method to be employed was agreed with the District Nursing Officer who had sponsored the study, and set out in a protocol. MAS would provide a literature review and document details of established five day/short stay wards. The study would be undertaken by the Management Associate (Finance) since this fitted in with the current MAS workload and financial matters were expected to be a key element in the study. As it primarily concerned the collection of information, the study could be undertaken from the MAS base. It was MAS policy that district studies could be allocated no more than ten days of working time. The initial expectation, therefore, was that the study would be completed during July 1983. However, the demands of other work and holidays meant that it actually extended to September.

4.80 The evaluation comprised the following:

Separate interviews at the beginning of the study in the late spring 1983 and at its conclusion in late summer 1983 with:

the Management Associate (Finance) of MAS;
the District Nursing officer of the District concerned;
the District Nurse Planner.who participated in the initial interview together with the DNO.

Consideration of the report, 5 Day/Short Stay Wards: A Literature Review - Discussion Paper, produced by MAS for the District.

Stimulus

4.81 The DMT wished to know if five day wards were a good idea. A form of five day ward had been attempted in the District but was not thought to have worked very well. The idea was also seen as having important implications for nurse recruitment. The district could have undertaken this work themselves but they lacked the time and resources for research. They could perhaps have approached the Region, but Region was seen as a source of authority and accountability rather than offering a consultancy service on district problems. MAS was external to the service, not involved in its authority relationships, and it offered a research facility. Five day wards, however, was only one of a number of topics put forward to MAS by the district, but it was one that had considerable implications for efficiency. If the report led the district to proceed, they might well wish to involve MAS in collaboration on the introduction of five day wards. It was also possible that the work would provide a model of good practice that had wider application in the service.

4.82 From the MAS standpoint, although the study was helping a district with a management problem, it was also relevant to the teams' objectives of encouraging efficient use of resources and improving the planning process. The method agreed was capable of being performed with limited resources and was considered appropriate to the topic. It would not, for example, have been practical for MAS to undertake a survey of existing practice since the information was not routinely available and the team lacked the time for a special data collection exercise. However, it was hoped that the study would, in addition to meeting the district's specific needs, provide a compendium of useful information and perhaps suggest a model of good practice.

Collaboration

4.83 This was felt to have gone well by both MAS and the district, although it involved little direct contact. The MAS report collated the national policy statements that had been made on five day wards, indicating some of their advantages and disadvantages. It also

provided a literature review under the following headings:

operational policy;
patient groups and types of admission;
size of wards;
workload;
staffing;
supporting services and facilities;
financial consequences;
the success of 5 Day/Short Stay wards.

This review indicated the reasons for establishing five day wards and key areas in their management. The report was discussed over a day with the DNO and her senior nurses. As a result of the discussion, it was revised to focus upon the specific district situation. The intention to include material on the operation of established five day wards had been abandoned, so the report was essentially a library study. MAS was able to complete the study within their ten day limit although, as mentioned above, the overall completion period had extended from one month to two and a half. The cost for the district had been small; a little of the DNO's time in initially formulating the study, and her time and that of her senior nurses, in discussing the draft report. However, perhaps because direct contact was so limited, the DNO felt that the collaboration had brought home that MAS was based a long way away. If MAS was ever to undertake work with district staff or services it would require a local base.

Results

4.84 The DNO did not feel that the report told the district anything that they did not know but it had objectively brought the relevant information together. The district lacked the resources to undertakensuch an exercise itself. The report provided a tool that enabled further thought to be given to the idea of five day wards. The next stage was to distribute it to the DMT and the clinicians. In this context it helped that the report was clearly presented and easy to read. The study had become

relevant in view of its implications for making economies although it had not been undertaken with this in mind. There was a possibility, then, that the district would implement five day wards, although this was most likely in respect of particular activities rather than as a comprehensive policy and would not necssarily be a 'first priority'. At least the existence of the study meant that the idea could be properly considered in the district. If they did decide to go forward it would be useful to involve MAS in the implementation process providing that this was not likely to create too much additional work for the district. Since the report succeeded in bringing out the pros and cons and the impliications of five day wards, it was relevant to other districts in the NHS.

4.85 From the MAS perspective, the report was also seen as an enabling device. It would help the district to proceed further if it wished. The analysis showed how five day wards could be used to promote two objectives - cost saving or expansion of services. It was the former that was felt to be relevant for the district. If the district did decide to go further in implementing five day wards, MAS would consider working with it if asked. However, MAS would not have the resources available for such an exercise until the new year. It was felt that the report could be useful to other districts and it would be presented to the Supervisory Board for publication. This was duly done in October 1983 when it was agreed that the published report be circulated to the district and made available to the other districts in the two regions on request.

(D) REVIEW OF SELECTED SERVICES FOR THE ELDERLY

4.86 This study was undertaken by MAS between December 1982 and May 1983 using data for all the districts within the two Regions. It represents a Category II type study, concerned with helping districts to review their services against policy intentions. The study thus satisfied a number of MAS objectives in that it:

provided a basis for districts to monitor their own performance;

contributed to the development of planning by encouraging authorities to debate the practicality and reality of existing policy and to reformulate policies in such a way as to make their achievement measureable;

dealt with a service involving a considerable and growing proportion of total NHS resources and hence with a significant management issue.

4.87 Soon after the establishment of MAS, the task of developing 'performance indicators' had been identified. Experience in undertaking its first four studies had led MAS to conclude that rather than focussing on efficiency concepts per se it was important that policy intentions were clearly articulated by regional and district authorities in order that standards for monitoring performance could be established. It was also seen that policy fulfilment took MAS a step nearer to a concern with service outcomes than the more usual concentration on process and resources.

4.88 The work on the Report was primarily a 'desk' activity within MAS, and was the particular responsibility of the Management Associate (Administration). The first stage was to identify existing explicit policy statements from the DHSS, and from the two regions. Some of these had to be disregarded as 'unmeasurable' and the study focussed on those policy aims that were expressed in terms of, or could be directly related to, resource levels or patterns of activity. MAS used NHS data aggregated to district level which were routinely available at region (for example, from SH3s), supplemented by some data on relevant local authority personal social services obtained from the DHSS in London. This chosen approach of relying on existing data rather than mounting special data collection exercises, was seen as most relevant to a 'first level surveillance approach' for DMTs and authorities.

4.89 The Report was issued in July 1983 only a couple of weeks after the planned date.

4.90 The evaluation of the MAS exercise comprised the following:

an interview with the Management Associate (Administration) of MAS at the final stages of the preparation of the report;

consideration of the content of the report;

separate semi-structured interviews, in autumn and winter 1983/84, with:

the Regional Medical Officer, SW Region;
the Regional Planning Officer, Oxford Region;
a Services Planning and Information Officer from a district in the SW Region;
a Specialist in Community Medicine from the same district;
a District Medical Officer from a second district in the SW Region;
an Assistant District Administrator from the same district;
a District Medical Officer from a district in the Oxford Region.

The Origins and Nature of the Report

4.91 The report was an internal product of MAS. Neither the subject matter nor the approach adopted to it appeared to have stemmed from specific district or regional requests. The preparation of the report did not involve the districts in supplying material, and, despite the listing of studies in progress made in MAS Bulletins, those not closely associated with MAS became aware of it only when it was distributed to districts in its completed form in July 1983.

4.92 Using routine data the report attempted to monitor policy statements against levels and patterns of district provision and activity, and for the most part presented the information graphically comparing districts with each other and with the two regional averages. Additionally, it explored further the associations and interdependencies between aspects of provision by plotting districts' positions on scattergrams and comparing

actual patterns of provision with those that might be expected according to stated policy aims. The approach of starting from the basis of policy statements (whilst common to at least two other MAS studies on Services for Children and Services Based in the Community) was the unusual element in respect of earlier MAS studies and traditional NHS methods of monitoring efficiency. Nevertheless, in relying on existing data, it still looked at levels and patterns of resources and activity rather than outcomes.

The Reactions to the Study

4.93 The common reaction was that the study presented no new information. The data for a particular district were normally said to be well known to the officers, and the inter-district comparisons easily available at region.

4.94 Nevertheless, the presentation of the data and the comparison of data from the two regions were seen as convenient and easily accessible. The consideration of inter-relationships also relied on familar data, but placed it in a less familiar perspective.

4.95 It was put very forcefully by at least one respondent that the analysis was still in terms of resources and, as far as ever from the vital planning information on outputs or outcomes.

4.96 There was a disappointment with the relative simplicity of the idea, using routine data. Paradoxically, this simplicity, one of the study's merits from the point of view of continued use by districts in monitoring their own services, fostered an impression that the approach offered an insight of limited value. This reaction implied an expectation that MAS would be able to do, and should do, things that were technically beyond the scope of those actually managing the services, rather than lead the way for managers by indicating what could relatively easily be done with existing data.

4.97 It was evident that there were reservations about the detailed accuracv of some of the figures relating to specific districts - details that, it was suggested, might easily have been sorted out if MAS had discussed the figures and their proposed use of them, more widely prior to publication. More important, perhaps, there were reservations about the interpretation of the statistics. Rather than seeing the information as a way of judging whether policies had been achieved, the common reference was to 'league tables' that meant little unless a district happened to be at the top or bottom. Indeed, there was uncertainty whether the assumed desirability in the scatter diagrams of certain relativities of provision was necessarily appropriate; a point made explicit in the report.

Consideration of Policies and Strategies

4.98 It was clear that most of the initial effort had focussed on explaining the figures rather than developing an informed debate about policies, which MAS had seen as one of the aims of the study. On the one hand, although the policies were regional and national, they appeared not to be challenged by districts; on the other hand, the resultant perspective appeared to be rather remote from that of the districts. The report (and perhaps the policies) did not seem immediately to tally with the districts' perceptions of the important issues. As a result, the report seems to have been regarded as rather tangential to current district concerns. This may have been a question of timing. The districts were generally just beginning to organise their strategic review of services prior to formulating District Strategic Plans. It was expected, but this would need to be verified, that the report would prove most useful in this context. At regional level the report appeared to already have been considered in the context of the preparation of regional strategies.

Follow Up

4.99 One district had followed up the report by discussion with its main author, and were looking to him for assistance in planning changes to the service. In this instance, the Report appeared to have reinforced existing perceptions and provided additional momentum to internal developments. The report also stimulated a second district to seek MAS assistance in examining their services for the elderly. Elsewhere at district and region it was less easy to identify any follow-

up action, although the paper had been fed into the relevant system, for example, Health Care Planning Teams and Regional Specialist Sub-Committees. One suggestion was that MAS should (perhaps in each report) propose a plan of action, which then should be agreed, pursued and monitored.

4.100 This echoed a more general observation of the lack of strong support for action on the report from RTOs and DMTs. This, in turn, was a result of (or possibly resulted in) a lack of member interest, involvement, or expectation.

4.101 Generally officers welcomed the report as additional ammunition from a quasi independent source when the implications seemed to tally with their existing views. There was less obvious evidence of it actually changing perceptions.

Collaboration

4.102 An almost unanimous view amongst those interviewed was that a more collaborative style of working would have been preferred, both in preparing the study and in identifying appropriate local responses and follow up. It should, however, be stressed that this did not seem necessarily to tally with DMT reactions. In one case at least, a proposal for such collaborative follow up had apparently been discouraged at DMT level. The views expressed by officers at region and district level all stated a conviction that MAS was a valuable resource, but that they would have preferred its efforts to be focussed in rather different and in most cases, locally specific directions. The report itself provided background information, on the usefulness of which views differed. It did not provide an immediate basis for improving services or developing a local strategy, as some would have liked. It offered a possible tool to assist managers (or planners) rather than proposing solutions to specific managerial (or planning) problems.

STAGE FOUR - LATER PERCEPTIONS OF THE ROLE OF MAS

4.103 This evaluation was undertaken in the autumn of 1983 and winter of 1984 to examine the impact MAS had achieved over a year and a half of work and the extent to which its objectives were perceived as being satisfied and relevant by the service. The opinions of MAS progress held by members of the Supervisory Board were also examined. For the purposes of this evaluation, the various perceptions of district, regional and Supervisory Board respondents are generally distinguished separately.

4.104 At district level semi-structured interviews were held with staff in six districts; three taken from each region. The districts were deliberately selected to include only those that had not been involved in the previous evaluative studies. Although the research team made initial contact with the district administrator in each case, it was indicated that they would appreciate meeting staff from a range of disciplines. It was left to each district to decide whether to arrange for separate or group interviews of the respondents. In the event, as can be seen from the list below, the researchers succeeded in interviewing a wide cross-section of staff. Separate interviews were held with:

a District Administrator, District Nursing Officer and Assistant District Administrator from a district in the Oxford Region;

a District Administrator, District Nursing Officer and District Treasurer from a second district in the Oxford Region;

a District Planning Officer from the same district;
a District Planning Nursing Officer from the same district;
a Unit Administrator from the same district;
an Administrator, Medical Services, from the same district;
a District Administrator, District Medical Officer, District Nursing Officer and District Treasurer from a third district in the Oxford Region;

a District Administrator, District Medical Officer and Deputy District Administrator (MAS Liaison Officer) from a district in the SW Region;

a District Administrator from a second district in the SW Region;
an orthopaedic surgeon (UMT Member) from the same district;
a plastic surgeon from the same district;
a District Administrator from a third district in the SW Region;
a District Medical Officer from the same district;
a consultant surgeon from the same district.

4.105 At regional level semi-structured interviews were held with a number of authority members and officers who, by virtue of their respective roles, were likely to have had a significant connection with MAS and therefore able to form some impression of its work and contribution to the service. Separate interviews were held with:

the Regional Chairman, Oxford Region;
the Regional Administrator, Oxford Region;
the Assistant Regional Administrator, Oxford Region;
the Regional Medical Officer, Oxford Region;
the Regional Planning Officer, Oxford Region;
the Regional Treasurer, Oxford Region;
the Regional Chairman, SW Region;
the Regional Administrator, SW Region;
the Regional Forward Services Planning Officer, SW Region;
the Regional Medical Officer, SW Region;
the Regional Treasurer, SW Region.

4.106 Semi-structured interviews were held with all of the current members of the MAS Supervisory Board. Questions on this particular aspect of the evaluation had been taken with the two Regional Chairmen, the two RTO representatives and the two Regional Administrators when gaining regional perceptions of MAS. Interviews were also held with the two District Authority Chairmen, one from each region, who represented the districts on the Board, and with the independent member.

4.107 Points arising from two interviews with the Director of MAS were fed into the evaluation where relevant.

Contacts with MAS

4.108 At district level, as might be expected, it was the senior officers who appeared to have the greatest knowledge of MAS, particularly the administrators who had provided the main point of contact. Every district but one reported that the MAS Director had met with members of the DMT and MAS had also been mentioned in regional inter-disciplinary meetings. Below the chief officer level knowledge appeared more haphazard. Staff would know something of MAS if they were involved in a MAS study, if the work of MAS had been drawn to their attention by seniors, if they had been circulated with MAS reports or if they had heard about the experiment through their own professional networks.

Otherwise, the level of knowledge was low. This was partly attributed to a failure in the service. Senior staff had been so preoccupied with reorganisation that they had been unable to give MAS the attention it deserved; 'the service from MAS had been better than the health service, itself, could cope with'. However, there was also some feeling that MAS had failed to sell itself sufficiently; it was felt that most clinicians would be unaware of its existence or aims.

4.109 The major source of knowledge derived from the reports and bulletins which the districts received. These came to the District Administrator and in every case were distributed to members of the DMT. In four districts copies were also sent to the Authority Chairman and a fifth district distributed the shorter digests of reports to all members of the Authority. Two districts had distributed some reports to all members of the Authority but other respondents were adamant that this was inappropriate; the material was too detailed for this purpose. Further consideration and circulation of the reports was determined by the DMT or District Administrator or, in one case, by the nominated liaison officer. Such consideration was governed by the nature of the reports and perceptions of their relevance to the district. In the majority of cases the reports were circulated for information and it was left to the recipients to respond to the DMT if they felt so moved. One district publicised the reports in its regular 'despatch box' which drew their existence to the attention of a wide range of senior staff. The mention of their existence in reports to the Authority was seen as performing a similar function. In two districts respondents mentioned that now reorganisation was complete they would be able to formulate procedures for dealing with MAS reports; a move stimulated, in one officer's view, by the inclusion of MAS reports as an item in District Reviews.

4.110 At regional level all those interviewed were familiar with MAS and its work. In both regions members of the RTO routinely received all reports. Indeed, some RTO members, as well as the two chairmen, were familiar with the work by virtue of their membership of the Supervisory Board. The degree of personal contact varied. Members of the Supervisory Board obviously met with the MAS Director at regular intervals, the latter had met a number of times for general discussion with the SW RTO, only once with that of Oxford. Otherwise it depended upon whether individuals were involved with a particular study. The SW RTO, for example, was collectively involved in the strategic planning exercise reported above. The MAS Director had developed regular meetings with the two regional administrators and with the two planning officers, which were seen as valuable in maintaining liaison. All of those interviewed echoed the districts in believing that contacts with, and knowledge of, MAS below the senior officer/chairman level were more variable. Officers would have some knowledge if they were involved in a project or had been asked to comment upon a study but such knowledge was partial. Authority members would know of the existence of MAS but were uninformed as to the detail of its work.

4.111 This situation was largely explained by the procedures that the two regions had developed to process MAS work. In both cases action on MAS studies was determined by the RTO which, if it considered the subject was worth taking further, would look to an appropriate member, generally the administrator or medical officer, to co-ordinate action. This involved referring the report to the appropriate parts of the regional organisation for further consideration. There was agreement that this procedure, which reflected the other pressures and priorities facing the regions was not particularly effective. By the beginning of 1984 one region had instituted a review of the action it had taken on all the MAS studies, and the other had nominated a second in line administrator to co-ordinate action on MAS and provide a point for liaison.

4.112 As might have been expected, members of the Supervisory Board had not experienced communication with MAS as a problem. They believed that communication with the service was adequate. At senior management level in the service the knowledge of MAS was felt to be high. At lower levels and as far as practitioners were concerned, it was variable. Senior officers had not communicated as much about MAS as they should have done, but their attention was taken up by other demands. One respondent felt that MAS had not helped themselves in this respect. They produced too much paper and presented themselves too pompously to receive much attention in the service. MAS, itself, was aware of the problems of its presentation relying upon the written word and promulgation by the service. Throughout the life of the experiment the Director gave high priority to promoting MAS and making contact with the service. By 1984 MAS was proposing to devote more time to personal contacts; making presentations to individuals and in seminar format in 1984.

The Value of MAS

(1) To Districts

Use

4.113 At district level the majority view was that particular MAS studies had been useful. They were likely to be seen as useful if they had touched upon a district problem or showed the district to be below average in some aspects of its performance. The bulk of MAS work lacked such direct relevance but had served to bring information together, to confirm views and suspicions and to contribute to a climate where staff were prepared to consider their performance and the possibility of change. As mentioned above, a number of staff felt that they could have gained more from MAS if they had been able to give the studies more attention. However, all categories of study were seen as potentially useful in providing information and all had their supporters and critics. Thus some respondents felt that studies dealing with specific district problems (Category V) were the most useful, whereas others stressed the value of region-wide comparative studies (Categories I and II) in providing districts with political ammunition in seeking additional resources. Another view was that comparative studies were misleading, concentrating attention upon the outliers and encouraging good and average performers to rest upon their laurels. One particular characteristic of the studies picked

up by a number of respondents, concerned their essentially descriptive nature. They omitted to provide practical recommdnations for overcoming problems. Others, however, saw this as a virtue, allowing districts the freedom to develop their own solutions.

Cost

4.114 The only cost that MAS had imposed upon the districts was that of time - time in supplying information and in reading and considering reports. The majority view was that this was all part and parcel of management and could not be regarded as an extraneous burden. In any case, it was a burden with which the service could more easily cope with the completion of reorganisation.

Content

4.115 Very few district respondents saw the studies as providing any new insights. Rather, they confirmed explicitly what was already implicitly known and added to the general armoury of management knowledge. A number praised the high standards of presentation. Where the studies mentioned particular districts they were mostly seen as being fair and accurate, although there were cases where incorrect data had been used. However, the general nature of the reports meant that they presented an oversimplified picture that might easily be seen as inaccurate at the local level. Inevitably this had detracted from their impact. It was suggested that such difficulties might be overcome by circulating reports in draft to a senior member of staff of each district examined. However, opinions varied as to how far studies should or could take account of local factors. Clinicians interviewed felt that reports were valueless unless they allowed for individual circumstances which explained and qualified general statistical indicators. Senior officers, however, were more prepared to accept that reports could not be too parochial. It all depended upon the nature of the study. Comparative region-wide studies would of necessity be constructed at a higher level of generality than studies of particular district problems.

(2) To Regions

Use

4.116 Regional views of the value of MAS ranged across a spectrum from seeing MAS as of little benefit to viewing it as qualified success. Opinions varied with individual and role, although in general responses from the SW region were more positive than those from Oxford.

4.117 Those who were more positive believed that MAS had improved the region's capacity to monitor their districts. Further, the studies had sharpened regional thinking; providing a catalyst for debate and leading to some innovation and change. The information collated by MAS provided a valuable source of reference and the comparisons between two regions were stimulating.

4.118 Critics argued that, perhaps with one or two exceptions, MAS had produced nothing useful, nothing new and certainly nothing that the regions could not have produced themselves. Comparisons between the two regions were not productive because they had little in common and the information supplied was superficial, sometimes incorrect and marred by faulty interpretation.

4.119 As to the approaches developed by MAS, regional respondents were most critical of the comparative studies based upon activity measures (Category I), although these had been proposed by the regions in the early days of the experiment. The regions could do this themselves and there was a danger in producing 'league' tables based upon superficial or faulty information. By contrast, the comparative studies based on policy intentions (Category II) were widely regarded as innovative and useful. Opinions varied as to the collaborative development work (Category IV). Some respondents felt that it was not producing anything significant to the service as a whole, while others saw the studies as useful and, what was crucial as producing a commitment to change. The value of models of good practice (Category III) depended upon whether districts had any incentive to find out about them and apply the models.

4.120 There was a measure of agreement that MAS had faced a major contextual and structural problem in its reliance on the service to promote and implement change at a time when there were so many other pressures. If, for example, the information supplied by MAS was crude, this was largely a reflection of the current information bases within the service. Unless MAS studies could be seen to be directly relevant to service problems they were likely to be dismissed as a low priority and resisted as 'one more demand.' Further, it was

not easy to work with two regions with their own traditions and priorities. Also, and with hindsight, perhaps MAS would have benefitted from a clearer brief, or at least one that was better understood by the service.

Cost

4.121 Most respondents felt that MAS had not represented a significant cost to the two regions; largely because it had not been given a great deal of attention. A few respondents, however, felt that it had imposed a considerable burden on senior officers. Two respondents also drew attention to the sometimes considerable costs involved in supplying MAS with information. Most, however, believed that overall such costs could not be disaggregated from the normal demands of managing the service and were probably outweighed by the benefits derived from MAS.

Content

4.122 The regions were seen to have influenced the work undertaken by MAS, particularly in the initial phases of the experiment. It was suggested that the regions strove for balance between studies concerned with service outputs and with resource utilisation. A minority of respondents, however, considered that MAS had been allowed too much autonomy in determining its own programme and had followed its own particular interests rather than taken up studies of most benefit to the regions.

(3) To the Supervisory Board

4.123 Members of the Supervisory Board believed that HAS had achieved most where focussing upon problems encountered by specific districts. Indeed, district demands on MAS were increasing, which provided some evidence of satisfaction. The regions had also made use of MAS, both for improving their monitoring base and for promoting service development, although the South Western Region had, it was felt, done rather more in this respect than Oxford. Limitations on MAS achievements could be partly explained by the context. However, it was questioned how far MAS had actually resulted in improvements in efficiency. It was suggested that it was too parochial and had failed to identify, from comparisons or other means, ways of improving working practices.

4.124 MAS was seen to have employed a variety of methods in its studies but the members of the Supervisory Board were somewhat divided as to their utility. While most respondents gave MAS credit for hard work and individual competence, three expressed reservations regarding the methods employed and one had more serious doubts as to the quality of work. MAS methods were seen to have evolved, moving away from the 'quick and dirty' comparative studies with which it began, 'to more qualitative collaborative work focussed upon district problems. It was suggested that as the experiment proceeded, MAS had gained greater confidence, had learned from the critical reaction to its earlier studies and had accepted that it had to motivate managers to promote change rather than implement change itself.

4.125 In an experimental situation, Board members believed that MAS was right in seeking to try out a number of approaches. The comparative studies based upon activities (Category I) were experienced as the least useful, since they encouraged 'a league table' mentality. This form of comparison was most useful, one respondent suggested, if it was historical; allowing authorities to see how their own performance varied over time rather than in comparison with others. The comparative studies based upon policy (Category II) were seen as innovative and useful as, with more reservations, were the collaborative developmental studies (Category IV). The studies of specific district problems (Category V) were valuable insofar as through collaboration they encouraged change. Studies developing models of good practice (Category III) attracted a more varied response. Some saw them as useful, others as uninfluential. The effort displayed by MAS in developing this range of approaches was recognised. Critics, however, wondered if fewer, more detailed qualitative studies would have proved more effective in gaining attention from the service and thus promoting change.

(4) In Undertaking District Studies

District Viewpoint

4.126 Of the six districts examined, five reported commissioning studies of specific problems (Category V) from MAS. The issues involved were described as posing longstanding problems for the district and potentially being of value for other districts elsewhere. In two districts the work was at too early a stage for any evaluation to be made. In the other three cases reactions varied. In one district MAS was felt to have provided valuable direct help with one issue while on another commission it had moved away from its initial brief. In a second district MAS involvement was seen as initiating a useful dialogue and its presence provided a catalyst for change. In the third district the MAS contribution was dismissed as unhelpful.

4.127 Three of the six districts had been or were collaborating with MAS in developing management process (Category IV). In all cases this concerned some aspect of the strategic planning process. Collaboration was justified by reference to the expertise possessed by MAS staff, the fact that as they were 'outside the service' the MAS could provide an objective viewpoint and avoid becoming caught up in inter-service rivalries and by the direct resource they could offer in data collection. The district had to prepare a plan, so if assistance was available it made sense to use it. MAS involvement was also seen by one respondent as giving the strategic planning exercise a higher status than if it were being undertaken by the district alone. Respondents expressed satisfaction with the results of such collaborative work. It was constructive. The presence of MAS had helped identify issues and had given direct assistance to hard pressed staff. Certainly it had cost staff time in attending meetings and in collecting and presenting information, but they would have had to spend the time on strategic planning whether or not MAS were involved.

Regional Viewpoint

4.128 The regions believed that the district studies were helpful. Although MAS work had encountered problems of lack of attention because of other preoccupations, it was valuable that MAS was there 'to do the thinking for the service'. It had provided resources which districts lacked, undertaken studies which would not otherwise have been made and generally laid the foundations for change.

4.129 Following questions raised in the District Reviews, most regional respondents felt that districts supported MAS. The increasing number of subjects proposed by district for MAS study was evidence that they found its work relevant. It was natural that the districts would find those studies dealing with their specific problems most useful, but the comparative studies (Categories I and II) had also been found helpful, particularly that dealing with Units of Medical Time, as had the Management of Transport Study which was an example of a model of good practice (Category III).

(5) In Undertaking Regional Studies

4.130 The majority of MAS studies were seen to focus upon the operational level and were therefore more concerned with district than regional services. MAS considered that the increased emphasis upon accountability in the service had allowed it a role in helping regions to monitor and plan. Some of our respondents agreed and considered that MAS had broadened and sharpened the regional information base. However, any benefits were likely to be long term and indeterminate; evidenced by more informed management and an appreciation of good practice.

4.131 It was suggested that MAS should have undertaken more studies that were directly concerned with regional activities and clearly the mechanism for this existed through regional membership of the Supervisory Board. Yet where this had occurred, as with the studies on capital planning and regional strategic planning, responses were mixed. Collaboration between one region and MAS on the study of strategic planning (reported above) was felt to be good, although this was partly attributed to MAS providing the region with an additional resource. And even on this study, the presence of MAS was seen by one respondent as slowing down the planning process although another saw it as instrumental in developing new approaches and improved procedures. The value of the MAS conception of planning, in terms of wider participation leading to improved plans carrying greater commitment, remained to be tested. The capital planning study was seen as saying nothing new and indeed, by respondents in one region, as advocating nothing that was not already being done. Respondents felt that, partly for these reasons, and partly because of other priorities, this study had not been given much attention.

Promotion of Change

(1) District Views

4.132 Respondents in five of the six districts believed that MAS had been instrumental in promoting change. This was largely indirect. Particular studies - those mentioned were Units of Medical Time (by four districts), Waiting Lists, Orthopaedic Services, Transport Management, District Strategic Planning and Services for the Elderly - confirmed and reinforced perceptions and efforts already being undertaken to resolve district problems. In rare instances they alerted senior staff to the existence of a problem. The MAS contribution, then, was to aid consideration of practice; adding to the climate for change, influencing thinking and speeding up examination of issues. It was much harder to associate any change directly with MAS although staff in two districts felt that the Units of Medical Time study had been directly instrumental in the introduction of new procedures and in one of the same districts the study on Services for the Elderly had led to the formation of a planning team for Care of the Elderly. The work of MAS had, therefore, contributed to saving money, to new patterns of care and to improved management processes. For the most part, however, it was impossible to disaggregate the contribution of MAS from that of other influences. Where the work of MAS had been instrumental in promoting change it was seen to be due to senior officers or clinical committees taking up reports and arguing through their implications for the district. Thus the MAS reports that were seen as most influential in promoting change were those that could prove that the district was out of line in some aspect of its performance and thus stimulated managerial action.

4.133 Compared, however, with the range of topics covered by MAS, the product in terms of change was felt to be small. Reasons given to explain this were:

the service being preoccupied with reorganisation;

the service being swamped by other management initiatives;

districts having their own priorities for action;

MAS reports being too descriptive and failing to focus upon basic issues for the districts;

limited circulation of MAS reports;

the fact that MAS reports lacked teeth and so could safely be ignored;

the failure of district staff, for any of the above reasons, to consider reports in detail;

the difficulty in getting the clinical organisation to take an interest in the work.

4.134 Only one district had brought in MAS to follow up one of its studies with local staff, although staff in two other districts felt that they might call on MAS in this capacity in the future. Doubts were expressed, however, as to whether such involvement would be productive in inducing change. The managers must manage the service and the contribution of MAS was analytical rather than executive. Bringing in outsiders could easily exacerbate local difficulties. MAS involvement in following up their recommendations could not be automatic but must rather depend upon the judgement of district officers as to whether it would be of help.

4.135 None of the districts had experienced the regions as seeking to enforce district implementation of MAS recommendations. However, they were all aware that action on MAS would be an issue in District Reviews and this meant that MAS would become an element in the accountability network; a part of the region's monitoring and evaluative capacity. Both regions had also circulated a questionnaire to the districts, seeking their reactions to MAS.

4.136 In seeking to promote change MAS was seen by the districts as being concerned with all of the following:

achieving economies;
improving the efficiency of management processes;
improving the quality of service outputs.

The second, the concern with efficiency, was perceived as the major focus, although a number of respondents felt that over time there had been a shift towards a concern with quality of service. This, for example, was seen as the intention in the studies dealing with Services for Children and for the Elderly.

(2) Regional Views

4.137 Regional respondents took the same view that it was not possible to link any changes directly to the presence of MAS. The most positive responses suggested that MAS had succeeded, despite unpropitious circumstances, in changing service attitudes and, in one respondent's view, contributed to improved cost effectiveness and better planning. Its studies had alerted service managers if they were 'out of line'. The most negative held that it represented a minimal impact in relation to the resources expended. Studies were too superficial to be of use and indeed, made change harder because of the inaccuracies they contained. The service had too many other pressures upon it at this time. MAS was insufficiently known in the service to provide a focus for change and, in the opinion of one respondent, where it was known it engendered resentment.

4.138 Change was, of course, dependent upon service managers. Regional respondents were clear that MAS could not themselves execute change. This would either lead to them becoming surrogates for weak managers or to conflict with the more able, and would undermine accountability. In this situation regional action on MAS studies was necessary if change was to come about. It was the Region's role to encourage and support districts in considering MAS findings and to monitor what action they subsequently took. It was felt that the regions were beginning to do this through District Reviews, through meetings between the RTO and DMTs, through interdisciplinary meetings and chairmen's meetings. A few felt that the MAS Supervisory Board should have played a role in following up action on recommendations. It helped, too, as MAS recognised, if MAS maintained a close contact with service managers. The nomination of district liaison officers was cited as helpful in this respect.

4.139 The majority of regional respondents considered that MAS had been as concerned with service outputs in its work as with management processes or ways of securing economies. It was suggested that this breadth of focus was not understood by the service and might be a source of confusion. MAS was far from limiting its concerns to management process, although some believed that this was what it should concentrate upon, and was available to help authorities provide more effective services.

(3) Supervisory Board Views

4.140 Although Supervisory Board Members believed promotion of change was crucial in judging MAS as a success or a failure, it was not easy to assess and did not attract much agreement from our respondents. In any case, there were clearly difficulties in judging MAS upon this criterion when change depended upon service management. Regional support and follow up were identified as important in achieving implementation of MAS recommendations; yet the two regions were thought to vary considerably in the importance they attached to MAS. Most respondents felt that MAS had affected little change overall to date but were divided in that some saw this as inevitable, change being generated by a more questioning attitude which took longer than the period of the experiment to take effect, while others saw the absence of change as indicating the failure of the experiment. A minority of respondents felt that some change had occurred. MAS had led to greater efficiency and the introduction of improved practices. Regional monitoring procedures had, it was suggested, been sharpened by applying information supplied by MAS.

4.141 Board members were divided as to what factors promoted or hindered MAS in effecting change. The former were seen to include the quality of work, local availability, provision of a direct resource and provision of comparative insights from working across two regions. However, the latter, also included poor quality of work, that studies were too superficial, regional comparisons unhelpful and that the recommendations made had failed to gain commitment from the service and particularly from relevant professional interests.

(4) Compared with Other Mechanisms

4.142 In comparing the value of MAS as a force for change with other mechanisms in the service, opinions at all levels were fairly evenly divided. Devices such as the Health Advisory Service and the National Development Team for the Mentally Handicapped were seen to have certain advantages:

greater authority: they were inspectorial and had more teeth including reference to the Secretary of State;

they monitored what happened as a result of their interventions;

their concern was with quality of service which is, or should be, the prime objective of the service;

unlike MAS, they had had the time to become established in the service and had gained professional recognition;

a clear institutional focus in their recommendations;

they provided clear practical recommendations for change.

However, MAS was also seen to have advantages. These included:

time to collect information in detail;

approachability and receptivity to service needs;

expertise allied with objectivity;

provision of a wider range of studies than other initiatives;

the willingness to work collaboratively with authorities on the latters' problems;

lack of authority, thus if districts or regions took up MAS recommendations it was because they were committed;

higher standards of clarity and presentation in their reports.

One respondent stressed that it all depended upon the motivations of service managers. Strong, self-motivated managers would take equal advantage of MAS or any other change agent. Weaker managers were likely to see MAS as more influential since it undertook a wider range of studies and its recommendations passed into the regional monitoring system.

(5) MAS Views

4.143 MAS, of course, is a new initiative and thus still has to demonstrate its status in the service. From the MAS perspective NHS managers needed advice and assistance. That was the whole point of the 'experiment'. The problems of commencing 'from cold' in the immediate post-reorganisation context had been anticipated and MAS strategy shaped accordingly. This involved rapidly undertaking a large and wide range of studies to become known. By 1984 MAS had demonstrated its value through the work done in the first two years and the wider recognition it had gained, as, for example, in assisting the Griffiths Inquiry. MAS had overcome the lack of commitment in parts of the service and had 'built up' its position. MAS's own understanding was that much of their work had been found useful by the service; it had already resulted in some change and MAS now occupied a strong position to achieve greater change in the future.

Role of MAS

(1) District Views

Independence

4.144 The majority of district respondents felt that MAS had maintained its position as an independent service within the NHS and that it was important that it did so. Independence secured objectivity in looking at the service. It avoided the sensitivity of authority relationships which, most thought, would discourage districts from wishing to use MAS if it was seen as a regional or national service. As it was the districts could stand back from recommendations without feeling that they were flouting higher authority. Independence had also, it was suggested, preserved flexibility and speed of response; qualities which would have been lost had MAS been part of a larger organisation. One respondent, while accepting that MAS was indeed independent, believed that this was detrimental in that it might have exercised more influence if attached to higher authority. Two respondents felt

that effectively MAS was a regional service but neither saw this as particularly significant. As long as the regions were diplomatic with the districts in their use of MAS findings, the precise status of MAS was unimportant.

Objectives

4.145 In five of the six districts, the majority of respondents felt that MAS had, at least in part, satisfied its particular objectives. Contributions to planning and the dissemination of good practice were most commonly perceived. It was accepted that MAS had attempted to resolve significant management issues, however the districts' definition of significant was not necessarily that of MAS. Similarly, the dissemination of good practice largely depended upon the salience of particular topics to district needs.

The Future

4.146 In looking at the future role of MAS, most at district level supported its continued existence, arguing that it was important for the service to be able to turn to external consultants. One respondent took this a little further, suggesting that MAS should operate on the open market. On the whole the same mixture of objectives and approaches was seen as relevant although there was, as might have been expected, some stress on MAS concentrating its efforts upon district problems. Suggestions that might be worth future consideration included deeper qualitative studies, the creation of methodologies that districts could then apply themselves and the experimental testing of management processes in one or two districts. However, suggestions also included on the one hand a concentration of studies at unit level and, on the other, a continuation of region-wide studies focussed upon acknowledged major areas of difficulty in the service. Suggestions from the districts as to appropriate areas for study included clinical organisation, patient services, district management structures post-reorganisation and the application of nursing manpower. However, it was also suggested that MAS should stay away from the clinical area because of the overriding importance of the local context. MAS had a further value in that it provided a centralised source of management and information expertise. This resource would be lost if the staff were dispersed across the service.

Another aspect of the future role, mentioned by three respondents, was that MAS should devote considerably more attention to publicising its existence and work. Two respondents, both clinical, were sceptical. The work being done by MAS should be done, if at all, by unit managers.

4.147 In five of the districts those interviewed were asked whether if MAS operated in a free market they would wish to pay for its services. Nine respondents, drawn from four of the districts, replied in the affirmative. They stressed, however, that they would expect payment to be accompanied by a greater voice in the selection of topics for study. MAS would have to account to the districts for the work it had undertaken. Eight respondents drawn from four districts, replied in the negative. Reasons given included the presence of more important local priorities for finance and the existence of district or regional facilities that could do the work of MAS. It is interesting that those in favour of districts financing MAS included six administrators and no doctors, while those opposed to the idea included one administrator and four doctors.

(2) Regional Views

Objectives

4.148 Respondents at regional level gave credit to MAS for its efforts. It had undertaken a considerable programme of work in difficult circumstances. What was more in question was whether that effort had been well directed. Majority opinion suggested that MAS had met its own objectives, at least in part, but it was less clear whether the results had met the objective of the Secretary of State in actually improving service efficiency. In other words MAS might have made recommendations on significant management issues, contributed to the development of planning, supported districts in monitoring their performance and disseminated good practice, but it did not show up in improved performance. This was partly due to the dependence of MAS on service management at a time when it had other preoccupations, but a number of respondents also saw it as a result of misdirected effort. Thus it was suggested that MAS had been seduced by the need to display quick results into carrying out what was essentially regional monitoring work. There had been too many studies at too superficial a level. Those with this viewpoint argued that MAS needed to concentrate more directly upon improving

the effectiveness of management; studying its practice qualitatively in the operational situation. The greatest potential for contributing to efficiency was still seen to lie in the field of clinical organisation and it was also suggested that most could be achieved through undertaking studies that were seen as relevant by the districts. Those who were less critical argued a growing realisation by the service of the value of MAS work. It had proved particularly effective where meeting specific requests and should continue to strike a balance between service development and service monitoring.

Independence

4.149 All regional respondents felt that MAS was seen as an independent or quasi-independent service. Most felt that this was important as it gave MAS freedom to undertake studies without being seen as representing a particular interest and encouraged the districts, always sensitive of regional authority, to participate. It was potentially easier for an independent body to promulgate new ideas. However, a minority noted that independence can also be accompanied by a lack of authority. A further minority suggested that MAS had enjoyed too much freedom and would have had greater effect if its subjects of study had been directed to significant issues.

Staffing

4.150 Two regional respondents raised the problem of staffing MAS. One suggested that the lack of medical planning experience had shown in the way in which some studies were reported, although this had been a gap which the MAS Director had been seeking to fill by the appointment of a community specialist from the inception of the experiment. A second respondent strongly supported the practice of staffing MAS by secondments from the service, since that ensured that the work was in touch with reality. Posts with MAS needed to be seen as part of a career in the NHS, not a dead end. However, it was understandable that MAS had found staffing difficult. Secondments were unpopular because of worries about job security.

The Future

4.151 It was necessary to evaluate MAS and consider its contribution and the relevance of its objectives. The regions were attempting to make such an evaluation through the District

Reviews and the MAS Supervisory Board had sought the advice of an external consultant. Of the 11 respondents interviewed, five felt that, on balance, the regions and districts should, if necessary, finance MAS for at least a further limited period. This would enable a fairer test of its worth. One respondent believed that much of the work that MAS was set up to undertake was now being done by the regions as part of their own accountability mechanisms. MAS work should therefore be incorporated as a regional service and not provided independently. Another respondent made the same diagnosis but thought it preferable to cover more than one region. Regional control would ensure that MAS undertook relevant studies and attention for its recommendations. The remaining four respondents were unsure.

(3) Supervisory Board Views

Independence

4.152 Members of the Supervisory Board acknowledged that initially the role of MAS was uncertain. A minority believed that over the period of the experiment the advisory role had become both clearer and more tenable. Others were not so sure. It was suggested that MAS could still be viewed as a regional agency, as a service adviser or as an information collection service. If MAS continued in the future, it was argued, it must either become an inspectorate or a district advisory and developmental service. It cannot follow both paths. Members of the Supervisory Board felt that MAS had functioned as independent or quasi-independent from the rest of the NHS but were divided as to whether this was important or necessarily a good thing. On the positive side, independence gave MAS freedom in pursuing its studies; it was not the creature of any authority. Independence, as opposed to regional or DHSS control, also encouraged district participation. However, the independence of MAS was ambiguous in that its results were used for regional monitoring and it was dependent upon the regions for promoting its recommendations. From the more critical viewpoint it was suggested that MAS needed greater accountability. This would be provided if it was incorporated as a regional or, if comparative studies were felt fruitful, a multi-regional service.

Objectives

4.153 Most Board members felt that MAS had satisfied its objectives in part, although it was recognised that they were wide and the degree of satisfaction varied from 'barely' to more generous assessments. The influence of MAS on the service was difficult to assess but it was suggested that it had provided a catalyst, encouraging the service to think, had tried to establish new truths and had broadened horizons through its comparisons.

4.154 Opinions were divided as to whether the MAS objectives were still relevant or were necessarily the most relevant for promoting efficiency. Two respondents argued for a much stronger focus on the operational level, providing a more detailed examination of managerial objectives and their fulfillment. Others suggested that MAS should continue to balance its work between developmental studies, best pursued by examining issues seen as relevant by the districts, and studies that aid regional monitoring. For this latter aspect it might be fruitful if MAS covered a larger and more varied slice of NHS activity than was provided by two regions. For some, however, the comparative aspect of the work had proved disappointing.

The Future

4.155 It was apparent that members of the Supervisory Board felt that it was time to review the objectives of MAS as well as its future. The latter should depend upon whether relevant objectives could be best met by a body partly external to the service or in some other way. It was suggested, for example, that improved accountability mechanisms in the service made the presence of an external body redundant. If MAS was to continue it needed to review its methodology, concentrating its activities upon those approaches which had proved effective in achieving change.

(4) MAS Views

4.156 From the MAS viewpoint, since the experiment was first conceived central initiatives had strengthened the accountability role of the regions. MAS could thus help them monitor and evaluate the health service. However the transformation of the Region into an inspectorate relieved MAS of that responsibility and left it free to concentrate upon a developmental role without the familiar conflict between inspection and advice. By 1984 MAS saw its most productive future role in terms of combining a consultancy service with help to authorities in defining their objectives and ways by which these could be measured. This would

entail a greater focus on the operational level; working with districts or with units and/or staff groups within units. MAS also proposed developing its information facility, collating and updating data that would furnish authority profiles and make this accessible to the service.

Expectations of MAS

4.157 Respondents were asked whether they had held any initial expectations of MAS and, if so, whether these had been satisfied. Expectations mentioned covered a wide range and conflicted. The basis for their foundation was unclear as was the degree to which they had been transmitted to MAS. In three districts, two located in one region and one in the other, the view was that the experience had exceeded initial expectations. One respondent had seen MAS as undertaking a management survey but had been impressed by its contribution to a changed management climate. In a second district, respondents had expected little; MAS was imposed upon them at a difficult time. In the event, MAS had provided useful information, was starting to undertake productive studies in line with district needs and was beginning to settle into a role and see its work taken up by the districts. In the third case, respondents had expected 'a helping hand' and, in particular, suggestions for improving management processes. Although the timing of MAS was unfortunate, the districts had been given help and as the services began to have the time to take up the studies, so improvements in process were starting to come. In two of the districts, experience appeared to match expectations. In one, MAS had been expected to provide a source of assistance but also a source of demands for information. This is what had happened, although MAS had not functioned as an arm of the Region as one respondent had feared. In the second district, the respondents had feared that MAS would be undertaking rapid and rather general and superficial studies. This, on the whole, is how MAS has been experienced. Finally, respondents in one district had started off with higher hopes than had been realised in practice. 'MAS promised more than it delivered.'

A respondent in this district had felt initially that MAS offered an opportunity to look objectively at the service but this had not happened. The blame, however, lay as much with the service as with the quality of MAS work. A third group of respondents in the district had looked for sharp and specific criticisms and recommendations. These, they felt, had not been forthcoming.

4.158 Expectations at regional level also appear to have varied considerably, as does the degree of satisfaction. Expectations that had not been satisfied concerned the subjects of study, their focus on districts rather than regions, their results, both in terms of providing a basis for changing management practice and in actually engendering change, and the failure of MAS to adopt a trouble shooting role. Expectations that had been realised included the success of the advisory role, the creation of a development tool for the service, innovation from the demonstration of effective performance and improved management practice. In all, four respondents, three from the SW and one from Oxford, expressed themselves satisfied in part. Six, two from the SW and four from Oxford, felt that their initial expectations had not been met.

4.159 When respondents on the Supervisory Board considered their expectations of MAS, four considered that these had been met. MAS had acted as a development tool, had performed an advisory role, had identified some significant problems and had not imposed a major drain on resources. Two respondents whose expectations had not been met, pointed to the failure of MAS to perform a trouble shooting role and its inability to promote management efficiency.

<u>The Role of the Supervisory Board</u>

4.160 This was discussed with members of the Board in view of comments (see paragraphs 4.121, 4.138 and 4.149) that MAS had been allowed too much autonomy in selecting areas for study and that the Board might have played a stronger role in promoting MAS recommendations. Respondents' comments reflected their particular view of the proper role and authority of the Board in exercising accountability for MAS. Although there was some feeling that the Board's role had never been fully defined, there was agreement that its presence was necessary: 'it provided a base and point of accountability, rather than leaving MAS to operate in a vacuum.'

4.161 The argument for loose control was that it was no part of the Board's role to manage the work of MAS. This was what the Director had been appointed to do. MAS had to take the lead and use the Board, which contained senior and experienced members of the NHS, as a forum for testing ideas. The contribution of the Board's members was to provide feedback; filtering ideas, reshaping and reformulating. The control exercised by the Board was over broad areas; selection of the Director, approval of the budget and agreeing the programme of work. In reacting to proposals from MAS, the Board indicated priorities, bearing in mind the objectives of the experiment. It was no part of the Board's brief to take executive action with the service on MAS findings.

4.162 A number believed a more detailed form of control would have been preferable. The Board left it to the MAS Director to aggregate or respond to individual viewpoints; there was rarely a corporate view. This meant that Board expectations were sometimes unclear and that the cumulative atmosphere was critical rather than positive. The absence of an agreed view also made it difficult for the Board to promote MAS with the service. Cumulatively, this all raised doubts as to the degree of the Board's commitment to the success of the experiment. Membership was also weighted towards the two regions and the Board was thus unable to fully represent district opinion.

PART III

EVALUATION

4.163 In this section the assessments of the MAS experiment made by members of the service, and the Supervisory Board, together with the observations of senior members of the MAS team, as reported in Part II, are combined with the researchers' own judgements under the headings of the Evaluative Framework.

OBJECTIVES

4.164 The MAS Supervisory Board defined its specific objectives as being:

> to identify, examine, make recommendations (and influence implementation) on significant management issues;
>
> to contribute to the development of planning within the NHS;
>
> to support districts in monitoring their own performance;
>
> to encourage the use of research resources and disseminate good management practice.

4.165 All these objectives are compatible with those of the Secretary of State. In its work MAS has struck a balance between the various objectives, which in any case interrelate. Clearly there are differences in perception between and within districts as to just what is significant, what contributes to planning, what supports districts or represents good practice. Although initially dependent upon Supervisory Board perceptions, over the period of study MAS has given increasing attention to identifying district needs. However, it is still necessary to weigh

concentrating upon a district, or indeed unit, priority against taking up issues that have significance, but may not be perceived locally as the most urgent priorities across the regions. Again, MAS with the advice of the Supervisory Board, has attempted to maintain a balance.

4.166 Evidence from our research suggests that these objectives have been consistently maintained. However, MAS and some respondents in the service, felt that the role and authority of MAS had changed during the course of the experiment. The inspectorial sanctioning aspect had diminished as accountability for efficiency had become strengthened within the service. This enabled MAS to emphasise its advisory role both in respect of how the service should set about monitoring efficiency and in helping authorities to become more efficient. Thus the possibility of conflict in promoting its objectives from a standpoint of managerial accountability and from assistance had diminished. What remains uncertain is whether following these objectives had produced results which had been translated into service efficiency.

4.167 The objectives were seen as a reaction to the need for tighter resource control in the health service and to the consequent needs for increased managerial efficiency and for management to reach an accommodation with professional freedom. They also reflected a belief that MAS could help the regions fulfill their accountability for promoting efficient management in the context of devolution of authority to districts.

4.168 Given the above objectives, MAS saw its main task as being to assist and advise management; changing managerial attitudes and encouraging managers to clarify their aims, question what they were doing and seek more efficient means of performance. This, however, was recognised as necessarily long term and somewhat indeterminate. One specific way in which MAS could further this priority would be by showing the service how to use available information to measure efficiency and achievements. Because of its comprehensive focus, the planning system was seen to offer enormous potential for improved

application of information and the identification and measurement of objectives. Throughout the period of study MAS was aware that one of its practical priorities was becoming known in the service. Authorities were unlikely to work with MAS, or take much note of its conclusions, until they were convinced that it had something of value to offer. This meant that in the initial stages of the experiment MAS had to balance expenditure of time in publicising its existence with the need to quickly demonstrate its work.

CONCEPTUALISATION AND DESIGN

(1) Objectives

4.169 The objectifes stated in 4.164 are explicit and have remained in force over the period of study. As mentioned above they are compatible with each other and are capable of contributing to the promotion of efficiency. Nonetheless it is apparent that those in the service, including, on the evidence of regional perceptions, those most closely involved with the work of MAS, held a variety of expectations, some of which conflicted with each other, regarding the purposes of MAS. The MAS Director perceived, for example, that the two RTOs saw the objectives of MAS differently; as a development agency and as an information source contributing to regional monitoring respectively. These varied expectations do not appear to have been clarified or discussed with MAS. Likewise, not surprisingly given all the other preoccupations, MAS objectives and their implications were not clear to the service from the outset or necessarily understood. Here, again, MAS saw such understanding as requiring time.

(2) The Model

4.170 Initially there appeared to be widespread ambiguity regarding the role and authority of MAS. Although it was part of the NHS, MAS was expected to act independently from authorities. Would it then act as an inspectorate serving, from the district perspective, as a de facto arm of the region? Alternatively, would it provide a consultancy service to be drawn upon as authorities determined? There were also different ideas regarding its involvement in the change process. Some saw it as creating a product - information - which the management of service would then determine how to apply. At the same time, it was perceived that since the reason for having MAS was to promote change in the service and its success or failure

was likely to be measured in these terms, so MAS could hardly avoid becoming involved in the change process.

4.171 The role seen by the team, and that which emerged during the experiment, stands between these extremes. MAS is an independent region-wide advisory service. Its independence and region-wide focus secure its work from dependence on particular authorities. Its advisory nature preserves it from being seen as an inspectorate, imposing prescriptions. MAS can thus function as a motivator, continuously encouraging and assisting authorities towards efficient practice.

(3) Structural Arrangements

4.172 Paradoxically, the independence of MAS was achieved by making it accountable to a Supervisory Board. This provided it with an institutional focus, while separating it from the service and enabling it to promote its objectives with all authorities within the two regions. The authority of MAS was implicit and consisted of the right to:-

seek information;
advise authorities of its findings.

MAS preferred, however, not to stress its formal authority but to see it as sapiential, stemming from expertise and capability. However, because the implementation of its work was a matter for management, it could not help but be conditioned by service relationships. This could not be institutionalised in advance but rather had to be resolved as the experiment proceeded.

(4) Models of Change Underlying MAS Change or Intervention Processes

4.172 In terms of the theories of organisational change outlined in Chapter 3, MAS was to provide an external intervention. It would provide a source of expertise to help the service towards efficiency, while its independent status would preserve it from the sensitivities of service relationships. However, at the same time, the regions, albeit with different emphases, were promoting MAS and promoting it as a source of change. At the outset, then, districts harboured suspicions that effectively MAS would operate as an arm of the

region; a means of promoting uniformity. MAS, while recognising the need for 'top down' initiatives to promote change, was equally concerned to promote it from the 'bottom up' by educating and collaborating with district management.

4.174 The means by which MAS results could be translated into service change were never specified in structural terms. Much of MAS work would be undertaken at a distance from the field. In terms of techniques for promoting change, it relied upon a rational/empirical approach. MAS provided the information and indicated the conclusions that could be drawn, it was then up to management to take the necessary action. However, the approach also contained the possibility of collaborative work with NHS staff. Here MAS would have scope to apply a normative/re-educational approach, based upon its own experience and perception of service needs.

4.175 MAS recognised that it could not achieve change 'overnight'. It could not impose its recommendations; they would only be acted upon when, and if, authorities were convinced of their utility. In terms of the change processs its work was likely to lead to tension and encounter resistance before being accepted and acted upon. The programme of work and methodology were shaped by these considerations. MAS would have to demonstrate its contribution to particular problems and assessment of performance before its work could become part of organisational self-learning. Again, however, this strategy and its implications were not necessarily clear to, or accepted by, the service interests most concerned with MAS.

Evaluative Approach

4.176 The evaluative approaches to be applied by MAS came from the middle to the expressive end of the spectrum of approaches discussed in Chapter 3. It would not be undertaking classic scientific experiments. The data to be used would be primarily quantitative but qualitative information would be necessary for interpretation and analysis and would play a larger part in some approaches than others.

4.177 The approach can be defined as formative. The MAS work leads to action on the basis of information regarding performance and clarification of aims. A high premium is placed upon reliable information that can be used systematically by managers to gain a clearer indication of performance and by authorities to help formulate policies and monitor their achievement.

4.178 There was to be no built-in self-evaluation of MAS although it was recognised that the DHSS, the Supervisory Board and the two regions would need to form a view of the achievement and value of the experiment. At the end of the second year of the experiment the Supervisory Board sought the advice of an external consultant, and of the regions and districts, as to the desirability of continuing MAS without DHSS funding.

Criteria and Methods

4.179 MAS would evaluate service activities against local regional or national standards, against models of excellence, against regional or national averages, as appeared possible and/or useful in the context of particular studies. Activities might also be evaluated against policy statements, although initially these were seen as too sparse or general to readily provide suitable data. For the most part, it was envisaged that MAS would make use of information that was routinely available, although in some circumstances fresh information might need to be sought. Given the nature of available information within the NHS, this meant that most data collected would concern service inputs and activities.

4.180 The general framework to be adopted consisted of:

determining the nature of the problem;

seeking information regarding suitable criteria for measurement or models of good practice;

analysis of information, selecting relevant forms of measurement or models;

collecting data from the service to compare performance against selected measures or models;

reporting the results.

This framework was particularly suited to the comparative studies with which MAS commenced their programme but it was felt that the approach would be appropriate for other forms of study. However, the approach did not conclude with the report. MAS were concerned to promulgate good practice and hoped to be able to engage in collaborative work to implement their findings.

4.181 The Supervisory Board gave the MAS team considerable freedom to develop their own methods of work. The employment of high calibre individuals was felt to carry the corollary that they would have their own ideas as to how they worked.

Scope of the Scheme

4.182 Clinical performance was explicitly excluded from the MAS brief, but otherwise it was felt that any area of service activity could be studied, with some feeling that the greatest results would come from examining areas of clinical organisation. Similarly, functions performed at different levels, district and region, were open to investigation. Particular studies might require the involvement of agencies outside the service, such as local authority departments. For the most part, however, MAS would be 'in house' to the NHS and was not envisaged as entering into a dialogue with consumers or their interest groups. The scope of the initial work (see Part II) was felt to be constrained by the need for MAS to quickly make its presence felt and by its lack of resources.

(5) Feedback and Follow Up

4.183 The essence of the MAS approach was to feed back findings to the service; initially in the form of reports, although MAS saw the utility of developing other methods such as collaborative working and seminars. Follow up of the results of their work was desirable but not seen as a high or particularly productive priority given the short life of the initial experiment.

IMPLEMENTATION AND COHERENCE BETWEEN OBJECTIVES AND RESULTS

(1) The Model

4.184 As the experiment proceeded, MAS and some of our respondents felt that the advisory role became more prominent. A minority, however, saw the continued combination of inspectorial and advisory roles as dysfunctional and a source of weakness.

4.185 MAS was regarded as independent or quasi-independent of service management: it had a continuous existence in the NHS as an institution in its own right. Most, and particularly those who saw MAS as a development agency for the service, saw this as a strength. It provided MAS with freedom of action and encouraged districts, sensitive of their authority, to participate. A minority noted, however, that the dependence of MAS upon regional management to promote its recommendations made this independence ambiguous. Those who saw MAS as ideally contributing information to regional monitoring felt that it had enjoyed too great an independence. MAS would have been of greater benefit if its subjects for study had been directed towards the major needs of the service.

4.186 There was no agreement that the model adopted by MAS was necessarily the most effective in promoting change; for this is largely dependent upon managers' motivations. Comparing it with other longer established mechanisms, such as the Health Advisory Service or the National Development Team for the Mentally Handicapped, respondents drew attention to its 'lack of teeth', its failure to immerse itself in the field, its lack of professional status and the absence of any 'follow up'. Others, however, saw the lack of sanctions as an

advantage. If MAS recommendations were taken up it was because authorities were committed to them. This made the possibility of change more likely. MAS was also seen to have advantages which might motivate weak managers in terms of time to devote to its studies, local availability, being in touch with 'day to day' reality of the service and feeding into the regional monitoring system.

(2) Institutional Arrangements

4.187 Initial fears of some at district level that MAS would prove to be a regional agency in a different hat appeared to have diminished with experience. Indeed, as the experiment proceeded it became apparent that distribution and, even more, action upon its studies were inconsistent between districts across the two regions. Uncertain arrangements in this sphere proved a continual problem. The Supervisory Board did not function as an executive to develop common procedures for handling results and in any case, was not well constituted to express district opinion. In these circumstances MAS had to give time to identifying needs and negotiating outcomes with management in the various authorities and to developing mechanisms, such as the nomination of liaison officers, for processing its work. This way of proceeding, although time consuming, was not inconsistent with the advisory model adopted by MAS.

4.188 Although its meetings provided a focus and framework for MAS work, the Supervisory Board gave MAS a loose rein. It looked to the latter to provide a lead while itself providing a forum for testing ideas and ways of working. Some members felt that MAS could have been more productive if the Board had developed clearer corporate policy. This might have clarified different expectations of MAS and engendered greater commitment to the experiment.

(3) Change or Intervention Processes

4.189 No doubt there is no 'right time' to introduce organisational innovations but for one such as MAS where success depended upon managerial action in inducing change, 1982 and 1983 were difficult years. As a result, MAS found it hard to gain space on management agendas. Responses from the districts and regions (reported in Part II) stress

how pressures from local reorganisation and the increased number of new national and regional initiatives, coupled with other heavy, if routine demands, left little time to do MAS justice. Although this problem had been foreseen by MAS, without management patronage its approach fell between two stools. On the one hand, as an external adviser, MAS had no clout to enforce its recommendations. On the other hand, a strategy of collaborating with individual authorities in implementing recommendations and developing change from the 'bottom up' would be slow since it depended upon MAS becoming known and accepted. Authorities, too, were reluctant for MAS to be seen as taking on management responsibilities. Change, then, would be slow and inconsistent unless regional management as the superordinate authority provided some stimulus. This meant the regions taking up MAS recommendations within their own accountability relationship with the districts. Here there were differences of opinion as to how far it was region's role to determine which studies were taken up and to define the appropriate process and whether they should enforce action or 'hold off' and leave change to local discretion. Enforcement could lead to MAS being seen as a regional inspectorate; 'holding off' might result in no action. Although the two regions varied in their approach to MAS and were seen as following different philosophies in their relationship to their districts, they, too, appear to have come to a middle course; trying to ensure through such devices as District Reviews and disciplinary meetings that MAS results received consideration.

4.190 There were, of course, early examples of MAS stimulating change from the bottom up. As might be expected these occurred where MAS had collaborated with particular districts in developing new processes or had made a study of a particular district problem. However, the region-wide comparative studies could also prove a stimulus for change, in some respondents' opinion the most powerful, where it was demonstrated that local practice was deviating from the regional or national norm.

4.191 The latter points to success for the rational/empirical approach to inducing change. However, as mentioned in the study of Later Perceptions of MAS (reported in Part II), the degree of change achieved was felt to be slight in comparison with the range of studies undertaken. The greatest likelihood of change occurred where particular studies confirmed or, more rarely, uncovered a local problem. As shown from the two planning studies (discussed in Part II) MAS did apply a normative/re-educational approach in its collaborative studies. In these examples they sought to instill staff with their conception of the purposes and process of planning. It is too early to gauge their success. Respondents who had been involved saw the process as constructive; in the case of the district strategic planning study: 'It provided the district with a planning method'. However, one of the main benefits in these studies was seen to be that MAS provided a direct resource to hard pressed staff. It must be questioned how far other authorities would feel moved to adopt the methodology from learning about it as a rational/empirical strategy, without the incentive of MAS assistance with the work.

4.192 MAS explicitly sought to gain the commitment of senior management in promoting change. Given its limited resources, this was probably the best strategy. However, in the NHS much of the work is generated by the professionals working at the periphery of the organisation and in particular by doctors. Apart from where they were studying particular local problems, MAS lacked the resources to connect with staff at this level and senior management lacked the will to proselytize for them. District respondents felt that MAS would have achieved more, particularly with clinicians, if it and its objectives had been better known. Staff at the service delivery end of the NHS were felt to be unaware of the existence of MAS or if they were aware, saw its work as out of touch with local realities. Given the evidence of political clout carried by professionals in the NHS when it comes to determining priorities, this must represent a weakness in the ability of MAS to promote change. MAS were aware of the problem and sought its solution through

devices such as nominating liaison officers in each district, maintaining regular contacts with senior management in the various authorities, providing seminars anhd producing bulletins and digests that presented their work in a shorter and more readable form. Knowledge of their existence, however, appeared to percolate very slowly through the service.

(4) Evaluative Approach

4.193 To date, MAS has undertaken general strategic reviews covering a range of services and functions within the two regions. The intention has been formative, emphasising how management can apply routine information to measure performance. The majority of such information concerns inputs and processes but MAS has also undertaken studies to encourage authorities to clarify policies and measure their fulfilment as a proxy for service outputs.

(5) Criteria and Methods

4.194 The methods employed by MAS evolved over the period of the experiment. This was only to be expected. As Delbecq and Gill (2) point out, under conditions of technical complexity expectations of programmes

> 'have to be much more tentative, much more experimental, promise less and lead to organisational learning as opposed to some magic solution.'

MAS applied a range of approaches. As it became better known or, it was suggested, learned from experience, MAS was able to move away from the early 'quick and dirty' comparative studies to developing management process and models of good practice in collaboration

with the service and new means of measuring performance. For example, MAS considered that monitoring of efficiency in the NHS was traditionally based upon information on resource levels and activities which stand as proxy for service outcomes. However, in the studies of Services for the Children, for the Elderly, and on Community Services, MAS sought to identify policy aims and statements of good practice as a base for assessing performance and then to link information to these criteria. This, it considered, provided a more comprehensive basis from which to assess performance and a wider perspective for review than merely assessing whether available resources were being used to the greatest advantage.

4.195 MAS were able to obtain and process much of the routine information required for their studies. As might be expected, information was easiest obtained when it was collected and collated regionally. In this connection MAS employed an information officer who was based in the SW Regional Headquarters. Information that had to be collected from the districts took longer to obtain and occasioned delays, particularly if it was the subject of a special investigation. In the collaborative studies there were pressures on MAS to obtain the necessary information and while this could be valuable in terms of normative re-education, demonstrating to staff what information was available and how it could be obtained, it was not necessarily the most productive use of MAS time and skills.

4.196 MAS felt that it had to work fast. The short life of the experiment gave little enough time to prove its worth and it had a demanding programme of work in a difficult environment. From the perspective of staff in the field, with other demands upon their time, the MAS timetables were frequently experienced as too tight and slippages occurred.

4.197 In promulgating its results, MAS largely relied upon the written word in the form of reports, digests and bulletins, although it recognised that these means were probably the least effective means of promoting change. Attempts to reach the service through seminars and workshops failed to get off the ground in the early stages of the project, although, as MAS had predicted, they appear to have been more successful once MAS became better known.

4.198 Where MAS studies required collaboration with the service as in developing new management processes or tackling specific problems, relationships proved good, often despite initial suspicions from the service. Respondents gave credit to MAS staff for their effort and expertise.

(6) Scope of the Scheme

4.199 As can be seen from the list of studies reported in Part I of this chapter, the scope of the studies proved to be wide. As the programme developed emphases changed. Changes followed the MAS strategy as well as its interests. As MAS became better known and as the service settled down from reorganisation, so individual districts increasingly sought its help with their problems. MAS and the Supervisory Board which approved its programme had thus to arrive at a balance between studies that:

helped authorities to monitor efficiency and those that were developing new processes;

had a region-wide significance and those that focussed on specific and perhaps individual problems.

Some critics suggested that the resultant programme neglected regional priorities, which suggests a failure by the Supervisory Board to elicit opinion.

UTILITY OF PROCESS

(1) Costs

4.200 The figures quoted in Part I of the chapter provide the direct costs incurred by MAS. It can be seen that there was significant underspending on the budget in 1981/82 and 1982/83 and that underspending is expected in 1983/84. This is partly attributed to delay and inability in securing staff and the absence of any necessity to 'pump prime' particular studies, but also a result of the policy of dictating the build up of MAS by the work being undertaken.

4.201 The costs to the service in working with MAS are difficult to calculate and have not been translated into financial costings. On our evidence the costs were not seen as high. The presence of MAS undoubtedly led to extra costs in terms of time spent in providing information, attending meetings and reading reports, particularly for senior officers who also served on the Supervisory Board, but this was generally seen as part of the job. The presence of MAS on collaborative studies was largely experienced as a bonus. Because MAS largely used routinely available data, the costs of supplying information were kept down. However, it also seems clear that part of the explanation for MAS being seen as inexpensive was that its work received little attention from the service.

(2) Use of Resources

4.202 A number of respondents drew attention to the expertise displayed by the MAS team. From the MAS viewpoint better results might have been achieved if the team had included a high quality information scientist. The latter could have taken on some of the quantitative analysis and freed other senior members to work at developing the personal contacts with authorities which were seen as crucial in implementing change. Similarly the team would have benefitted from more supporting junior staff. As it was, all staff had on occasion to drop their own commitments to meet a crisis or immediate need on some other project. Although MAS sought staff with general managerial or analytical skills, rather than those of any particular NHS discipline, some service respondents suggested that the studies were weakened through the absence

of expertise in community medicine. This, too, was a gap which MAS had consistently sought to fill and eventually covered by a part time appointment. The obligation to follow established NHS staffing procedures meant that MAS was unable to approach directly individuals with the relevant aptitudes. Clearly recruitment was hampered by the inability of MAS to offer any security of employment beyond March 1985. Staff were officially seconded to the team from other employment. Although this arrangement had potential benefits in terms of broadening the experience of NHS managers, it was not felt to attract those who looked for clear career paths and security.

4.203 The collaborative projects made heavy demands on MAS time because, among other factors, of the regular travel involved. When, as frequently happened, the timetable slipped, the rest of the MAS programme was thrown out of gear.

4.204 There was little perception from the service that MAS could have made more effective use of their resources. The experiment required active leadership and this was supplied by the Director. MAS undertook 27 studies in under two years and most respondents gave credit to the work that had been accomplished. Some, however, felt that the programme was too ambitious and that MAS would have benefitted both itself and those with whom it worked by undertaking fewer and more detailed studies over a longer period. Another view was that it might have avoided errors and misinterpretations of its results, with the subsequent loss of credibility, by seeking local opinion of its work from each authority involved in a draft stage. This would, however, have significantly lengthened the time scale for studies. In any case, the screening function was performed by the Supervisory Board and the team submitted drafts to others in the service who were felt to possess appopriate knowledge. The involvement of Reference Groups from the service, latterly adopted by MAS in connection with individual studies, may prove a means of meeting this criticism.

(3) Commitment to Evaluation

4.205 At the outset of the experiment those interviewed in the service had felt that efficiency was important and had welcomed the idea of help in its achievement. At the conclusion of our study respondents

indicated that all MAS studies were potentially useful in providing information and that some had proved of direct help. The most positive feelings were expressed by some, although not all, of the senior managers in one of the two regions and in those districts where MAS had collaborated with staff or attended to a local problem. It cannot be claimed, however, that by early 1984 MAS was regarded as an outstanding influence in promoting self-evaluation of performance. It had rather, along with other initiatives, contributed towards a climate where management was more ready to consider change and added to the armoury of relevant knowledge at managers' disposal.

4.206 The specific objectives followed by MAS were seen by the service as relevant to the promotion of efficiency. Majority opinion felt that, at least in part, MAS was meeting these objectives although they were general and open to subjective interpretation. If MAS were to continue, and most supported its continued existence, the same mixture would be relevant.

4.207 There was less certainty as to whether meeting the objectives had actually resulted in improvements in efficiency. In part this reflected the dependence of MAS on take up by service management. However, some respondents felt that MAS was too broad-brush and superficial in its approach and would have achieved more by concentrating more directly upon management performance.

4.208 MAS also felt that its objectives remained relevant. In the future it would hope to continue to offer an advisory service but would also wish to place greater stress on promoting efficiency by helping authorities and units and departments within authorities, to define their own purposes and the means of measuring their achievement.

(4) <u>Needs for Change Identified</u>

4.209 Given the range and detail of MAS work it is impossible to provide more than the most general indications under this heading. One recurring theme was for better use of information. Data existed to help monitor service performance, to inform planning, to suggest ways of overcoming problems and were often collected as

a matter of routine. However, they were not applied to the greatest effect. The failure to make the best use of available information was not limited to quantitative data. Far greater use could be made of staff knowledge and experience.

4.210 A second theme was for greater clarity in management. In planning, for example, it was necessary to identify the key issues facing the authority rather than plan from the partial view afforded from the perspective of individual services. A number of MAS studies drew attention to the lack of clear and explicit policies. If these are absent or vague it is difficult to know whether or not service are efficient.

(5) Establishment of Criteria

4.211 MAS sought to apply criteria that, for the most part, were already available to the service in the form of data on resource utilisation, processes and policies. This information could be presented to indicate comparisons between different authorities. This was perceived to be useful by some senior managers although, apart from the comparisons with other authorities, it was claimed that it did not necessarily tell them anything new.
Such information, underlined by 'league placings', could however, reinforce the perception of a problem or, in a few cases, signal its existence. However, some interviewees, particularly clinicians, were sceptical of the value of such criteria, feeling that they were superficial and/or reflected higher level perspectives. They ignored local conditions and practices which had proved to be the most efficient responses to local needs. One view expressed was that if the comparative approach must be used, it is of more value to illustrate an authority's performance over time. Perhaps it is the publication of the 'league table' that is significant. These criticisms attended the inter-regional studies but were not associated with the studies of individual districts which also frequently applied comparative criteria. Opinions also differed as to whether regional comparisons, or more specifically

comparisons between Oxford and the SW, were of value. On the positive side it was suggested that the twin regional perspective provided MAS with a varied repertoire of cases. The negative argument was that the two regions were too dissimilar to be relevant to each other.

4.212 Studies developing policy statements and accepted standards of good practice as criteria and applying data on resource levels and activities to indicate their level of achievement were at an early stage of development when our evaluation was concluded. They had not received much consideration from the service, but were perceived as promising. It can be presumed that this form of study would be relevant to members of authorities, however, our evaluation suggests that as a group they have had little contact with MAS. MAS's own contacts with the service have been primarily directed towards senior management and the latter, with some exceptions have not felt it appropriate to involve authority members in detailed consideration of particular studies.

4.213 Other developments undertaken by MAS include the formulation of a particular model of strategic planning, (considered in Part II) a new approach to measuring nurse staffing levels and the application of a computer based model for resource allocation. In these cases the criteria were developed and tested in collaboration with particular authorities. While our evaluation of the district planning study indicates that senior officers of the authority concerned were satisfied with the criteria and their application, the question of wider value remains to be seen. Criteria leading to good practice in one authority are not necessarily or easily seen as being relevant to others.

4.214 MAS also developed models for preparing planning briefs for capital schemes, for managing transport services and for implementing five day wards. Such models bring together national policies and guidelines and reports of accepted good practice to produce a framework which authorities can apply for themselves. The first had led to further consideration by regional planning staff, although not all saw it as providing an improved approach. The second, the management of transport services, had been tested in three districts and found to be useful.

(6) Capacity for Adaptation

4.215 The main needs for adaptation were predicted at the outset and have already featured in this evaluation - the service preoccupation with reorganisation and other management initiatives, the authority and accountability relationships between authorities and working with two regions.

4.216 MAS accepted that the former would make its task difficult, in that it would be harder to catch the attention of the service. Service respondents were clear that reorganisation significantly reduced the attention that could be given to MAS.

4.217 On the second, MAS had made it clear that they were not part of the accountability structure of the NHS and this view appears to have largely been accepted by the service. As a concomitant, however, MAS had to devote a considerable amount of time to negotiating with individual authorities and even then were perceived as insufficiently selling themselves.

4.218 On the third, the two regions, as it seemed in Supervisory Board discussions and elsewhere, had different priorities for MAS studies and appeared to want to use them in different ways according to their own relationship with their districts. This again, and particularly in relation to the issues of regional action on MAS studies and the distribution of the latter to district authorities, had to be resolved by negotiation.

4.219 It is also the case that the methodology employed by MAS evolved over the life of the experiment. This has been discussed in an earlier section.

UTILITY OF OUTCOME

(1) Data

4.220 Even if managers felt that MAS said nothing new, it provided a reinforcement and reminder, and many were more positive than that. Yet there were also widespread criticisms that the information was unreliable. It contained errors of fact and interpretation (although MAS was always ready to rectify these if justified, and pointed out in time) and was too general. This led to misinterpretations and perceptions of irrelevance, and criticisms that MAS failed to present and indicate the most relevant data. Staff in two district authorities believed that their own service evalutions provided information that was more readily applied and similar criticisms came from one of the regions. Reports were criticised as lacking practical suggestions for change upon which managers could act. Many of our respondents, however, saw this as a strength. The determination of new processes was a matter for local identification rather than external prescription. The former was a pre-requisite for committed change.

4.221 Some respondents expected that MAS would produce new insights from manipulating information. However, it could be argued that MAS met its brief by indicating to service managers what could be done with existing data, rather than developing more sophisticated means of analysis. After two years work MAS still saw data provision as a high priority and was proposing to offer an information service to the two regions, collating and updating the data that would furnish authority profiles.

4.222 A general criticism, expressed most strongly at regional level, was that none of the MAS approaches focussed sufficiently upon processes of operational management. To the extent that this was the case, it can partly be attributed to problems of promoting MAS work with staff at the operational level. MAS were aware of this demand and saw it as a future strategy to aid managers at all levels of the service to define their objectives and measure their

achievement. It was argued, however, that this work required a fundamental change in approach, away from rapid, broad-based statistical studies, to longer more detailed qualitative work that would provide detailed recommendations for change. It must be a matter for speculation whether such studies would have overcome the contextual obstacles and gained any greater attention from the service.

4.223 Differences over the relevance of information are common in organisations and likely to be serious in the NHS given the number of different levels and disciplines with their own values and standards. As Harrison writes (3) with reference to manpower planning data, quantitative norms and standards appear objective but are in fact subjective and constitute value judgements. They provide an illusion of neutrality and therefore avoid confrontation with the true political nature of decisions. Significantly, such differences in interpretation were minimised in the collaborative studies where MAS was better able to engage and negotiate the political meanings of information.

(2) Changes in Planning

4.224 MAS has been instrumental in changing planning systems and processes in those authorities with which it has collaborated on developing planning. It still remains to be seen how far the models thus developed will be taken up elsewhere. In its approach to planning MAS stresses the crucial importance of planning to authority activity and hence the need for it to involve senior management and authority members. It also stresses planning as an open activity drawing upon wide sources of information and experience rather than as the preserve of a discipline or limited service group. It can be seen from the studies on planning reported earlier that even in the special conditions of collaboration these conditions were not fully met.

4.225 However, if MAS is to be judged a success all its studies should potentially be instrumental in changing the content of plans across the two regions. It is too early to judge if this will occur. Certainly some respondents felt that particular studies had led to change in the content of their plans. If MAS is successful in stimulating a climate of change in the service this cannot help but be ultimately reflected in planning.

(3) Changes in Operational Efficiency and Effectiveness

4.226 It proved impossible for either the researchers or their respondents to disaggregate the contribution made by MAS from that due to other forces. This was consistent with the objectives of the experiment. MAS aimed to change managers' attitudes, making them more informed and questioning. Its influence would, therefore, be indirect. At the strongest, studies provided 'new truths' or a catalyst; the reports providing a source of creative tension. But more probably the studies reinforced managers' own feelings or messages from other sources. Studies were most likely to receive attention if they touched upon acknowledged problems or publicised that an authority's level of performance was below the standards of its neighbours. A much smaller number of respondents saw MAS studies as directly instrumental in promoting change and the example most cited, Units of Medical Time, gained salience because it was the subject of new DHSS requirements.

4.227 Our evidence suggests that MAS faced two problems in seeking to engender change. The first was one of the context. MAS was a time limited experiment. It had to make its mark quickly, publicising its existence through studies and other means; testing and developing a range of approaches and generally becoming known to a service pre-occupied with other demands. MAS had predicted that its work would led to tension and encounter resistance. On our evidence MAS was indeed seen by some as superficial and general and/or irrelevant. MAS were 'jacks of all trades', lacking the specialist expertise looked for from advisers. MAS felt that such criticisms were inevitable but that its strategy had 'paid off'. MAS had produced work that was seen by the service as useful in unpromising circumstances.

It had in fact already been instrumental in promoting considerable change and in the process had become known. As a result it had gained a degree of acceptance in the service. MAS could now assist organisational learning and was positioned to influence change at a greater rate; a claim supported by increased demands from the districts and a general upsurge of interest from the service. From this perspective the results achieved were consistent with expectations. Two years was too short a time scale for evaluating MAS's ability to promote change.

4.228 The second problem is rooted in the structure of the NHS. Change is a political process and it is a characteristic of the NHS that considerable political power resides with the professionals at the operational level. If, then, administrative preoccupations mean that MAS work does not readily reach the operational level for consideration nor does it make use of criteria or standards that are readily accepted by staff working at that level, the potential for promoting change is reduced. In this context, MAS is further weakened because authority members who might normally be expected to arbitrate between professional and administrative interests have, as mentioned earlier, a minimal knowledge of MAS work. The use of Reference Groups of practitioners in connection with particular studies may provide the latter with patrons committed to its recommendations and willing to expend energy in promoting change within the service.

(4) Dissemination of Good Practice

4.229 This constitutes one of the specific objectives of MAS and dissemination is an important stage in all the studies. Some studies, such as the reviews of management processes, brought conceptions of good practice together and MAS has also produced an abstract of efficiency measures developed by different authorities in the two regions. Studies focussing on specific district problems were partly selected on the basis that they were likely to highlight good practice that was relevant to a wider audience. However, to date, as has already been said, the service has not felt able to devote much attention to MAS studies unless they are clearly related to a problem experienced by their own authority or show that one exists through their use of comparative information. Staff, too, are sceptical as to the value of good practice developed in other contexts.

4.230 MAS has consistently worked to improve procedures for disseminating its work and the service has,perhaps belatedly, begun to follow suit. MAS, too, believes that there will be more mileage in developing personal contacts rather than relying upon the, often lengthy, written word. As more work is done for, and in collaboration with individual authorities, so, it is argued, MAS will become better known and its work will receive greater attention.

(5) Changes in Industrial or Professional Relationships

4.231 This could be claimed for the collaborative studies. Thus the study developing the district strategic planning process required NHS planners to work with a wide range of staff from inside and outside the NHS in formulating the key issues facing the authority. The similar exercise at regional level was intended to bring together regional planners with a range of staff drawn from the districts for the same purpose. Wider participation, claimed MAS, would improve the planning process and secure greater commitment to the results.

4.232 On the evidence of the two studies evaluated it must remain uncertain as to how great a change occurred, for many of the planners saw themselves as working in an open participative way in their former processes, and, to the extent that it did, whether it was beneficial? Respondents in the district study pointed to fractured working relationships and wide and open discussion was not seen as necessarily leading to consensus, let alone commitment.

4.233 More generally, MAS sees itself, and is seen by some respondents in the service, as changing attitudes. It is concerned with the climate of the NHS, not its daily weather. The use of terminology is significant; climatic change only becomes apparent over a long period of time.

(6) Changes in Consumer Expectations

4.234 MAS has had little direct contact with groups representing consumer interests. The CHC Secretary was involved to a minor extent in the district strategic planning study and CHC members attended the final planning forum. In early 1984 the SW Regional Association of CHCs approached MAS to undertake a study of the Organisation of Out Patients Clinics. The subject was approved by the Supervisory Board. However, it seems unlikely that the CHCs will be treated as the clients for the study or much involved in the provision of information.

4.235 At early discussions of the Supervisory Board it was agreed that since MAS studies were likely to contain sensitive information, wide publication could result in authorities and their senior managers experiencing pressure and criticism. If studies were seen as a threat, they were not likely to receive rational consideration. Interest groups do not, therefore, usually have access to MAS work, let alone have their expectations changed. CHCs receive copies of digests of studies and bulletins. They can, if they so wish, request copies of individual reports. A few have done so, but, with one or two exceptions, CHCs do not appear to have used MAS studies as a source for exerting pressure upon their own authorities.

(7) Influences of Context

4.236 During the period of the experiment, the NHS has coped with reorganisation and experienced a leap in the emphasis placed upon economy and efficiency in the context of accountable management; largely as a result of central initiatives. The new and turbulent context has raised questions for MAS. Over the period of the experiment it has meant that the service has been preoccupied, restricting the attention available for MAS. MAS and some of our respondents in the service feel that this problem was foreseen and has largely been surmounted. Indeed, the focus upon efficiency within the service had emphasised

the relevance of what MAS had to offer and made its independent, advisory, non-authoritarian basis more attractive. Others read events differently feeling that little had been accomplished and since authorities have developed stronger mechanisms of accountability, so activities to promote efficiency are more productively located within the NHS structure.

A brief summation of the major conclusions drawn in the Evaluative Framework is provided in Chapter 6.

REFERENCES TO CHAPTER 4

(1) MAS, An Interim Report, November 1983.

(2) A. Delbecq and S. Gill, Political Decision Making and Program Movement, in Translating Evaluation into Policy, (ed, E. Rich), Sage, 1979.

(3) S. Harrison, The Politics of Health Manpower, in Manpower Planning in the National Health Service (eds, A. Long and G. Mercer), Gower, 1981.

CHAPTER 5

WESSEX PERFORMANCE REVIEW

The Brunel Research Team's Approach

5.1 The work and impact of performance review were evaluated over a two year period, Spring 1982 to Spring 1984. Over this period the researchers interpreted their task as being to:

(a) monitor the progress of the experiment, principally through contacts with the Regional Performance Review Group and access to the documents produced on performance review;

(b) gain an understanding of the perceptions held by NHS staff and authority members in Wessex of the objectives, process and impact of performance review, both in connection with particular reviews and in general terms;

(c) make their own assessment of the logic and value of performance review in the light of their knowledge of its work and of theories of evaluation and strategies of organisational change as discussed in Chapter 3.

5.2 The Brunel team's approach was determined in part by the limited resources and time scale of the project. The team ultimately selected for detailed study three out of a total of nine performance reviews, and, as a result, worked in seven out of ten districts in the Wessex Region. The date fixed for the completion of fieldwork was April 1984. By that time, no measures were available of the outcome of reviews; the first cycle of most was not yet complete. The first measures of outcome were expected by the Region to be available by July 1984.

5.3 The report is, therefore, primarily concerned with issues of the planning, conceptualisation, design, implementation and efficiency of process of performance review. Evidence about the efficiency and effectiveness of outcomes of performance review is as yet sparse. The evaluation is presented in three sections:

Part I - An Outline of Performance Review
Describes the conceptualisation of performance review, its organisation, staffing and the mode and range of its work during the period of study (paragraphs 5.4 to 5.14).

Part II - Main Empirical Components of the Study
Describes the initial perception of the role and value of performance review held by a range of role holders at region, district and unit levels, interviewed between Spring 1982 and Autumn 1983. It reports on the three reviews studied in detail and describes implementation, impact and commitment as perceived by participants interviewed in the first few months of 1984 (paragraphs 5.15 to 5.149).

Part III - Evaluation
Assesses performance review within the evaluative framework developed in Chapter 3 (paragraphs 5.150 to 5.180).

PART I

AN OUTLINE OF PERFORMANCE REVIEW

5.4 The Wessex Performance Review Scheme was initiated in April 1982, as part of the two year national trial of Management Advisory Services. However, as a result of its work on the Regional Monitoring Policy, Wessex had been planning to introduce systems of reviews of performance since 1979: an initiative quite independent of the national trial.

Objectives

5.5 We have seen that the national trials were intended 'to explore the value of establishing an independent source of advice (emphasis ours) to the district and regional health authorities on the efficiency of their services.' (1) But the Wessex Performance Review scheme was designed to test a contrary proposition: that 'health authorities are capable of systematically reviewing and improving their own performance without outside interventions.' (2)

5.6 Performance Review was to be a 'systematic way of examining the performance of health services. It is undertaken by management to maintain or improve the quality of health services for which it is responsible.' (3) Individual Performance Reviews were to be examinations of the performance of particular services in districts. Reviews were to be voluntary and to be managed by districts within a common regional framework. They were ultimately intended to become part of the regular workloads of managers at all levels using a minimum of information additional to that currently available.

5.7 The title Performance Review seems to have been adopted only when the proposal for participation in the trial was put before the RHA in January 1981. The concept was explicitly developed out of the work done (in particular by the Regional Administrator and the Head of the Management Services Unit) and lessons learned from the Regional Monitoring Policy between 1977 and 1979. Monitoring had been seen as 'a vital component of management' and monitoring

programmes were to be 'capable of being used with ease as part of the routine work of managers and authorities.' (4) Success was dependent upon systematic collaboration between authorities at different levels and explicit agreement upon policies and standards of service. These ideas were taken up by a small regional steering group concerned to promote the philosophy enunciated in Patients First of developing local management and were transplanted into performance review. Two shifts of emphasis were, however, made in formulating the objectives of PR. First, it was to be a systematic method of examining the effectiveness (not simply the efficiency or inputs and processes) of the services: the primary objective was to improve the quality of health services and outcome criteria such as the health state of patients and patient satisfaction would be established where possible. Secondly, although each authority was to review its own services, reviews in the regional trial were to be designed so that they could be adopted by other districts relatively easily. The aim of this was economy of effort. It was hoped that districts would continue the reviews after the experimental period as part of routine management. Remedial action would thus be built into performance review in the sense that reviewers and managers of services were to be the same. PRs would not be concerned simply with the creation of potentially inert data and information but would directly inform behavioural change. By the same token, PR was seen as an educational movement disseminating attitudes as well as information.

Organisation

5.8 Because performance review was conceived of as a tool of district management, additional institutional structures were to be minimal. The roles of the region were those of enabler, catalyst and co-ordinator. The main machinery for carrying out these roles was to be the Performance Review Group (PRG) a multi-disciplinary group established for the trial period, 'to assist districts in carrying out reviews; and to co-ordinate the overall performance review programme, and to advise the RTO and RHA on its progress.' (5) There were to be three core members of the PRG, a specialist in community medicine, a nurse and an administrator who was to act as the overall co-ordinator of performance review. These three members were to be supported by other specialists.
Originally they were to have had a multi-disciplinary steering committee with representatives of each DMT in the region. This

was to reinforce and reflect the concept of a district centred enterprise. However, when participation in the national trial was agreed, it was decided that the Performance Review Group should report to the existing Regional Monitoring Committee, to reflect regional responsibility for the operation of the trial.

Staffing

5.9 For most of the period of our study, the core membership of the PRG comprised a specialist in community medicine, working part time, and an administrator. There were three different nurse members of the group but in Autumn 1983 it was decided not to have a permanent nurse member. Instead the RNO was to act as adviser to the group on nursing matters. A health economist was then appointed as a third member. The support staff of the PRG changed over time as the PRG clarified its role and adapted to changing demands. Appointments were made to the Management Services Division and to the Statistics Department to compensate for support given by these departments to PR activity. The annual budget for performance review, £70,000 (excluding the salaries of the PRG staff), reflected the minimal role intended for the region in performance review. The PRG had no full time secretary and only one office. The aim was to demonstrate that the improvement of management performance did not need the input of either external resources or substantial internal resources.

5.10 It was originally envisaged that each performance review would have its own regional professional leader. This was to be 'a selected individual or small group of members of the relevant profession' who would provide 'professional leadership in the design and implementation of reviews'. (6) However, responsibility for the management of reviews was to stand with the DMT which was to appoint a District Co-ordinator for individual reviews. Thus district autonomy was to be married with professional acceptability and applicability beyond district boundaries. Professional leaders and district co-ordinators would together form project groups for the design and implementation of individual reviews. In the case of the care group reviews, the concept of regional leadership was abandoned in favour of involvement of the appropriate regional speciality advisory committee.

Mode of Working

5.11 Performance reviews were to be embarked upon only if at least two districts decided that a review would be valuable to them. Thus the principle of self-review by districts was combined with the aim of generalising the process. In the event, two reviews were effectively carried out by one district alone. Varied patterns of managing reviews emerged in the course of our study. The PRG and professional leaders took different roles, as reviews differed in the degree of centralisation and cross-district and cross-discipline collaboration.

5.12 The intention was that all reviews would consist of three stages. At the design stage, policy objectives of the service under review were to be defined, criteria and measures of performance determined and systems for collecting data established. In the second, implementation stage, data were to be collected and information processed. In the third, review stage, districts were to determine the action to be taken on the information gathered. Action and decisions about further review were built into the process. These were to be the responsibility of DMTs and DHAs. In other words, decisions upon review were to stand with the districts and to be voluntary, although performance review was seen potentially as a means of institutionalising and clarifying policies and objectives across the region.

Range of Work

5.13 The programme of reviews began in the summer of 1982, following preparatory work by the Performance Review Group. Initially, seven reviews were established of two main types of service: four of services for specific care groups (maternity, elderly, young physically disabled and accident and emergency) and three of support services

(catering, estate management and ambulance). In the autumn of 1983, two further reviews were set up of supplies and patient reception services. Districts opted into varying numbers of reviews, from one to six. In the case of two reviews further districts joined after the reviews got underway. Other districts dropped out at an early stage of reviews.

5.14 At the time of the start of the trial in April 1982, the PRG was still clarifying the conceptualisation and function of performance review, and structural arrangements were not settled until July 1982. At the same time, the PRG had rapidly to begin its work as a catalyst for performance review and as enabler and co-ordinator of the work to be done. Performance review had actively to be sold to the districts and this was done both through DMTs and DHAs and down the functional management line. The division of time to be spent on encouragement to the districts to take on performance review as a tool of management, on publicity for the work being done in reviews, and on enabling and co-ordinating individual reviews was an issue for the Performance Review Group from the beginning.

PART II

THE MAIN EMPIRICAL COMPONENTS OF THE STUDY

5.15 The research team undertook field work in the Wessex Region in four main stages. The first, begun in May 1982, was mainly an attempt to clarify with the region the overall objectives of performance review, their relationship to national objectives for management advisory services, and the institutional arrangements for implementing performance review. At the same time, the team formulated and gained agreement for a programme of work in districts. They selected for detailed study two performance reviews: those of catering services and services for the elderly. These reviews involved six districts in all. It was agreed later that the accident and emergency review would also be evaluated; this brought a seventh district into our study.

5.16 A second stage began in January 1983 and entailed work with the four districts participating in the catering review and the regional professional leader of this review. The team had two purposes at this stage: to interview individuals and groups at district level about their general expectations of performance review and to follow the first stage of the catering review. For resource reasons, the team decided to make a detailed study of this review in two districts only. This meant interviewing key participants at district and unit levels in these authorities about their understanding, expectations and experience of the review process. In the remaining two districts, they aimed to get an overview of the process.

5.17 A third stage of work was begun in December 1983 on the performance review of services for the elderly. At this point, too, the review on accident and emergency was added to the study. Work on both these services entailed interviews at regional level and with the two participant districts in each case.

5.18 A fourth stage of work began in February 1984 to assess the impact of performance review. It was conducted at regional, district and unit level, and was concerned with perceptions of the impact of performance review in general, as well as of these three reviews in particular.

5.19 Interviews throughout the study were semi-structured. They were based upon and supplemented by analysis of documents about performance review in general and those produced for these three reviews in particular. Some study was also undertaken of documents produced for other performance reviews. In all, a total of 61 individual interviews and 17 group interviews with 79 members of staff and authorities was undertaken.

INITIAL PERCEPTIONS OF THE ROLE AND VALUE OF PR

5.20 During the first two stages of the project, then, the team worked at region and in the four districts participating in the catering review. We now report on the initial expectations of the newly introduced concept of PR, as perceived by its creators, by the regional PRG, and by members of the DMTs and UMTs in these districts before we give an account of three reviews studied in detail. The material that follows derives from four group meetings (including one DMT meeting) and 12 individual interviews with a total of 20 staff.

The Region

5.21 Regional thinking in developing PR contained a number of strands. The improvement of health care was seen, particularly by administrators, as crucially dependent upon changed conceptions of and behaviour by managemement. Managers, and particularly members of DMTs and UMTs, had to understand and accept that they held responsibility for the overall running and development of services. This meant a shift from crisis management and problem orientation to the determination of clear policies and explicit standards, backed up by reliable and relevant information about inputs, processes and particularly outcomes of their services. Managers had to develop the habit of systematic and continuing analysis. They had also to direct their thinking and action towards performance, that is performance of services and not the work of individual role holders.

5.22 A doctor outlined parallel changes in attitude already occurring among clinicians which contributed towards the conceptualisation of PR. There was a move from practitioner empiricism towards a more scientific approach: a closer identification of objectives and attempts to develop technologies for clinical audit. Even if clinical audit itself would be excluded from PR clinical organisation would not be. Clinicians would be fully involved in the PR of care services. Performance review was seen as an opportunity for nurses, too, to think about objectives and to move into qualitative issues by starting from quantitative measures of care.

5.23 At regional level, performance review was perceived as institutionalising and focussing already identified general objectives. Pressures on resource allocation had sharpened attitudes in a region strongly committed to rational planning,

monitoring and evaluation. In PR the value of these institutions was reinforced, but as a means towards the overall objective of better outcome.

5.24 However, even amongst the architects and protagonists of PR, there were different views about the scale and feasibility of its objectives. One respondent thought that reviews, at least of the more complex care group services, would need to be focussed by problems, even if these were broadly conceptualised. This respondent also thought that attitude change was an important objective while others at region were more sceptical of its relationship to outcome. Another thought that only limited behavioural change could be expected from those responsible for services who were primarily professionals rather than managers. Systematic change by such groups could not be achieved without more rigorous task analysis of services and more structured participation and support in the review process than was envisaged.

5.25 However, if views varied about the extent of potential for change in PR, there was a general perception at regional level that PR was an improvement on monitoring because it provided for remedial action within and by district and unit management. There was strong, if not unanimous, commitment to the voluntary principle of PR and a belief that this, together with collaborative procedures for the design of PR, would promote systematic rather than uniform reviews. It was hoped that a framework had been created which allowed for the diversity of district traditions, patterns of service and needs. For performance review was conceived of as essentially district-based and district led.

The Districts

5.26 Not surprisingly, as our studies moved from the originators of PR and the Performance Review Group into the districts, perceptions of PR became more various, less clear and often less sympathetic.

5.27 We have already noted that district participation in PRs varied widely. Of the four districts with whom we worked in the first two stages of our project, two opted to join one review only (catering), a third committed itself to two, but one of these, in the event, it carried out on its own. The fourth worked on two reviews and one aspect of a third.

5.28 Districts' reasons for low participation in PRs also varied. In one district it seemed consistent with an emphasis on a development role rather than any comprehensive conception of management. In the others it was attributable to the development in the DMTs and DHAs of their own philosophies and institutional arrangements for better district management. One was developing its own strategic approach to information, planning and management. The other was committed to a more interactive and dynamic philosophy of management in which service change would be practitioner led and authority members and consumers, too, would actively participate in the processes of review and change.

5.29 Understanding in district and unit management of the regional concept of PR was highly variable. Only one DMT had systematically discussed it since reorganisation in 1982. In another, by contrast, only two members had a clear understanding of its nature and purpose. At unit level too there was confusion, in particular between performance review and performance indicators. The exercise was predominantly seen by district and unit management as regional and, even if not explicitly regarded as low priority, as in competition with other priorities. The key objectives, management's appraisal of its own services and the improved effectiveness of those services, were not universally identified. One respondent thought that PR had irreconcilable objectives: cuts and more economic use of resources as against improved standards of service. Others, however, focussed more on PR's contribution to efficiency and process: its potential to reduce costs, to identify waste and gaps in services, to clarify policy and to develop performance indicators. Two respondents, while aware of such potential, also considered other mechanisms might be more effective. One administrator with few expectations of PR thought it was intended to produce proposals that would

improve the standard of service and produce cost efficiency. Others, including those critical of 'normative planning' thought the objectives were to evaluate standards, to identify a norm and perhaps measure the shortfall between the norm and its achievements. A nurse thought the objectives would be to enable there to be a look at existing services, 'to take them apart', analysing costs as against quality, thinking about ways to use manpower. It might help to promote centres of excellence but, more important, to establish general improvements across the whole range of services.

5.30 Two of the features strongly pressed at region, district-centredness and the incorporation of management change in the model of PR, were almost entirely absent from the perceptions of district and unit management in these four districts. PR was predominantly perceived as a regional exercise in norm setting, although some understood its emphasis on outcome.

5.31 It was generally appreciated that, unlike monitoring, PR was a voluntary exercise. One administrator thought it an improvement on monitoring on the grounds that its scope would extend to the organisation of clinical services (although this was in fact part of the monitoring system but with a low profile). He and others expressed the view that this and clinical outcome constituted the area of work in greatest need of review, study and change. But those who discussed these issues did not think that PR would have much impact upon the clinical services. One said that its contribution would be one among a number of current initiatives (for example, specialty costing, clinical budgetting, performance indicators), the distinctive influence of which would be difficult to identify.

5.32 There was general, though not unanimous, support for PR as an 'in-house' rather than external institution. There was, however, support from one DMT member, with a clear understanding of PR, of an external Management Advisory Service. He thought that standards set and judgements made would carry more weight if they were more objective. He also thought that PR could only work if the district, rather than the managers or professionals of the service

under review, drew up the rules or frameworks for the review. This view is linked with important ambiguities that emerged more strongly in the course of the study. Regional staff stressed the importance of managerial self-review and of PR as an instrument for change in district management. However, these two notions might be in conflict. The more intense the review by professionals and functional managers of their service, the more its language, objectives and standards might be obscure to district and indeed, other service management. Some district management teams certainly encouraged this possibility by total delegation of responsibility for the catering PR to caterers, although two second line district managers felt that PR could potentially contribute to corporate management decision making.

5.33 Perceptions of PR's objectives were often coloured by views about the choice of catering as an area for the exercise. It seemed to some to be an area in which the norms were relatively easy to establish, where most work had already been done, where benefits of review were more easily transferable, and where the organisation of the service made it possible to run a PR with less difficulty than those areas where institutional and substantive factors made review more difficult. These perceptions made it the more possible for non-catering staff at district and unit level to assume that the catering PR, and its objectives, were matters determined by the region which could be safely left to functional management, namely, the catering professionals, to get on with.

5.34 In sum, early perceptions of PR showed a divide between region and the districts. The regional conception of PR was not generally well understood at district and unit levels of management. In particular, the notion that PR was an institution of and for districts had not taken root. Moreover, the idea that fundamental change in managerial attitudes and behaviour might be achieved through a regional initiative was put under question. Some districts were developing their own ideas and taking their own initiatives; in another case, PR was still a largely submerged and ignored regional exercise.

THREE REVIEWS EXAMINED

(1) Catering Performance Review

5.35 This was a review of patient food services, undertaken first by four districts, and eventually a further five out of a total of 10, under the professional leadership of the Regional Catering Officer (RCO). Our evaluation undertaken in the original four districts, involved the following:-

meetings with regional officers concerned with performance review in general;

three meetings with the Regional Catering Officer;

a total of six interviews with two District Catering Officers;

three interviews with two District Catering Co-ordinators;

four meetings with three Unit Administrators;

two interviews with three Unit Directors of Nursing;

two individual and two group meetings with a total of nine Unit Catering officers;

in addition, meetings were held to discuss the catering review within the context of performance review more generally with a total of 19 District Administrators, Treasurers and other members of administrative and related staffs in four districts, totalling 17 individual or group interviews;

one interview with a dietician;

interviews with the Chairman of the Regional Monitoring Committee and one District Authority Chairman and a DHA Member on both the catering PR and its wider implications.

5.36 The review is considered below under the following headings:-

Expectations Entertained of the PR;

The Roles and Structures Implicit in it;

Methodologies;

Perceived Benefits;

Implementation and Dissemination.

Expectations Entertained of the PR

5.37 We have already (see paragraphs 5.21 to 5.34) described the expectations held of PR by administrators at regional, district and unit levels. As far as region, district and unit catering managers were concerned, there was strong consensus about the original objectives of PR. The regional catering emphasis upon improvement through setting clear objectives, standards and measurements of performance and thus pinpointing weaknesses in the service was understood and accepted. Regional views about the need for unit administrators to take hold of their co-ordinative responsibilities were reflected in district and unit level catering expectations that PR could identify the interdependence of catering and other services in achieving good performance. Some hopes were expressed that problems peculiar to individual hospitals would be better understood but there was also general commitment to the need to measure standards against agreed norms. One Unit Catering Manager, whose service had a high reputation, stressed the importance of making performance public and the potential for change deriving from more reliable and detailed knowledge of performance. District catering managers saw PR as an opportunity to review their own work and the services delivered and this aim, that managers should review themselves, was perceived at unit level too. The process of measuring standards of performance, by peer review from professionals who knew the service, was also strongly supported against the notion of an external advisory service.

5.38 The general consensus about and commitment to the objectives of PR amongst catering managers were congruent with a more general impression of this functional management group. Regional leadership was strong, charismatic and built upon a decade of work on standard setting. Commitment had been generated not to an abstract notion of outcome but to good patient food and to the contribution it could make to patient care. The experience of PR and, more particularly the politics

of privatisation, might have generated doubt about the carrying through of objectives, but confidence in the regional and district functional managers seems to have been sustained.

5.39 A more opportunistic objective also emerged as other districts joined the exercise: it was necessary to prepare comprehensive and accurate specifications of both cost and service prior to putting the service out to tender. PR was an excellent way of tackling this task.

The Roles and Structures Implicit In It

5.40 The structure and role relationships of the catering PR emerged as distinctively different from those of other PRs. The Performance Review Group at region was mandated by the Regional Team of Officers and the Regional Monitoring Committee to encourage and help districts to review their services under professional leadership. But there was a previous history, in the monitoring system, of Wessex catering services being led in a strongly functional structure by the Regional Catering Officer. He had already established models for improving food services to patients both in his work at region and through various publications. (7) The performance review now caused him to extend and deepen the process through a strong collaborative network of those in the same functional line as he, namely, the district catering officers and the district catering co-ordinators. Whilst this structure in no sense restricted the strengthening or emergence of professional management in catering at the district level, it was a collective enterprise led by somebody with whom the district catering officers formed a strong network. An important reservation to this pattern should be noted: the catering PR also incorporated a non-line relationship, namely that which now grew up between caterers and dieticians who participated in the PR.

5.41 This combination, however, of managerial structure with strong professional functional arrangements is likely to be strongly modified by the 1982 reorganisation and by the implementation of the Griffiths Report. More authority will be delegated to the units and corporate management will be emphasised at each level at the expense of functional management. It is not clear whether this will enhance or reduce the ability of professional leadership to emerge at operational levels.

5.42 A further aspect of structure is that whilst senior regional administrators spoke of PR as being a way to ensure that policy making was developed corporately, the catering PR, apart from its connections with the dieticians, was not engendered jointly with such other groups as nurses or those responsible for domestic, cleaning and portering services, although there had been some interdisciplinary work in the previous regional monitoring exercise.

Methodologies

5.43 The design of the review was based on a series of hospital performance assessment packages, setting out explicit standards for 12 selected aspects of the service together with methods of measuring performance. Assessment was to be carried out by a review of existing information, by visits to hospitals by independent assessors and by questionnaires. Hospitals were selected for assessment by district managers. Performance in these hospitals could be measured against six of the 12 aspects of the service to provide a standard evaluation of 'safety, quality and value for money.' (8) Performance review of the other six aspects was intended primarily for the largest hospitals and for those catering for 'at risk' care groups. Incentives were built into the design: hospitals achieving good performance ratings in hygiene, nutrition, food care (menus, cooking, service), all process measures, and patient satisfaction, an outcome measure, could apply for Wessex accreditation and a star rating. The procedure was derived from American accreditation processes.

5.44 Performance ratings were to be expressed numerically using ratios and percentages and reported in hospital and district digests, with commentaries interpreting the digests and summarising action required to improve performance.

5.45 The usefulness of the methodology cannot be fully assessed until results of the first review have been seen by district catering officers and district and unit management. The reports as seen by the evaluation team, however, appeared to be systematic, consistent with the objectives set for the performance review, and capable of uncovering causes which underlie problems. For example, the exercise on the nutritional aspects of catering was able to show several reasons why patients were not receiving appropriate diets. The study is now moving to assessment of outcome, that is of the resulting nutritional status of patients. A study of patient food waste - cooked meals - showed that ward food waste ranged from 10% to 51% of cooked food issued to wards as calculated in value and not weight. It identified the different types of waste and the causes of waste. It proposed action to reduce waste. It pointed out the need for nursing as well as catering staff to participate in efforts to reduce waste. And it uncovered the inadequacy of information on patient food costs. For example, reports of expenditure on patients' food in district cost statements were thought to be inaccurate in 16 of 19 hospitals surveyed.

Perceived Benefits

5.46 Almost every catering officer interviewed at all levels had found PR valuable. Where doubts were expressed these related largely to particular circumstances in which PR might not be useful. Caterers liked the idea of assessment by professionals from outside their own authority. They felt that it enabled them to find out what was going wrong and that the exercise also identified what was well done. They appreciated the on site assessment exercise. This enabled there to be informal contact with other experienced professionals, who had, as part of the assessment process, talked to patients on the wards. The exercise had made it possible for there to be a really

detailed analysis of the work leading to specific identification of problems and causes. Both external assessment and patient questionnaires had caused managers to think more carefully about the detailed operation of their services. The PR analysis had enabled issues to be raised for the attention of nurses and other staff, by virtue of the fact that the PR was undertaken by external and district management. The limited extent to which this initiative was taken further by catering managers themselves is noted later. They saw PR as an exercise that could be universally applied in catering. They expected it to become a regular feature of catering management in the district. It would be valuable for new managers coming into jobs where there were people entrenched under them and it would strengthen arguments against resistance to change. There would be an authoritative statement of regional standards and on how the district stood and clear information about how things were working. Within this context, therefore, PR seemed to respond well to a functional line of management.

5.47 The main reservations expressed by those interviewed about the effectiveness of PR were of two kinds. First, there was some critique of both its concept and methodology. Secondly, there were reservations about its location within broader institutional settings and problem solving. These criticisms, however, were made in the more general context of the whole notion of performance review and were not exclusively directed to catering. The specific issue concerning catering was the extent to which it was locked within one profession, and therefore reinforcing those forms of normative planning which might not be capable of corporate negotiation and adjustment. A further point was not so much a criticism as a reservation about generalising from catering to other experiences: catering and diet might be capable of generating concepts of adequate performance which could be transferred from one unit or district to another. In other services, however, where individual patient care and practitioner prescription of it were more individualised, the creation of general indicators or precepts would prove to be less appropriate.

Implementation and Dissemination

5.48 The evaluation of how far recommendations arising from PR have been implemented is not possible at this stage. As a result it is not possible to identify the extent to which the exercise differs from that of monitoring. The timetable of the first review was much extended and its results had not been fed back to districts at the time when we were completing our fieldwork. Later (in July 1984) some of the results of different studies within the performance review had percolated to parts of the system.

5.49 If, however, no full analysis of outcomes of PR is possible, it is feasible to infer from the analysis of process certain institutional characteristics of the catering performance review which are already thought by some interviewed to affect the likely outcome.

5.50 The catering PR was conceived by non-catering staff who might have been implicated in the process as an exercise that was both regionally led and determined and contained, for the most part, within one professional line of management. Two consequences were thought to result. The first concerned the chances of implementation across disciplinary or service lines and the second the extent to which the exercise would meet the objective of strengthening professional perceptions and actions at the district level.

5.51 On the first of these issues, interdisciplinary working, the virtual containment of the exercise within catering, with the exception of dieticians and of those concerned with performance review at region, meant that no impact was perceived, or thought likely, beyond the domain of catering itself by those who had not been directly involved in the exercise. But those who had been involved, namely the caterers, eagerly looked forward to issues concerned with the transport and serving of food and the administration of good diets being taken up by their neighbouring services, namely, nursing and domestic services and portering.

5.52 On the positive side the methodology employed was strong in that it moved into qualitative measures of efficiency and, to a significant extent, of outcome. The digests contained clear recommendations for action. The catering PR sharpened the perspective of caterers that they were involved in basic issues of health care for patients. The PR had been concerned with nutrition intake by patients. It was scheduled to incorporate such other aspects as the contribution of catering to the training and independence of long term institutionalised patients although these had not as yet been pursued. Were this to happen, further impetus might be given for inter-professional working and institution building. Given that the studies that were made tended to show that the delivery of catering services was having an adverse effect on the nutritional status of patients, some later effect could be expected.

5.53 But if caterers had looked forward to working more closely with their colleague disciplines, they could not report much development of that kind, except with dieticians.

5.54 The second issue, of the institutional patterns involving region, district and unit goes deeper into the philosophy of PR. The region had hoped that it would provide leadership and give the opportunity through which the districts would voluntarily embrace the notion of performance review and thus sharpen both the professional and the corporate leadership in improving performance. Because of the functional leadership exercised by the region, district and unit catering management was fully involved in the processes of performance review and implementation within the undisciplinary frame could be expected. But the move towards corporate or multidisciplinary commitment began to occur less systematically. This was partly because involvement of regional officers outside those working in the Performance Review Group and the Regional Monitoring Committee did not take place. None of the district management teams' members whom we consulted expressed strong commitment to either the concept or the process of performance review, at least in the catering setting.

5.55 Yet as we were completing our field work more direct evidence of district management take up of PR results became evident. One second line administrator had received first results from the exercise when interviewed. He thought these demonstrated the capacity of PR to identify problems in the service that needed intervention from corporate management. Further, he saw the potential of this kind of analysis of performance for other services. Possibly, therefore, the perceptions of others may be changed as results are actually fed back to them. As our report was being written and reviewed by regional and district participants, more direct evidence became available. Two districts decided to set targets on the basis of data gained from the catering performance review.

5.56 The Regional Catering Officer could identify the ingredients of the catering PR that would give impetus to change. Unlike regional colleagues he did not believe that PR should be voluntary to districts but, granted that it was, he believed that the process of accreditation lent incentives to managers, although usually only the 'good' catering managers. He felt that when such aspects of the PR as the nutritional intake of patients emerged, these might recruit the support of medical staff to the process of analysis. He also believed, in common with others interviewed, that particular problems might give stimulus to performance review. In this case, the need for caterers to analyse costs and processes so that specifications could be made against the eventuality of privatisation had concentrated their minds.

5.57 We shall return later to the question of how far institutional frameworks for effective PR have been established. The case of catering, however, does evoke the notion that prior thought about the relationships between catering and other services might have established a stronger basis for both the carrying out of PR and for the implementation of its results.

5.58 Two aspects of dissemination are relevant: across district boundaries and between disciplines. Because nine out of 10 districts were involved in the PR, the cross district issue was

not prominent. We have already referred to the relative isolation of the catering exercise from both the corporate and the other disciplinary concerns at district and unit levels. But the results of the first review had not yet been fed back to districts and the degree of dissemination as evaluated at present might critically change at that point.

5.59 A further aspect of dissemination is that performance review might work not only through the distribution of reports or manuals but also through the creation of exemplars of good performance. Some types of health service units might feel that they had everything stacked against them: yet the performance review in Wessex brought to light the fact that two of the hospitals which were performing best were a large psychiatric hospital and a small cottage hospital. The partisan or exemplary uses of information are important elements of dissemination: just as unpropitious sites could house well performing catering services, so some of the best services in the region provided meals for patients at 90p a day against the DHSS norm of £1.22.

(2) Services for the Elderly Performance Review

5.60 Within an overall conceptual framework the PR exercise on the elderly consisted of four separate reviews - two major and two relatively minor. The two major studies concerned patterns of referral to and action by consultant geriatricians; and a more general review of nursing of the elderly. In addition, limited work was carried out on selected community services for the elderly, and on costing geriatric care including the use of a zero-based budgetting approach. Whilst in theory the four studies were related to each other, each proceeded virtually independently and, at least at the time of our report, had not been drawn together. The Brunel team's evaluation focussed primarily on the two main elements on which most of the effort was expended.

(A) Consultants' Review

5.61 This element of the review was carried out by the consultant geriatricians in two districts and related the services requested on referral of geriatric patients to those services actually provided by the geriatricians. Our evaluation of this element of the review involved the following specific interviews:

meetings with two of the members of the Performance Review Group at region;
a meeting with the professional leader of the review;
a meeting with the Chairman of the relevant regional medical sub-committee;
meetings with three of the participating consultant geriatricians;
interviews with the District Medical Officer of one of the districts involved. (The other District Medical Officer was interviewed within a broader remit).

5.62 The review is considered below under the following headings:

The organisation and methodology of the consultant element of the review.

The expectations and perceptions of the review.

The perceived benefits and costs.

The emerging views about PR more generally.

The Organisation and Methodology of the Consultant Element of the Performance Review of Services for the Elderly

5.63 This strand of the review focussed on the relationship between requests for, and responses to, referral of patients to consultant geriatricians. As such, responsibility for it rested firmly and exclusively within the medical profession. The proposal for medical involvement in the review appears to have come from region, with the suggestion that the geriatricians, together with other groups of clinicians, would need to begin to account for the services they were providing. Rather than have a system imposed from on high, they should perhaps become voluntarily involved. This suggestion seems to have been sympathetically received, particularly by the Chairman of the relevant Regional Medical Advisory Sub-Committee who, with the help of particular colleagues, began to consider 'what measures could be used to assess the service' and, in particular, the appropriate measures of outcome, or reasonable surrogates for it.

5.64 The first six months were devoted to the production of a document setting out the characteristics of a 'good geriatric service'. This, drafted by the professional leaders and by the clinical member of the PRG, was put to the Geriatric Sub-Committee and the Regional Advisory Committee and, after various detailed criticisms and amendments, was accepted as a model for provision. It focussed on the need for locally identified policies, relating to local conditions. The document emphasised districts explicitly setting out their own policies rather than attempting to propose a single policy for all districts. In practice, because neither of the participating districts had formulated detailed policies on the elderly, both DMTs chose to measure their services against the regional document's proposals and to use the results in the subsequent development of local policies.

5.65 Once the policy document was drafted, a survey was begun to attempt to quantify the extent to which policies were being achieved. The actual provision of service was to be compared with requests for services at the point of referral. The survey, begun in April 1983, looked at all new referrals to geriatric hospitals in the two participating districts, using a standardised referral form. The

major aim of the survey was to provide what was seen as a 'surrogate outcome measure', namely disposal location, as compared with referral location on discharge from the geriatric service. Its other aims were listed by a member of the PRG as being to:

(a) compare service provision with demand;

(b) quantify where lack of resources led to delay or failure of provision (and use in planning);

(c) quantify the delays in provision, and identify which elements were least easily provided (and used in planning);

(d) examine the other (i.e. apart from lack of resources) reasons for failure to provide and attempt to improve (local organisation and planning);

(e) provide data on the total workload of the service;

(f) provide patient-related total data, not episodes as at present;

(g) provide data to calculate:

(i) total costs of services to patients with different specified outcomes;

(ii) costs of different elements of the geriatric service, particularly where different modes of provision were available.

5.66 A standardised referral form was used to record patient details, patients' present locations, the sources of referral, the services requested by the referring doctor and the services actually provided. In addition to this routine information, reasons for any difference between requests and provision of service were recorded. Eight geriatricians were involved in recording this information on 'demand and supply' of their services. Individuals' results were to be processed at region and returned in strict conficence to the individual consultant concerned. Additionally, aggregated results for each

district were to be supplied to all members of the DMT and to unit administrators. The analysed results from the first six months' data were returned to the consultants early in 1984, although it was recognised that these first six months' results suffered from limitations which would be overcome in presenting results for the full year. Consultants received both detailed computer output in the form of cross-tabulations and a series of graphical presentations of the more interesting information, and they were asked to indicate what tabulations/analyses they would like in future. At the time of our interviews the first year of data collection was nearly completed and it had been agreed to continue for another year.

The Expectations and Perceptions of the Review

5.67 Regional officers hoped to get the clinicians fully involved in the overall review of services for the elderly - other parts of which were in the hands of other professional groups. The system was to be voluntary and as a result a pragmatic and non-threatening approach was adopted. The participation in this part of the review of all the relevant consultants from the two districts seems to have vindicated the style adopted.

5.68 The lead was taken by the professional advisers through the Regional SAC rather than directly by the consultants whose services were to be reviewed. Certainly, the professional leaders were enthusiastic about the idea - not so much in terms of the specific Performance Review System but a wider willingness to undertake and encourage geriatricians to evaluate their work. But the impression was given that the level of enthusiasm at the top did not extend to all participants, although none appeared actively hostile. Surprisingly perhaps, no great concern was indicated for the fact that this review 'strayed' very close to clinical audit: that is to say there was no real concern, given the guaranteed levels of confidentiality. There was, however, no common acceptance of 'peer review' nor acceptance that information should be passed to non-medical staff. The scope for analytic criticism was thus reduced. Rather, there was an insistence on the need for absolute confidentiality, and the view was firmly expressed that the information on individual clinicians should not be passed even to the relevant DMO.

5.69 Though the consultants were prepared to participate, few clear expectations were expressed as to what benefits might be expected to ensue from the process, or clear ideas as to how they expected to use the information. It was generally agreed, however, that the exercise was a waste of time unless the information was used, and it was frequently commented that they would find it interesting, and possibly useful, to have comparable information from other districts against which to assess the performance of their own service.

5.70 There was an interesting divergence of emphasis. Some spoke of the review as evaluating the performance of a geriatric service, whilst others spoke in terms of it measuring the performance of themselves as individual geriatricians. Some focussed, accordingly, on the implications the information might have for the balance and mix of the various elements within the geriatric service, with the focus very much on planning of physical provision. Others emphasised the questions the information raised about the way they, as individuals, handled their workload and managed their patients. This latter emphasis led naturally to questions about criteria for making domiciliary visits and for discharging patients.

The Perceived Benefits and Costs

5.71 The exercise had been set up so that it brought together the relevant data in a standard form. This inevitably created additional work in data collection and analyses.
Most of the data collection was handled by the consultants' secretaries who recorded on a regular basis the information described above, relating to each patient referral. In the early stages this involved some consultant time, particularly in ensuring that the data collection systems adopted did not miss any groups of patients. This was foremost in the mind of at least one of the consultants interviewed who noticed that the analysed information showed that not all patients had been picked up. He was concerned that if information was to be used comparatively, no systematic biases could be allowed to result from the exclusion of particular groups of patients, for example, those seen at outlying hospitals.

Typically, the recording of data relating to any one consultant's patients occupied a secretary/clerk for approximately five hours a week. Once the system was under way consultants' time was involved only in considering the results of the analyses and their indications. Thus this element of the time cost depended upon the extent to which the individual consultant chose to devote time to it.

5.72 At this early stage it was unclear how much use the consultants would in fact make of the data. Many concerns were expressed about the comparability of results from individual clinicians. Emphasis was put on local differences in service provision or population demand; on differences that resulted from consultants operating effectively within certain 'sub-specialties', or traditionally being referred particular categories of patients. This concern in case comparisons were made without a full appreciation of underlying differences implies an expectation or fear that individuals' performance would be compared, despite the reassurances that individual data were entirely confidential to the consultant concerned.

5.73 In most cases the consultants suggested that the first six months' results had not revealed any major surprises, but had generally confirmed and perhaps sharpened their perceptions of the performance of the service locally. It had clearly emphasised certain characteristics of their performance to a couple of the consultants and had led them to consider, for example, how the lag between patient referral and their making a domiciliary visit might be reduced. Indeed it had led to the questioning of the value of the domiciliary visit for certain categories of patients for whom the probability of subsequent admission was high.

5.74 There was a definite view that in the longer term it could not be sufficient that the information was merely interesting; it had to be shown to be positively useful, and to lead to changes of some sort. Nevertheless, the impression given was that in the short run, because of the inherent interest of their own figures, they would like to see the exercise continued. This acceptance follows the facts that the review made few demands upon them personally and that confidentiality was assured.

5.75 Suggestions were canvassed as to how the review might be developed. One suggestion was that the patients should be classified using a disease index (at least for important/interesting conditions) to make it possible to identify and compare the pattern of care provided to particular types of patients. Since we completed our field work this suggestion has been adopted in one district. Another suggestion was that this sort of information could only be useful if it was integrated with information on the costs of providing particular services to patients. The consultant concerned saw this as a positive step towards clinical budgets. It might be possible to make individual patient decisions reflect in part the relative costs of alternative patterns of care, particularly for those patients whose clinical condition did not clearly indicate any one preferable course of action. Work is now in train on the costs of particular services.

A Self-Contained Exercise

5.76 None of the consultants who were directly part of the review spoke in terms of managerial responsibilities. This element of the exercise was put not into a context of managing change or organisational development, but in terms of its relation to clinical audit. The general view was that it was close to the latter concept, but opinions were split as to whether it had strayed into that sphere. The similarity to audit did not seem to worry them, at least whilst the guarantees of confidentiality ensured that the audit was self-audit and even peer review was a voluntary extra.

5.77 There was certainly a fear of 'big brother', and adherence to traditions of working as individual consultants answerable, in the most part, only to themselves. None of the consultants interviewed appeared to have discussed their individual results even with colleagues within the same department or in the same unit. At that stage at least they had made no attempts systematically to compare their results or collectively to draw implications from them. Meetings were on the horizon to begin tentatively this process, but certainly even if the review could be said to verge on clinical audit, the structure had kept it quite free of connotations of peer review.

5.78 It is not, therefore, surprising that little seemed to be known about the details of the review by those were not directly involved, or did not receive the aggregate data (DMOs). They had not yet had a chance to influence planning of the geriatric service - nor was it clear how in future they might. The exercise was seen as separated from the rest of the Review of Services for the Elderly and of the overall performance review concept. There was no suggestion from those taking part that it should become multi-disciplinary in any way, and no links across to the other elements of the review were remarked upon or noted.

5.79 The intention underlying the review, was to move towards outcomes rather than processes, and efforts had certainly gone into considering ways of measuring outcomes. The approach adopted was nevertheless essentially one that considered process, albeit directed to the achievement of particular policies.

(B) Nursing Services Review

5.80 This performance review was undertaken in two districts. It was concerned with identifying nursing objectives in geriatric services, developing policies and identifying performance measured against policies. Nurses in the two districts worked independently of each other. It was conducted as a separate exercise within the wider performance review of services for the elderly although it arose out of the policy document produced by the geriatricians (see paragraph 5.64). Work on it started in August 1982.

Our Evaluation

5.81 The nurse member of the PRG was interviewed in December 1982 before the completion of the first stage of the nursing performance review. Interviews were conducted with the following role holders at region and in the districts between December 1983 and March 1984, after the implementation of the first two stages of PR had been completed:

the two remaining permanent members of the PRG;
two District Nursing Officers (one acting);
one District Medical Officer;
one District Administrator;
District Nurse Care Planning Group for the Elderly
(one Director of Nursing Services, four Nursing Officers);
Director of Nursing Services;
Senior Nursing Officer;
two ward sisters;

Interviews were supplemented by the study of documents produced by the PRG and the district participants.

Expectations and Objectives

5.82 The PRG's outline design suggested three stages of review for the total exercise on services for the elderly, with an interval of one year between the first and third stages. It was proposed that in the first stage of the nursing review (input) nursing priorities should be defined, in the second (process) nursing processes should be studied, and in the third (assessment) results related to outcomes.

5.83 No clear boundaries were set for the scope of the review. The nurse member of the PRG accepted the geriatricians' premise that it must be limited in order to be feasible, but the nursing exercise was not necessarily to be confined within the limits of the hospital geriatric service. One district attempted to incorporate community hospitals and community nursing into its review. It was also hoped by nurses at regional and district levels that the whole review would extend to notions of clinical team practice, and encompass a holistic approach to services for the elderly. However, there was no attempt at the beginning of the review to link the nursing exercise with other strands of the review.

5.84 Stress was laid at regional level upon the need to define the objectives of geriatric nursing care and to establish policies on the basis of these. For many nurses, this would entail a radical change in their conceptualisation of their work. But contrary to the general principles of PR, here it was also seen as designed to solve specific problems in geriatric nursing, in particular the routinisation of the patient's day. A change of practice to individualised care, based upon the concept of the nursing process, would achieve better and more economical care.

5.85 Performance review was conceived of ultimately in terms of outcome but through process in the form of attitude change, and the opportunities for nurses to identify objectives, policies and standards for themselves. Self-assessment, peer review and cross fertilisation of the achievements of PR were hoped for at regional, district and unit levels: between participants and from participant to non-participant districts.

5.86 One DNO hoped that PR would establish a framework within which nursing of groups other than the elderly could be assessed in the future, and that it would contribute to strategic planning of the nursing service.

5.87 Nurses at unit and ward level placed more emphasis than those at district and region upon performance review as a means of increasing the input of resources, particularly manpower. Some hoped that it might be a means of enhancing the status of geriatric services and drawing attention to particular needs of elderly patients and their families. Not surprisingly, all were more concerned with PR as promoting the quality of the service than the economic use of resources.

Structures and Roles

5.88 The implementation of this PR was a 'bottom up' exercise. Although the initial impetus for participation came from the nurse member of the PRG, she engaged the interest of an existing nurse care planning group on the elderly in one district and worked with groups of nurses who came from ward, hospital and unit level to gain commitment and to identify issues in both districts. Her concept of her role was that of critical but supportive catalyst, with a responsibility for ensuring that work kept within the overall objectives of the review.

5.89 Both DMTs gave their commitment to the exercise, and in one district the DNO was delegated the responsibility of co-ordinating the total review of services for the elderly. However, co-ordination of the detailed work was further delegated to, in one district, a director of nursing services and in another a senior nursing officer, who co-ordinated one and two groups respectively.

5.90 Moreover, as a result of the illness and enforced retirement of the nurse member of the PRG, the departure of both DNOs and of the co-ordinator of the working groups in one district, in both districts the work was carried out with little involvement on the part of anyone above director of nursing services level. Effectively, there was no professional leader for their strand of the review.

5.91 In one district, action had been identified as required at ward sister, nursing officer, director of nursing services, UMT, DMT and DHA level. For those issues that required policy and possibly resource commitments outside nursing, the UMT had been identified as a crucial point of decision, but at least in the eyes of the DNO any progress depended upon commitment to an overall policy from the DMT. Meanwhile the role of senior nurse managers in the district, in her view, was to legitimate the objectives, standards and policies formulated at lower levels and to put them together with resource needs for the DMT.

5.92 In the other district, where work progressed more slowly, but on a wider front in an attempt to include community hospitals and community nurses, the mechanisms for further action were less clear. The exercise was less controlled, the new DNO had only recently been appointed at the time of our study, and there were large questions about what was to be the next appropriate action.

Organisation and Methodology

5.93 Between the summer of 1982 and the autumn of 1983 four tasks were undertaken in each district: the identification of the objectives of one part of the nursing service for the elderly, the hospital geriatric service; the design of a questionnaire to test whether these objectives were being met; the administration of this questionnaire in randomly selected wards to test its validity and reliability but also to use it as a basis for determining policies at ward, unit and indeed district level; the analysis of the results and production of a report. These tasks comprised the first two stages of PR as outlined above.

5.94 Although the districts identified their objectives independently, only one produced a questionnaire. This was then used by both districts.

5.95 The work on objectives and the subsequent questionnaire were based on the nursing process, although the questionnaire was concerned with both requisite environment and requisite attitudes. One of the groups concerned thought this focus on process a key difference between the nursing and the geriatricians' exercise which they saw as based upon an input-output model of service. There was strong commitment, at least in this district, to collaboration and consultation with nursing at unit and ward levels throughout the exercise. An important and highly ambitious aim was to produce quantitative measures of performance where possible on the assumption that quality of care is, to some extent susceptible to quantitative measurement. Questionnaires were completed by members of the group working in pairs on each ward, on the basis of observation, and verbal questioning of the patients and the ward sister. The completion of this task thus entailed peer review.

5.96 The main criticisms of the organisation and methodology voiced by those interviewed were:-

(a) that the exercise had not been co-ordinated with the geriatricians' exercise: the various professional groups involved in the PR had not identified common aims before they began;

(b) that the review was based upon one part of the nursing service, and did not encompass either psycho-geriatric care or community nursing;

(c) that it suffered from lack of technical advice; it would have been better to involve the management services unit for example;

(d) that too much responsibility had been placed upon the working groups, who had conducted the exercise without an adequate clarification of the manpower and financial framework. In consequence unrealistic expectations of resource allocations could have been built up.

5.97 Further criticism of the validity of the questionnaire could be suggested. Some key questions had the answers built into them: for example, 'Do you use all opportunities to show interest in and an awareness of the patient as a person by establishing a mutually trusting relationship?' Such a question could only begin to be answered by either observation or perhaps semi-structured interviewing of staff. As it was, the questionnaire was completed in one day only by a combination of observation and direct questioning of staff and patients.

5.98 The questionnaire was too ambitious in that it was concerned with both environmental - resource needs (for example, ward temperatures or numbers of commodes) and also requisite professional attitudes for the model of care envisaged. But a rigorous development of measures for the quality of the nursing process would have exercised experienced researchers in the field of evaluation (9) and some benefits did accrue to the nurse managers from what was necessarily a fairly basic beginning exercise.

Perceived Benefits of the Review

5.99 Participants enumerated a number of benefits:

(a) they found it an extremely valuable exercise in collective learning, clarification of their role as managers and in reflection upon and analysis of their work;

(b) although on the whole there were no surprises in the review for them, it highlighted and made more specific existing problems;

(c) it enabled them to identify the action that was needed and often this was attitudinal rather than dependent upon new resources;

(d) it gained the commitment to review on the part of ward sisters;

(e) it reinforced and gave impetus to changes that were already beginning to be made;

(f) it clarified for them what the nursing process entails: they were able to quantify the additional levels of staffing needed to carry it through; and they were better able to pinpoint differences between the underlying philosophies of the nursing and medical groups. They began to think that these might to some extent be in conflict: medical priorities were about the efficient use of wards and throughput; nursing priorities were to do with the individualised care process;

(g) the review had given them a basis for establishing ward policies where these did not exist;

(h) minor allocations of resources had followed the review (such as more commodes) and also some changes of practice had been implemented (institution of diversional therapy on at least one ward);

(i) but the exercise had also created expectations that more resources would be allocated;

(j) for a DNO the review had begun to provide a framework for the review of other nursing services and had constituted some contribution to manpower planning in nursing. It would also feed into an existing working party on the nursing process.

Implementation and Dissemination, Including Institution Building

5.100 The tests of performance review's capacity to promote change were still largely to come at the time of the study although there were some immediate improvements. So far PR had been an insulated exercise.

5.101 The performance review process was one that assumed at least some commitment at district and unit level to derive policies and resource allocations from a bottom-up approach; and that policies such as manpower resource allocation could be built up from professionally based setting of standards and norms as against being built up within for example a cash limit framework. One of the DNOs conceptualised PR as one component in a policy building system, the various components of which would feed into and upon one another. Such a conceptualisation did not, however, seem to have been made either at DMT or at regional level.

5.102 The review attempted several things at once. The most significant benefits seemed to be derived from enhanced collaboration and collective learning about the processes of work with the elderly. The review also elicited preliminary attempts to find measures of quality of care but this would have demanded the development of technology not easily available to self-directed groups.

(C) The Minor Elements of the Overall Review

5,103 The major effort had been put into the consultants' and nursing reviews, but two other elements were considered as part of the overall review of services for the elderly, one so far involving one district, and the other involving two, but to a limited extent in one case.

5.104 The PRG commissioned a part time contractual worker with experience of community services to 'design a basic package' for reviewing three services for the elderly: chiropody; hearing aids, and incontinence. Originally eye services were included but problems with overlapping responsibilities for such services and the limited time available to the person concerned led the PRG to drop this element.

5.105 Although the package was developed within a framework of guidance from the PRG there was no formal support from a specific multidisciplinary or indeed unidisciplinary) group and it was appreciated that it lacked financial and medical information. The chiropody review was taken up by two districts, and the part time PRG member worked with one of them in developing the review, and rewriting the manual in the light of this experience. The structure of the manuals was similar to that of much other PR work: (i) a definition/classification of policies; (ii) an identification of procedures to meet these policies and appropriate work measures; and (iii) an attempt to see how observed procedures and work measures matched the desired policies, and the identification of the required management changes to improve the match.

5.106 The work was carried out one day a week for six months in close association with the District Chiropodist with little involvement of the DMT or other senior non-line management, and the assistance was seen as clearly coming 'from region'. It included the setting up of a system for detailed recording of treatments provided which at the time of interview was just being tried out by the seven chiropodists for a trial week.

5.107 Initially there had been reservations about the additional workload the review would impose on line management but it had been quickly accepted as central to the normal management function.

5.108 It was expected that some clear recommendations for changes in pattern of service delivery would emerge, for example, in the substitution of foot-care assistants for some fully trained chiropodists; in anticipation of this, posts were not being filled until the review was finished. There was, however, some divergence of view as to whether the PR exercise should merely point to, or should actually involve the making of the necessary organisational changes.

5.109 There was also a more general suggestion that the lack of take up of these reviews reflected in part the fact that the PR exercise had not been appropriately marketed, that papers had been too theoretical and 'academic' and were not adequately related to the everyday experience of the line managers.

5.110 The second 'minor' element of this PR involved one of the junior members of the PRG working with one district in trying to separate out the costs of services to the elderly (at least in terms of services provided by consultant geriatricians and certain specified community services). The resultant fairly crude figures at a whole district level were seen as an aid to strategic monitoring (rather than, say, to patient management as suggested by one of the consultants involved in the referral review). Additionally within one hospital they were attempting to establish 'zero-based' budgets for the geriatric services.

5.111 At the time of our interviews this costing work had not been fully developed and was still a quite separate part of the overall review. The incorporation of costing/financial information was nevertheless seen as a necessary next step by many of those involved in other elements of the overall review of services for the elderly.

(3) Accident and Emergency Performance Review

5.112 This review, originally adopted in three districts, but followed through only in two, focussed on the district accident and emergency services. Our evaluation involved the following interviews:

Two meetings with members of the Performance Review Group at Region
A meeting with the external adviser to the PRG
A meeting with one of the District Medical Officers
A meeting with a Unit Administrator
A meeting with a District Treasurer
A joint meeting with a District Administrator, a Unit Administrator and a District Planning Nurse

5.113 The review is considered below under the following headings:

The organisation and methodologies of the accident and emergency review.

The expectations and perceptions of the accident and emergency review process.

Perceived benefits and costs of the accident and emergency review.

Resulting perceptions of Performance Review in general.

The Organisation and Methodologies of the Accident and Emergency Review

5.114 For a variety of reasons, particularly the shortage of resources within the PRG itself, and the problems stemming from the numerous changes in relevant staff in the three districts that originally undertook to be involved in the A and E review, work was postponed whilst other reviews were begun. The PRG then decided to experiment with the use of the 'accreditation approach' by bringing in an external adviser who had had considerable experience with accreditation in Canada and was interested in evaluating its

usefulness in the UK. The DA of one of the participant districts had also studied accreditation methods and it was decided to try such an approach in the context of A and E services, as an aid to policy formulation.

5.115 The accreditation review was thus carried out by the external adviser who visited A and E departments in the three districts and used a standard check list of questions to obtain information on A and E facilities, organisation and procedures in order to assess the extent of divergence from an implicit 'ideal' department. The checklist was developed from the Canadian material for the Wessex exercise by the adviser. The accreditation review was designed to establish a qualitative baseline on the current state of the service and from this to identify improvements that could be made over time. It was intended to reflect a philosophy of non-normative standard setting and required follow up and discussion with districts of the results, which were returned to them with comments and suggestions shortly after the adviser's visits. There were, however, problems of communication in this part of the review. Those providing the accident and emergency services, mainly based at unit level, felt that they had received insufficient advance explanation of the purpose of the exercise. Thus the first awareness that many had of regional activity on this review was the arrival of the Gogolian 'accreditation official'. This led to some confusion and unhappiness in two of the districts about the nature of performance review and was at least coincidental with the decision of one district to withdraw from the exercise. There was also no follow up, because the PRG, unhappy about the quality of the results emerging from the accreditation exercise, decided to stop this line of review.

5.116 In August 1983 a paper setting out the elements of a good service was produced by the A and E consultants' group in Wessex. This initiative, carried out as part of the overall performance review process, potentially provided another set of criteria for judging district services.

5.117 By this point, however, one of the districts had already embarked upon its own exercise to review and amend the organisation of the A and E services because of locally recognised problems. This took the form of a steering group at unit level to produce a set of guidelines for the provision of the service. The guidelines were mainly a set of procedural instructions for a number of

specific aspects of A and E's work (for example, treatment of members of staff as patients) but also included matters such as patient waiting times which might be seen as measures of performance. The feedback from the accreditation process did lead to certain physical changes being proposed and minor capital developments being carried out. Work on these guidelines continued essentially without involvement from the PRG.

5.118 In the other participating district, the initial accreditation review seemed to have been a rather isolated event which did not appear to have influenced subsequent work. Substantive work on the review began many months later, and appeared to have been more strongly influenced by regional concepts of performance review. A group of officers from unit and district (including the District Administrator) considered existing policies and established new policies where needed. These reflected a list provided by region of areas to be covered in the review. They included procedures for treatment by GPs of their own patients whilst working in the A and E department; patients returning for inspection of wounds and dressing; patient waiting time; treatment of violent and aggressive patients; procedure for handling X-rays of patients; letters to GPs; and treatment of ward and clinic patients in A and E. The group then went on to look at procedures for implementing their policies in each of these areas, and at the time of our interviews were at the point of identifying a set of 'key performance factors'. In this district the exercise was seen as all the more relevant because of the need to establish appropriate systems for a planned new A and E department.

Expectations and Perceptions of the Accident and Emergency Review

5.119 The perceptions of, and reactions to, the PR review of A and E in two of the three districts seem to have been strongly coloured by the initial use of the accreditation approach. Those involved in the service locally seemed not to have been adequately forewarned of the purpose of the accreditation exercise. They were unclear whether it constituted performance review in its entirety, whether it was an integral part of it, or merely a prelude to it. However interpreted, it seemed to have engendered a generally negative reaction. Those working within the A and E departments, or responsible for their policies, felt that they had not been sufficiently involved in the process. At the regional level there were doubts about the accuracy and the validity of the information obtained. It was suggested that 'the right questions' had perhaps been asked of the 'wrong people'. Furthermore, the exercise raised doubts about whether the accreditation approach was compatible with the philosophy of performance review.

5.120 However, despite doubts about the way the accreditation exercise had progressed, the approach and many of the specific items within the check list had influenced one district. One member of the DMT believed that the use of such a check list should be repeated on a regular basis, and some work was put into revising its detailed content. In this district there seemed to be confusion as to what form the region intended a performance review of A and E to take, and whether the continuing exercise came under the umbrella of performance review or was simply an internal and independently structured management exercise.

5.121 In the other district where work continued, the accreditation exercise seemed not to figure significantly in either their perceptions of performance review or their detailed thinking about the A and E service. With recent active involvement from the PRG, they were following closely regional guidelines for performance review. Even so, the initial reaction was reported as having been somewhat negative. There had been a feeling that they were guinea-pigs for a regional experiment which might interfere with the

day-to-day running of the service. Once they had become actively involved, they had begun to see the benefits from PR.

5.122 In both of the districts, one of the main incentives for persevering with a review of A and E services was the expectation that it would provide direction for departments which, either because they had no consultant, or because they relied on general practitioners to provide clinical sessions, lacked strong management. The fact that the A and E service differed from other hospital departments because staff were involved in treating a wide variety of conditions, and in determining whether patients should be referred elsewhere, created particular difficulties. Both districts believed that good management was crucial in overcoming these and might be fostered by systematic consideration of service organisation and routine procedures.

5.123 Both districts, however, avoided the use of the term 'performance review' in describing the activity to their staff. Concerns about staff interpretation of this title were expressed. It was felt to be damaging in that it could be, and possibly was, interpreted as the appraisal of individuals' performance.

Perceived Benefits and Costs of the Accident and Emergency Review

5.124 At the time of our interviews, the performance review exercise had not operated long enough for all of the potential benefits to have manifested themselves. One district had just reached the stage of assessing its policies and envisaged considerably more work on developing a set of 'key performance factors'. A list (dated May 1984) set 'standards' for a variety of measures. By the time of the completion of our study the PRG reported that these had been agreed and data collection started.

5.125 The district which followed the regional approach engaged in detailed thought and discussion of the nature and objectives of the A and E service and felt that the process had been time consuming and 'tedious'. However, they identified several positive benefits. It gave an 'air of respectability to management considerations' making them more acceptable to medical staff.

It encouraged a multi-disciplinary approach, although in practice there had been little medical involvement. In their particular context of planning for a new district general hospital, it had ensured that they carried out an examination of the aims and purposes of the A and E services rather than simply examining how to transfer current arrangements.

5.126 This district was also concerned that procedures should be laid down for almost every aspect of work and that every task should be recorded. This was due to the complexities of the tasks performed in A and E departments, which cut across the natural boundaries of traditional hospital work and meant that staff could not always be expected to be familiar with the correct procedure. Performance review had offered the opportunity to assess and document these procedures.

5.127 The importance given to performance review compared with other management tasks had created anomalies. The externally imposed time scale was 'annoying' in that it meant the PR was competing with and taking precedence over what were felt to be locally more important issues. The attention paid to it reflected in part the special status that the District Administrator's involvement had given to the review.

5.128 In the other district, the organisation of their review, begun prior to regional involvement, had proceeded by starting from identified problems in service delivery rather than the more abstract consideration of objectives. Whilst this led them quickly to achieve specific improvements to the physical arrangements of the department and professional relationships, this militated against subsequent PRG involvement. Nevertheless, they saw clear benefits from what they were doing, benefits which were in essence similar to those reported by the other district. They argued that in A and E the doctors were constantly changing and often junior: it was therefore particularly important that standards were set so that all staff knew what was expected of them. It also provided a basis for ensuring consistent practice from the various GPs working within the department.

Perceptions of the Concept of Performance Review

5.129 Trying to describe PR in the context of the review of A and E services proved difficult for nearly all of the officers interviewed. The terminology used to express their perceptions was varied. In the district where the review process had conformed to regional expectations, the officers repeatedly used mechanical metaphors, such as 'tool' or 'mechanism'. At the regional level it was described more abstractly as a 'conceptual package'. A member of the steering group described performance review as 'part of a culture of better identification and measurement of objectives.'

5.130 The officers who had followed the full approach, though describing the process of spelling out detailed policies and subsequently procedures as a tedious exercise, did see that it had made them consider issues that they might otherwise have ignored. It offered 'a different style of thinking' - both extending the range of issues considered and requiring a different approach from line (unit) managers who traditionally tackled management issues in a reactive way. It made them think positively about the purposes of the service. Indeed, the performance review process was felt to have forced them to think creatively - 'writing a scenario for the future.'

5.131 The officers tried to relate the process of performance review to present management theory and practice. Performance review was described as a part of strategic planning, separated from the daily running of the service. One officer felt that performance review offered a means of achieving a philosophy for the strategic plan. There was little agreement on whether this constituted something that they would otherwise have undertaken unprompted. One district officer felt that it was something they would have done without region's encouragement and felt that, in any case, it was becoming accepted as standard management practice. A point of view strongly expressed was that performance review was simply one particular manifestation of an approach to management which is being both widely advocated to the NHS and increasingly adopted, though mostly in less formalised ways. One officer suggested that a less formal procedure would have probably

produced a similar result in many areas of the service. The experience in the 'go-it-alone' district tends to support that hypothesis.

5.132 The districts had differing views about the need and desirability for regional involvement. The district that had received substantive help was concerned that this might become interference and that the exercise would be seen as a regional enterprise. We inferred from comments made that the other district, which had so far worked with minimal regional assistance, would at that stage have welcomed help in further progressing the work.

5.133 There was no clear agreement as to the precise end-product of the review. Some saw it as the beginning of an on-going process, but none of the officers interviewed was clear how this initial exercise would evolve and be incorporated into routine management. Others saw the main outcome as a set of relevant management data that could be used to monitor the services (primarily by unit management but also providing information to the DMT). The identification of policy relevant 'key performance factors' was apparently a major element in the PRG's expected outcome from the review. These factors were seen by some as a step towards measuring outcomes. Others saw these measures as a form of quality assurance - throwing light on the quality of process rather than on actual health outcomes. The examples quoted to us - waiting times and level of complaints - seem to us closer to measures of quality of process than outcome. Indeed, it was suggested that whether or not objectives were achieved was the only sensible outcome measure for A and E. Certainly the nature of the A and E service seemed to make the identification of even surrogate measures of outcome, unless measured in terms of processes, somewhat elusive.

5.134 The extent to which the PR process reached its conclusion with the establishment of an appropriate data set, or was seen as incorporating the making of the changes implied by the data adduced, varied between those interviewed. Although some officers spoke of PR as being part of 'the management of change' none clearly identified what the nature or the mechanism of the change would be. It was

suggested that with the addition of specialty-costing information, it might be possible to build in financial incentives as a means of motivating changes in performance.

5.135 At both regional and local level, it was suggested that the usefulness of performance review was limited if it did not encompass clinical procedures. It was recognised that clinicians might well be reluctant to subject their work to such multi-disciplinary scrutiny, particularly as more clinically orientated performance review could strongly resemble clinical audit. For example, as an element of quality assurance, it had been suggested that the frequency with which clinical interpretations of X-rays differ should be analysed. For this to happen would require active involvement and co-operation of the clinicians concerned. At this stage such a level of clinical commitment had not been secured, but means of achieving such a commitment were being discussed.

IMPACT, IMPLEMENTATION AND COMMITMENT ACROSS THE PRs

5.136 This section is based primarily upon interviews conducted in the first few months of 1984 with the intention of assessing the impact of PR together with the modes of its implementation and the extent to which it generated commitment in the districts and units. A total of 37 interviews was conducted with 45 interviewees. Some were concerned with general issues of impact but many were, at the same time, directed to consideration of the impact of particular performance reviews. Those interviewed included:

five members of the RTO and the Chairman of Regional Monitoring Committee;
12 DMT members;
five second line managers, one district planning nurse and two community medicine specialists in six districts;
seven UMT members from five units;
and 10 catering managers at region, district and unit levels.

5.137 In this section we address the issues of impact, implementation and commitment under the following headings:

The levels of knowledge and understanding of and about PR.

Concepts held about PR.

Modes of implementation.

Results of PR.

Commitment gained for PR.

The Levels of Knowledge and Understanding Of and About PR

5.138 Those we interviewed at this latter stage of our study were a biassed sample inasmuch as they were selected as being directly or contingently involved in PR. In spite of this, however, knowledge about PR was shown to be patchy; in some cases, those indirectly involved with it had internalised their knowledge of aspects of PR and had reconceptualised the initiative to fit other existing or

potential frames of reference. It thus re-emerged among a substantial minority of respondents at least as a version of normative planning, or performance indicators or, indeed, independent attempts by line managers to assess and improve their own performance.

5.139 PR did not emerge as an item for formal discussion at RTO or DMT meetings, even in those districts where commitment to PR was most obvious and understanding of its potential most clear. In other cases, individual senior role holders at different levels might be aware of, or interested in, a single aspect of PR but had not had occasion to come to terms with the broad scope of its working and potential outcomes.

5.140 This was not through lack of attempts to disseminate information about PR from the centre. A seminar involving the districts had been held in 1981. From July 1982 the Performance Review Group had begun to issue Notes. Three PR Notes were issued early in the programme to outline the concepts and scope and the framework for putting it into practice. One placed PR within the context of the national trials. As work progressed two newsletters were despatched and intended to be part of a continuing series. Not only members of the PRG but also senior members of the RTO were involved in explanation and persuasion, as well as offering technical help, to districts over the period of the trial. The monthly meeting of District Administrators was also used as a forum for disseminating information about PR.

5.141 Districts involved in PRs concerned with the same subject might have information about work elsewhere within the region; this was certainly so of catering, estate management and, to a lesser extent, of nursing serviees for the elderly. The consultants' work on the elderly and the A and E project were not, however, communicated across districts.

Concepts Held About PR

5.142 The primary motive underlying PR was that managers should review their own services, establish agreed objectives and find ways of measuring their achievement and thereby improving performance. Some of the projects incorporated in PR did not meet this remit which invited stronger functioning of the managerial role. For example, clinicians' work on services for the elderly involved, in effect, methods of improving self-audit of their own work. At the same time, however, the project explicitly eschewed medical audit which would have implied a measure of externalisation of their analysis. Although the data that emerged from this review had implications for the management of geriatric services, only some perceived them. PR contained two potentially conflicting objectives: that of self-development and improvement which might be strongest within professional or functional boundaries, and the expression of those improvements within the more public and managerial domain.

5.143 A second set of perceptions of PR concerned the importance of developing measurements of outcome. For most, this implied the production of data sets more closely geared to good management practice, and was a primary goal of PR, rather than a means of achieving an ultimate purpose of improving services.

5.144 If the boundaries and the distinctiveness of PR were uncertainly perceived, there were also criticisms of the concept as related in the regional scheme. The first criticism was, indeed, that much as the region might insist that PR should consist of initiatives created voluntarily by the districts, the scheme was essentially a regional invention not directed well enough to the priorities of districts and units and practitioners. Data might be created by, for example, the catering PR addressing different expenditure time scales from those needed by a unit administrator whose best time scale might be that of a day or a week. A second criticism was that it involved 'normative planning' by which was meant the expression of the aspirations of professionals within particular disciplines whose best norm might not be compatible with those of general resource control and the norms of other disciplinary groups. A further conceptual objection concerned

the fundamental issue of transferability. Districts enjoyed different histories, different physical and manpower resources and different traditions. It was not clear that the results of individual PRs based upon districts could be useful beyond the boundaries within which they operated. Other criticisms were levelled at the internal and subjective nature of district led PRs. They might be neither objective nor expert enough.

5.145 A further issue concerning the conceptualisation of PR was that of its structural arrangements. Some believed that relationships could be clarified in one of two directions. The region should take a more explicit lead in both conceptualising and promoting action. Alternatively, PR should be more clearly recognised as a district function which could be enhanced by co-operation with other districts, including the bringing in, on a consortium arrangement, resources either from the region or from other external consultancy sources.

5.146 As with the criticisms of the concept of PR, so the statements made in its support varied considerably according to the subject being reviewed. Caterers were strongly in favour of the PR concept as it was identified in catering. It enabled inputs, costs and processes to be identified and calibrated according to standards which were assessed externally. It invoked collaboration with other disciplines, particularly dieticians but also potentially medical, nursing and portering and domestic staff. Others who supported the concept of PR, from a variety of disciplines, saw it as a way towards holistic concern for patient care which would enable there to be better operational planning involving all of the disciplines. It might further contribute towards strategic planning because of its concern with objectives and its encouragement of more creative future-oriented thinking.

Modes of Implementation

5.147 Patterns of management affected the implementation of PR. This subject is taken up later in our section on the evaluative framework. At the time we completed our field study it was not possible for respondents to make clear judgements on the extent to which plans that might have derived from performance reviews were implemented

because, as yet, the results of PRs had not been reported back to the districts. Lead times far longer than those originally planned proved to be necessary and time and energy were diverted in, for example, the catering PR to preparation for privatisation schemes which were imposed on the region and the districts after PR had begun. The PRG found itself propelled in some reviews into a stronger executive or leadership role than had originally been intended. This reflected the view of some districts that PR was a regional initiative, for regional purposes, anyway. It inevitably meant that the PRG must reduce its broader advisory and back-up function. In other districts, performance reviews were undertaken with little or no regional help. The problems of implementation were, therefore, those generic to the NHS at the time at which PR was introduced, namely, the problems of reorganisation, of initiatives such as privatisation, as well as those particular to the PR structure of a small PRG sufficiently committed to undertake a wide range of roles but lacking sufficient resources to meet the potential needs of the districts which themselves had not fully taken on board the commitment required for district led PRs.

Results of PR

5.148 It is already clear from what is said above that many who might have been involved in PR were not strongly aware of its existence and therefore were not likely to report results of it. But many of those who had worked on PR felt there were discernible outcomes of it. In catering, for example, key measurements of costs, wastage, nutritional intake time taken to deliver food and, perhaps eventually the dietetic state of patients were incorporated in the PR and significant data already achieved. Patient satisfaction measures were developed in catering and in ambulance services. In other areas criteria upon which policies might be built were expressed. In estate management, maintenance policies were developed. One district developed policies for A and E. In both A and E and elderly services different groups believed the performance review had caused them to think differently about their services. They were now thinking more systematically

and creatively about their objectives, and some groups had formulated policies. In some PRs there was direct testimony about the way in which review potentially enhanced the quality of process. In A and E, the PR moved them into finding quality assurance measures through, for example, elucidating the significance of figures on the reattendance of patients. At this stage, however, it was not easy to identify definite changes in service delivery as a result of PR although small scale examples were not absent from the interviews.

Commitment Gained for PR

5.149 A member of regional staff summarised as follows: 'Compliance with and not internalisation of PR had taken place.' This summary accurately reflects the dominant views held within the districts. Regional officers remain committed to the concept and believe that ultimately good results will occur although not within the time or of the scale that they had first hoped. A small minority of districts secured good results from a particular PR which persuaded them to join another PR. The catering leadership throughout the region and the districts committed themselves strongly to PR and the involvement remained unabated. It should also be noted that within the very broad umbrella of the PR concept clinicians engaged in forms of self-report in which they were not previously employed. For the most part, however, districts yielded to persuasion without full acceptance of the concept and commitment to its future working out; some questioned whether PR entailed anything different from good general management practice, apparently not aware that this was precisely what region wished to promote. Some districts felt that they had successfully worked themselves through the PR stage and no longer needed it because they would take up their own forms of self-development and review.

PART III

THE TEAM'S COMMENTS

5.150 The previous sections synthesised views derived from interviews conducted in the region, districts and units. We now give our judgements on the same issues which will involve us in responding to the questions posed in our Evaluative Framework. (Chapter 3). For the reasons given earlier, we could make no judgement on ultimate outcomes: our evaluation is therefore restricted to an assessment of the planning and conceptualisation of PR, the modes of its implementation, including the institutional arrangements for it, and the extent to which it achieved results mainly in terms of efficiency of process. A further issue is the extent to which PR met the national objectives for the MAS trials. This is a point which can be disposed of quickly: the national objectives for the MAS trials changed during the period of our study, and then disappeared altogether with the winding up of the trials. In this chapter, therefore, we are wholly concerned with the extent to which PR met Wessex's own concerns.

Changing Objectives

5.151 Towards the end of the evaluation we noted no fundamental changes in the stated objectives of those interviewed. We detected, however, some reluctant shifting of goals. Thus, the original formulation had explicitly rejected starting from specific problems but it was now conceded that this might be necessary in order to engage the interest of otherwise uncommitted managers. The original hope had been that PR would inform all managerial activities and engage a wide span of subjective concerns; there might now be some cutting of losses by identifying priorities and areas of potential success more clearly.

5.152 PR derived from the assumption that managers were too focussed upon immediate problems and did not direct enough attention to the conscious improvement of all round performance. PR would strongly reinforce the concept of an integrated service

through the growing of corporate management, the perception of management as an integral part of all service activities, and the collective monitoring of behaviour and behavioural change. The objective of creating outcome measures would also respond to national demands for more explicit measures of accountability.

5.153 The original priorities, therefore, had been to encourage behavioural change in management through focus on and measurement of outcome. These objectives remained but producing outcome measures proved more difficult than was hoped and was, with some exceptions, approached through the examination of process and of efficiency. Developing outcome measures at all was a highly ambitious enterprise. To develop them for working purposes as part of an action programme necessarily seeking results in the short or medium term was inevitably virtually impossible. To do so would require reflection about and testing of the many alternatives which have been worked on within the research field (see for example, Scrivens et al (10)). Moreover, different districts and units and different disciplines were at greatly different stages of development and some services were more susceptible to qualitative or logical analysis than others.

Conceptualisation and Design

5.154 The regional conception of PR was one in which notions implying externality, objectivity and a rational empirical approach to change sat alongside assumptions about the value and power of self-motivation and of collective learning. Emphasis upon products and outcome jostled with process related objectives. The regional view was that better management was the key to better outcome, and that management must be based upon a comprehensive approach to policy making and assumptions of a rational relationship between ends and means. But within that framework, district management was to determine its own priorities for review and create its own policies. The importance of district commitment and direction of reviews was underlined. The two emphases need not be incompatible but the movement from one to another, and the difference in the modes of working that would then be entailed, were not explicitly defined, or perhaps appreciated, by all of those concerned.

5.155 The difference between an essentially normative re-educative process and the creation of technologies for outcome measurement was reflected in divergencies of practice within a common framework. The alternatives were that districts could identify their own policies, objectives and practice or that there would be attempts to create agreed standards and norms which could be identified and taken on by all participants. From this decision, which initially is concerned with the substantive content of the performance reviews, issues arise which affect the constitutional arrangements for it. The second approach, leading to agreed standards, assumes that the results of performance reviews can be generalised and this, in its turn, affects the extent to which the exercise retains its voluntary nature. That which is self-generated is more likely to remain voluntary whereas that which participates in the creation of generalisable standards could form the basis for advances in managerial practice by the region.

Process or Product

5.156 There were shifts in conception over time. As already stated, the authors of PR had hoped that there would be discernible products. Creating a process, in the form of, for example, better management practice or changes in attitudes would not of itself be sufficient justification of PR. Not only were managers to direct their thinking towards the outcome of services, they were also to achieve changes in outcome. However, during the course of the trial less rigorous requirements of PR emerged. It was conceded that improvements in efficiency, in clarification of policies, and in commitment to considering service outcomes, would be evidence of the success of PR. Thus PR was seen as, at least initially, initiating a change process in Cope's formulation. (Chapter 3) However, we have also seen that part of this process was the creation of products such as new measures, new data and models of good practice, and that for some people such products represented the essence of PR. The original hard concept of PR became subject to multiple interpretation as time went on.

5.157 A further, if subsidiary point, was that PR did not assume the advancement of clinical audit although it was to involve the study of the organisation of clinical services. In fact, as we have seen, clinicians themselves engaged in a form of self-audit which avoided the broader connotations of PR and its attempt to improve general managerial systems but nonetheless came near to the boundary of clinical audit itself.

Structural Arrangements

5.158 At region, the performance review group worked under the guidance of a Regional Monitoring Committee (RMC) consisting of members and senior officers of the RHA. The RMC, an existing committee, was brought into the PR after the experiment began. The PRG, however, was part of it from the beginning and the multiple perceptions of its relationships with PRs in the districts reflected the range of regional-district relationships that ensued. In some reviews the PRG found itself propelled into a stronger executive or leadership role than had originally been intended. This was partly because some districts viewed PR as a regional initiative, with regional purposes. Sometimes it was a function of the newness of the exercise and after a while participants became more independent. In other cases, the PRG assumed that professional practitioners would take the lead from the beginning and keep it. In the catering review, as we have seen, there was strong co-ordination through the functional regional manager which reduced the part to be played by the PRG. This contrasted with the estate management review, where the regional functional manager took no direct part in the review. He supported participants at district level and encouraged dissemination of its work, but the formal co-ordination was undertaken by a PRG member. Finally, some reviews were in practice conducted with no regional co-ordination.

5.159 It is possible that some of PR's problems stem from the minimalist approach at region. Momentum might have been maintained better with a larger PRG group and more support staff. The original intention was to undertake PR 'on a shoe string'. The region wanted to show that the improvement of management performance did not need the input of either external resources or a large amount of resources.

5.160 Districts were competent bodies who should develop their own initiatives. The region would act as enabler and ultimately as monitor rather than in direct management line. But, partly because PR was conceived of as a regional initiative, and partly because districts felt that they needed help in defining the functions of PR as well as in implementing it, some in the districts and units felt that the region could have been more explicit and authoritative in its leadership. The PRG was seen as having insufficient 'clout'. Alternatively it was felt that districts' own attempts at review should be the primary mode of change albeit with the opportunity to draw on help from the region; perhaps, however, in the form of the management services unit rather than the PRG. Some of these districts wished to direct their own initiatives and to contribute towards knowledge about change on the ground, which could then be disseminated by the region. Certainly, the PRG faced a range and burden of work which, however committed and expert its members, were too heavy. Its dual role was to initiate commitment and provide technical expertise. Whether it was a catalyst or a technical agent, a rigorous assessment of the amount and range of resources required for the task seemed necessary. As it was, the members of the group achieved a great deal despite the difficulties of both resource and of role definition. But, it should be emphasised, the role expanded as a result of the reaction of the districts to the PR initiative. As a result, the original function of catalyst moved to an intermediate position to include that of technical adviser and, indeed, in some cases, primary project leaders.

5.161 Given these uncertainties of relationships with both the region and its PRG, indeterminate patterns of district commitment and structure for PR emerged. At the time of the inauguration of PR, the districts and units were moving from functional towards more holistic and corporate management. DMTs and UMTs were to be the pivotal institutions through which such management would be established. But the work of PR seemed to be mediated sometimes through functional lines from the region or sometimes through disciplinary interests recruited by the PRG. PRs were sanctioned by DMTs and by district authorities and then delegated to functional lines of management. At the

time of the evaluation there was still only occasional evidence of them being reported back and taken up by the corporate district system. In part, this lack of connection might have reflected the transition between functional and corporate management systems. Delegation from functional management at district to corporate management within the unit was taking place and PR would have to be incorporated into managerial thinking at both the district and the unit corporate levels. However, our observations suggest that the difficulties in achieving this may be more than transitional. PR had been developed primarily within functional management boundaries and had not as yet been used to develop inter-disciplinary management or planning. Indeed, it had been seen by some as likely to distort or distract strategic planning.

5.162 Whilst the region might hope that districts would embrace PR voluntarily, some of the districts were themselves pursuing different modes of review which were not associated with the regional PR. These could be related to actual problems as conceived in the districts. But they need not be disassociated from regional efforts and help; many of those most keen to advance their own reviews believed that the region or other external help would be useful to them. They felt that the region could also disseminate information derived from district initiated reviews. Some, indeed, felt that external norm setting, in which districts could, however, participate, was essential to objective thought and clear action. Some district initiatives were no less holistic than those promoted by the region. They pointed, too, to a process not envisaged by regional PR, that of identifying systematic changes made by districts and incorporating them into information to be disseminated throughout the region and beyond.

Models of Change Underlying Performance Review

5.163 There was no exemplary model for PR. It was a compromise between top-down and bottom-up models of organisational change (see Chapter 3), and, indeed, raised questions about whether that distinction is not over-simple. There was no explicit technology for the creation of change. Whilst the regions had invited districts to create their ways forward, districts believed that

the exercise was divorced from any change process. There was no prediction of the institutional contexts and changes which it might evoke. Another criticism of the modelling was that it did not incorporate adequate concepts of financial management and ways of improving it.

5.164 The initiative for PR came from the Region, and particularly the Regional Administrator, once the Chairman had set the scene, and it rested with the Regional PRG and other regional officers to encourage the districts to take PR seriously. At the same time as we have seen, reviews were to be of, for and by districts. A particular form of political action sets in when the superordinate level of a system sets out to persuade subordinate levels to seize initiatives. This jujitsu type of negotiation, in which the region hoped that it could engage the strength of the districts in meeting the region's purposes, was implicit in the expectations of the regional designers of PR.

5.165 The implementation process may be conceived of as administrative but it is also a political process entailing both bargaining and learning. A model of change could thus include many strands: improved states of self-knowledge; consumer perspectives of needs; ways of embodying new knowledge into practitioner behaviour, and changes in organisation. Most of these elements were present but not connected into a single model of institutional change. The PR project was somewhat apolitical. No sense of unstated needs and wants on the part of client groups informed the original concept: at its most rigorous the regional initiative was technocratic. Examples of attempts to review which incorporated both technical development and client and consumer perspectives of need could be found. However, the most positive incorporation of such perspectives was made by districts in reviews which had little or no regional input.

Evaluative Theories and Methods Underlying Performance Review

5.166 The model for PR explicitly aimed to incorporate a range of evaluative theories and methods, according to the nature of the service under review. There were, however, more general assumptions built into the overall framework.

5.167 Performance reviews could be described in terms of 'time series' evaluations. Current performance was to be measured against explicitly stated policies and norms and remeasured after specific periods of time. The approach was formative: performance review entailed action on the basis of information about performance and clarification of policies. There was to be a premium on reliable information that could be used systematically by managers to gain a clearer picture of the performance of services. Wherever possible performance ratings were to be expressed quantitatively.

5.168 The earlier monitoring system had developed two approaches: one for support services that could be broken down into discrete units for evaluation. The other was for services to care groups. This assumed a more complex relationship between resource inputs, service outputs and health outcomes, and between strategic, operational and medical management. It was recognised that multiple insights from different disciplines might be brought to bear on the evaluation of the care and treatment of different groups. But at the same time it was hoped to evolve more systematic and comprehensive models of care to be used as bases for evaluation. (11)

5.169 The dual approach had been carried over into PR. Elements contributing to the performance of support services were systematically categorised under three headings: input, process and outcome. Whilst those concerned with programme design were forced to focus more upon input and process, partly because of the lack of developed outcome criteria, the importance of these was not lost sight of and some surrogate outcome measures were evolved such as patient satisfaction in catering and ambulance services and nutrition intake in catering. Integrated cost information, was lacking in some of the PRs, although it was beginning to assume more importance as our study came to an end.

5.170 All reviews built into their design the evaluation of performance review itself. 'Improvements in process (efficiency) assumed to have a direct relationship with effectiveness will be taken as good results.' (12) Improvement of inputs were to be

assessed: for example, clearer definition of policy and objectives, roles and responsibilities, and standards for resources, and more enthusiastic and intensive consideration by managers and DMTs of the results of services. The review designs were thus concerned with the impact on attitudes and the perceived usefulness and acceptability of the reviews to managers as well as with the quality and reliability of the information collected. The emphasis on input and process in the evaluation of services was paralleled by a similar emphasis in the evaluation of the review itself.

5.171 The authors of PR emphasised its internalised nature. Review of the services was not to be by outsiders, without intimate knowledge of their development and problems. But there was a strong value laid on comparability in, for example, the catering review and a hope that reviews would incorporate evaluation by independent peers. Peer review was seen as important to establish catering as having its own internal norms and independent assessors were needed for external credibility, particularly of the accreditation system. In practice, more emphasis was placed initially upon inter-district peer review, thus reinforcing the notion of collective learning and standard setting and intra-regional comparisons. Hospital accreditation, envisaged as the next stage of the review, would to some extent redress the balance, and it was hoped to extend review to comparisons with institutions outside the NHS. The degree of internalisation, however, varied. The nursing exercise entailed intra-district peer review; the consultant geriatricians' work was essentially self-audit.

Data Needs

5.172 The PRG had hoped that PR could work on existing information. In practice, however, PRs generated new data, for example the dietary elements of the catering PR and the consultants' work on patient referral to geriatric services. As yet uncharted connections were expected to develop between PR and the regional information strategy project and, perhaps, the national performance indicators' initiative.

Feedback

5.173 At the time of the evaluation, feedback was only just in prospect for the reviews. Demonstrations of the process of PR were being mounted for the regional monitoring committee but not, as yet, for the district level. Digests were being or about to be produced. The extent of working them through with districts was, however, not explicit.

Implementation and Coherence Between Objectives and Results

5.174 Eventually, 28 reviews were conducted; all 10 districts had at least one; and one participated in six. A few dropped out and a few extended their range after reviews had been deemed useful. Some reviews, such as catering, took far longer to carry out than had been envisaged.

5.175 Whilst a great deal of potentially important and useful work was undertaken as a result of PR, the main objectives of the scheme, as stated by the Regional Administrator and others, were not to be fully implemented. The districts had not embraced PR as a way of organisational life and innovation. The failure on the part of the districts to accept PR wholeheartedly was attributed to several causes. First, there was settling down after reorganisation, together with the diversions caused by privatisation (although in one case, catering PR was seen as way of enabling managers to make specifications against privatisation) and, given other initiatives, PR was seen as yet another burden proposed from outside. The districts did not become convinced that this was their scheme in which region would play a helping hand. The institutions for ensuring acceptance between the region and the districts and across the disciplinary lines within districts were not established.

5.176 It did not seem from the evaluation that the technical content of PR was the obstacle to its acceptance. Institutional rather than substantive issues stood between the region and the districts in its acceptance.

5.177 The apparently passive or even negative views held by the districts of the regional PR should not obscure the fact that the districts themselves intuitively pointed to the role

of the regions in advancing the process of managerial review. Some of them, in advancing their own reviews, were, in effect, doing precisely what the region had hoped would result from PR. The fact that the region had inaugurated the process had made them feel that their own problems were not prominent and they might not have complete grip over the processes thus promoted. But they saw the need for technical help in the creation of analytic frames for review and in establishing modes of presentation of findings. Some of those interviewed referred to documents which they had found useful, including, in fact, those produced by the MAS team in Oxford and SW regions. They thought the region could pick up developing district practice and review findings and disseminate them. They thought the findings from district reviews could become important data for the district and regional annual review cycle. Indeed, it seems to us that the PRG could greatly help the districts in tackling the question of what categories of management might be susceptible to generalised norms and models of management and practice and what might be idiosyncratic to particular times and places. Such a dialogue between the PRG and the district would help clarify the boundaries of useful further review work and action. 'Normative planning' was certainly criticised by some general administrators as being too tied up with professional perceptions of what is needed. But there is a range in the extent to which norms can be generalised and practices transferred or copied elsewhere according to the discipline being reviewed.

Efficiency of Process: Costs

5.178 The extra costs of providing PR were minimal except for the opportunity cost of the limited managerial time involved. Districts did not discern any additional costs falling on them. Salary costs of the Performance Review Group and associated services were the only discernible additional costs involved. Time costs for others, such as district catering managers, geriatric nurses and consultants were felt to be time well spent, enhancing the ordinary business of management. The occasional additional employment of a secretary was needed to complete relevant referral forms.

Did It Establish Usable Criteria, Standards and Measurements of Performance?

5.179 We have already expressed doubts about the facility with which criteria and measurements of performance can be derived from relatively short term PR projects. In spite of the limitations of time and resources, however, certain PRs established usable criteria, standards and measurement of performance. This was evident in the catering PR. In both A and E and estate management, two district administrators thought that a large number of relevant performance factors had been identified. Priorities among them now needed to be determined and the indicators tested for operational use. In the elderly PR, consultants now had information on the time lag between referral and treatment. The A and E PR derived quality of process indicators from waiting times and levels of complaints. The usefulness of PR as a way of establishing criteria, standards and measurements is, it will be seen, patchy as yet and can only be assessed over a longer period of time.

Utility: Efficiency and Effectiveness of Outcome

5.180 At the time of the evaluation no systematic account of the outcomes of PR could be made. In some areas, more and better data were certainly created. No explicit changes in planning systems or processes were noted although some pointed to the potential contribution of PR to strategic planning. The great majority of those interviewed could not point to many changes that had taken place in operational efficiency and effectiveness; the emphasis was upon some that might take place. The catering PR, however, seemed likely to lead to the dissemination of good practice, partly because of the system of external assessment which involved district catering managers in going beyond their own districts, and partly through networks that already existed prior to the inauguration of PR. Nurses working on the elderly PR had developed commitment to it, and had achieved the objective of changing the ways in which nurse managers thought about their work. The dissemination of good practice across professional boundaries was, however, limited. Changes in industrial or professional relationships in the expectations of services by consumer or pressure groups were not noted.

REFERENCES TO CHAPTER 5

(1) Secretary of State's Speech, Birmingham, April 1982, quoted in Wessex RHA, Performance Review Note 3, June 1982.

(2) Wessex RHA, Performance Review Note 2, July 1982.

(3) Wessex RHA, Performance Review Note 1, July 1982.

(4) Wessex RHA, Wessex Regional Performance Review: Background Papers, (Paper R 367), December 1976.

(5) Wessex RHA, Performance Review Note 2, July 1982.

(6) Ibid.

(7) J. Rice, Better Food for Patients, King Edward's Hospital Fund for London for Wessex RHA, 1975.

(8) Wessex RHA, Catering Performance Review, Manual I, Patient Food Services, October 1982.

(9) See, for example, J. Leach, The Student Nurse Learning Project: A Preliminary Report. An Analysis of Practice Which Influenced Student Nurses' Clinical Learning, Nursing Education Research Unit, Chelsea College, Research Paper II, 1980.

(10) E. Scrivens, D. Cunningham, J. Charlton, W. Holland, Measuring the Impact of Health Interventions: A Record of Available Instruments, Unpublished, 1984.

(11) Wessex RHA, Wessex Regional Performance Review: Background Papers, March 1981.

(12) Wessex RHA, Performance Review Estate Management, July 1983.

CHAPTER 6

SUMMARY, COMPARISONS ACROSS THE PROJECTS AND CONCLUSIONS

6.1 In this chapter, we first summarise the principal findings of the two trials and then identify the similarities and differences between the initiatives undertaken by Oxford and South Western and Wessex regions. We then reflect on the nature of a nationally inspired initiative of this kind and on the issues raised in evaluating it.

Summary of the Two Evaluations

The Oxford and South Western Management Advisory Service Trial

Objectives

6.2 The philosophy underlying Oxford and South Western MAS was that local NHS management needed external help to perform efficiently. MAS would demonstrate the use of largely routine data in comparing performance and highlighting deviations with the intention of promoting good practice and stimulating change. The detailed statement of objectives was:

> to identify, examine, make recommendations (and influence implementation) on significant management issues;
>
> to contribute to the development of planning within the NHS;
>
> to support districts in monitoring their own performance;
>
> to encourage the use of research resources and disseminate good management practice.

Particular subjects for study could be suggested by all levels and interests within the service and by MAS itself. Choice of subject was vetted by the Supervisory Board, taking account of such factors

as significance, resource implications for MAS, nature of the overall MAS programme and the possible product of study.

6.3 As the trial proceeded the stated objectives were maintained although differences of application emerged. It was unclear how far MAS studies were expected to motivate authorities to change under their own volition or to provide the data for management action by the regions. The comparative region-wide studies appeared to be less popular, particularly with districts, than the collaborative studies which involved working on local problems experienced by authorities. At the same time, authorities appeared to have little motivation for learning from good practice elsewhere.

The Model: Conceptual Coherence

6.4 MAS provided an external source of assistance, examining a range of services and functions within the two regions. Its approach was formative. More efficient performance would result from learning about their own current performance in comparison with that of others or as measured against stated standards or policies. Performance was examined in terms of inputs, process and policy fulfilment. At the same time it was accepted that a purely rational model would not always work; learning would be promoted by MAS working with local managers to resolve local problems or to design new management processes.

Model: Thinking About Change

6.5 The MAS team believed that it would take time to promote change, particularly since the service was preoccupied with reorganisation and increased management demands. MAS would have to become known and its value perceived before it could feed into organisational self-learning. MAS thus sought to influence management by a rational/empirical approach that involved 'top down' promotion of change by higher levels of authority, and 'bottom up' normative re-education from collaborative studies. (See Chapter 3)
MAS focussed its efforts upon managers, particularly senior managers, in the various authorities. Clinicians and authority members, who condition and constrain the activities of managers, were far less involved.

Model: Structures

6.6 The independence of MAS had been secured by making it accountable to a Supervisory Board, which, however, preferred to act as a 'sounding board' rather than as a source of detailed direction. MAS stressed its independence and saw it as an advantage in encouraging district participation and in making it supportive and developmental to districts. Yet districts saw it as the creation of the regions and dependent upon them in achieving results, and as an instrument of accountability to the regions. Independence meant, moreover, that MAS was continuously in search of a client and therefore had to devote time and energy to selling itself and negotiating its purposes and activities with the service.

Implementation of the Scheme

6.7 MAS undertook 27 studies in under two years. In doing so it employed a wide range of approaches including comparative region-wide studies, the development of new management processes, the development and testing of models of good practice and the consideration of particular local problems. At the same time, attention was given to publicising results, collecting an information bank for the service, maintaining contacts with regions and districts, participating in educational events, engaging in research and assisting central government.

6.8 MAS found it difficult to recruit staff with the desired qualities. Those with whom it worked in the service encountered problems in respect of time. MAS timetables were commonly experienced as too tight and other demands meant that it was often difficult to provide MAS with new information by the date required.

6.9 Although by the end of the trial period MAS was undoubtedly better known than at the beginning, management was not able to give it much attention. Knowledge of its existence did not spread far beyond senior management levels which, with some exceptions, did not make much use of its work.

Results

6.10 The achievements of MAS are not clearly discernible and did not attract much agreement. This uncertainty on the part of clients is partly attributable to the variety of expectations, itself a reflection of the lack of knowledge of MAS and its objectives.

6.11 MAS was seen by many as providing more and better information, although not necessarily anything new or which the service could not have provided for itself. Some believed that it had led to change, again without necessarily providing the sole or major influence. And the degree of change achieved by no means matched the range of recommendations that had been made.

6.12 For some, including the MAS team, such results were expected. The nature of the NHS, and the context in which it worked, ruled out the possibility of achieving any more striking results. MAS had worked hard and productively. It had become known, largely met its objectives and was now being approached for help by the service. Others were disappointed: MAS had achieved less than they expected, both in providing useful data and in engendering change. The time limitations of the trial had led it to perform work some of which was thought superficial and not capable of translation into more efficient management practice.

Costs

6.13 The direct costs of MAS totalled some £258,300 from 1981 to 1984; £125,200 less than budgeted. Actual staff costs in 1983/84 were £89,500. The costs to those with whom MAS worked or who supplied information to MAS seem to have been small, although no attempt to disentangle specific costs was made. These mainly consisted of the opportunity cost of the management time involved.

Impact of Concept

6.14 At the end of our evaluation, the success or failure of MAS was unproven. Commitment to it was patchy; stronger in one region than another, stronger in districts than at regional level, stronger with administrators and senior managers than with practitioners. As regions and the DHSS had strengthened their accountability mechanisms since 1982, so the idea of an independent source of advice had become more attractive and more viable for many in the service. However, others felt that the new management context rendered MAS redundant.

The Wessex Performance Review Trial

Objectives

6.15 In contrast with that of MAS, the philosophy underlying Wessex PR was that districts should be self-motivated to review and to cause beneficial change in their services themselves, albeit with advice from an external body such as the Performance Review Group (PRG) on how to do it. This accorded with the region's general policy of avoiding interventions from outside. The objective was to cause change in managerial behaviour at all levels in the districts, in terms of commitment to the evaluation and review of service performance and outcome of services and the endorsement of a comprehensive approach. The reviews were therefore to be voluntary and district-led, with an emphasis on self and peer review. PR was thus to represent both a development and a change from the previous monitoring system with its implications of top-down change processes. PR was to become part of routine management.

6.16 During the period of our review there were shifts in the objectives being sought. Increasingly, the regional team realised that a comprehensive approach might have to be modified so that the way to achieve PR would be to pursue key performance factors or particular issues or priorities. At tne same time, a difference of focus emerged between those who looked for changes in managerial behaviour and those who emphasised the importance of self-audit by clinicians and other professionals.

The Model: Conceptual Coherence

6.17 PR was conceptually eclectic rather than coherent. The regional conception entailed both 'top down' and 'bottom up' approaches. It was both summative and formative: it contained notions of externality, objectivity, and linear ends-means relationships, together with assumptions about the value of self-motivation and of collective learning. Emphasis upon products and outcome jostled with process related objectives. Elements of PR looked towards regionally agreed norms and standards, while others expected districts to create their own. The review of services might lead either towards a functional and professional focus or towards a more corporate, holistic and integrated concept.

Model: Thinking About Change

6.18 The development of PR did not entail explicit thinking about the processes of change and we have seen that a mix of concepts was inherent in the conceptual model. There was minimum recognition that change entails political processes and requires the building and use of appropriate institutions.

Model: Structures

6.19 The PRG was made accountable to the existing Regional Monitoring Committee. This may have reinforced the notion that PR belonged to region rather than districts, and emphasised continuity with, rather than a break from, the concept of monitoring. The minimalist role assigned to the PRG was logically consistent with the objectives of PR. But minimalism was not sustainable. There was pressure from some districts for the region to play a stronger role and similar pressure, too, from regional administration concerned about speed of implementation.

6.20 The conception of the regional role reflected the tensions in the relationship between region and district. Some districts wanted more regional authority whilst others wanted no regional interference. District Management Teams were given a pivotal role in PR. But many of them did not take it on. This may have been because many PRs concerned operational management, at a time when, following the removal of the area tier, districts were focussing more on strategic management.

Implementation of the Scheme

6.21 11 reviews were embarked upon. Some results were reported by the Performance Review Group in all except two reviews.

6.22 Those concerned with PR encountered problems of time. The resources of the PRG were small. It had been assumed that existing information would be sufficient but new performance measures, and sometimes new information, had to be generated. PRG members found themselves taking major responsibility for some reviews. The technocratic and rational-empirical approach adopted in the reviews, with their emphasis on attempting to measure outcomes, did not allow for the slower process of creating self-motivation and of collaboration and

negotiation which were also implicit in the PR conception. Moreover, time was short for both management and professionals because of extrinsic factors such as privatisation exercises.

6.23 In the event, PRs were often not led by districts. Nor were all reviews undertaken collaboratively across districts. Two PRs were effectively carried by one district alone.

Results

6.24 Yet there were discernible results, some of which were being reported as our evaluation was being completed. In some cases there was better and more information and, sometimes, more people were informed. Some measures of performance were identified, more of process than of outcome, and found usable. Some participants testified to the changes in thinking concerning roles and tasks resulting from PR. There were shifts of emphasis towards objectives and policies and the evaluation of performance. In some cases, policies were written out and agreed. The process of change in behaviour was begun in the direction of more review and collaboration.

Costs

6.25 The PRG's annual budget was £70,000, met wholly from regional funds but this figure excludes the salaries of the regional staff involved. As for MAS, the indirect costs to region and to districts, mainly the opportunity costs of management time, cannot be easily separated from the costs of work that would have been carried out even if PR had not existed.

Impact of Concept

6.26 Understanding of PR was patchy and information about its progress limited at all levels in the authority. District commitment to PR was not achieved. Where it was, regional involvement tended to be resisted. Districts already pursuing the kind of exercise proposed by the region did not attribute this to the PR initiative but saw it as different from, or even a reaction against, it. There were exceptions but even where PR had an impact it was likely to be transitional; effective until districts evolved their own systems for managerial development. No doubt this is true of both trials, but participants in Wessex emphasised the extent to which

other events were already pressing districts towards changes in behaviour and attitudes: the Körner Report, privatisation, efficiency savings and cuts, and the impending implementation of the Griffiths Report.

Comparisons Between the Two Trials

6.27 Before commenting on the principal contrasts between the two trials, we briefly tabulate comparisons mainly on the basis of our evaluative framework. (But see the cautions expressed in paragraph 6.28)

	MAS	PR
Objectives	Multiple focussed	Service focussed
	Problem orientation incorporated	Problem orientation eschewed. Attempt to encompass PR within single dominant concept of performance
	Improvement in planning	Concern with planning not dominant, More orientated to operational improvements
	Educational Development	Educational development
	One-off exercise: consultancy mode	Embedded in managerial practice
Conceptual - Model	Rational-empirical and normative re-educational dualities in both trials	
	Conceptually eclectic, with a variety of expectations, within a particular view of the change process within the NHS	Conceptually eclectic producing tensions within an apparently simple concept
Structures - Model	Independent of NHS but accountable to a Supervisory Board	Internal to the NHS, accountable to Regional Monitoring Committee
- Scope	Joint regions	Single region
- Staffing	Appointment of external staff - more likely to bring new or own views	Internal staff - more likely to share conceptions
- Expertise	Expertise through secondment	Professional leadership
- Focus	Senior management-district/regions	District management
- Authority	Based on regional authority but increasingly a consultancy relationship	Intended to be voluntary but initiated mainly by region
Time Scales	Time Limited	Uncertain
Costs	Budgetted costs of team: 1981/84 £383,500. Actual spend: £258,300	£70,000 pa. Main staff on regional staff roll. Other costs diffuse
Knowledge - Technical Content	Existing knowledge	New knowledge though started with assumptions that existing knowledge would suffice
	Quantitative measures conspicuous in reports	Aim for quantitative measures for performance, including of quality
	Financial expertise fully incorporated into MAS team	Some financial information used but place of financial expertise in scheme not fully worked out
Generalisability	Reports contained data for general use. But doubts about generalisation across institutional boundaries	In support services aimed to generate agreed standards and norms, but care group services doubts about trans-district standards and norms
Results	Met objectives. More information - not all would agree better	Better and more information
	Some measures of performance identified including clarification of policy	Some measures of performance identified (more of process than of outcome)
	Development of models of practice and new management processes	Changed thinking on roles and tasks
	Shift of emphasis towards objectives and policies and means of measuring their fulfilment. Shift of emphasis towards collaborative working	Shift of emphasis towards objectives and policies and evaluation of performance. Some policies written out and agreed
	Behaviour change process begun but uncertain how widespread or deep	Behaviour change process begun, but uncertain how widespread or deep
Commitment	Variable - reflects differing expectations of MAS and approach to promoting change in the NHS by different authorities and interests. Unproven as to how far such intervention promotes efficiency and if more effective than other mechanisms for promoting change	District commitment not achieved. Own efforts disassociated from those of region. Where commitment generated might prove to be transitional
	Commitment uncertain. Achieved primarily with senior management in one region and in the districts involved in collaborative work	Most commitment achieved within functional/ professional boundaries

Comments on the Comparisons

6.28 The table contained in paragraph 6.27 depicts the more obvious contrasts between the two trials but cannot express fully their particularities or the ways in which they changed over time. The MAS and PR trials were established in quite different contexts and with quite different structures. Yet although their stated objectives were different, they began to converge as the trials progressed. PR had insufficient time and other resources to pursue fully the comprehensive objectives approach. In some studies, MAS increasingly attempted policy clarification. The Wessex model tended to assume that an emphasis on outcomes would induce behavioural change. The Oxford and South Western MAS team shared this belief but worked through a wide range of projects and styles to show managers how they could become more efficient. Convergence was not the result of imitation. It seems more likely that both initiatives were responding to similar climates of organisational life and opinion. It may be, too, that there are problems faced in common by all kinds of NHS organisation which would emerge irrespective of the stated starting point of a change process.

6.29 A second group of objectives was concerned with the educational function of the experiments. MAS produced lucid and well documented printed reports and disseminated them widely. It set out to disseminate analysis of good practice. It produced materials which would be educative beyond the limits of the regions involved. At the same time it espoused with the districts and regions development through collaborative ways of working. PR was more emphatically concerned to generate self-education within the districts. The performance review method entailed collaborative identification of norms and standards. It also aimed actively to disseminate information. But the results belonged to the districts rather than to an external development group.

6.30 MAS laid a strong emphasis upon the importance of planning and the contribution that it could make to it. Wessex had traditionally shown a strong interest in planning and development of its techniques. The Wessex monitoring system, from which PR was derived, had been seen as a tool of planning. But whilst planning was certainly in the minds of some of those engaged in PR, and they saw it as helping the planning process, it was not an explicit objective of PR as stated by region.

Models of Intervention

6.31 No explicit pattern emerges in terms of the models of intervention discussed in Chapter 3 of this report. Both trials evinced aspects of both top-down and bottom-up modes of intervention. Both trials contained elements of normative re-educational and rational empirical attempts to implement change. Both embodied the use of authority by the regions, if mediated through persuasion rather than through direction.

6.32 MAS began with connotations of regional authority but increasingly moved towards a consultancy relationship in which its work could be used for self-development by districts. At the same time their work was taken up in regional reviews, although it was not clear at first that this would happen. In conception, and indeed in implementation, Wessex PR exactly reflected the ambiguities of the regional-district relationship. It was, thus, voluntary in intention but, in the event, most PRs were initiated after a period of persuasion by the region.

6.33 Both were, however, indeterminate in their development of power structures and in resolving potential political conflict. MAS worked hard in building up relationships with senior management at all levels of the service but did not succeed in recruiting the interests of practitioners or members of authorities. PR, whilst spending a great deal of time in building up relationships with the districts and practitioners, through the professional leadership device, or the specialty advisory committees, did not successfully establish the processes and structures necessary for ensuring that PR was sustained in the main sites of action within DMTs and district authorities. PR assumed voluntary participation by district management which did not necessarily entail voluntary participation among those accountable to that management.

6.34 If, however, the schemes varied in their assumptions about the involvement of different levels of management and practice within the regions and districts, neither widely invoked the use of broader political and institutional frames. Some of

the elements of each trial included client views, although in PR this tended to happen in those districts which undertook their own reviews with little or no regional help. CHCs, interest groups, and local authorities were almost wholly absent from the sources of data and opinion affecting the progress of both trials. So, too, were connections between regional and district authority members as opposed to full time officers.

Structures

6.35 MAS was an independent institution with its own structures, relationships with districts, budgets and resource needs. Its independence was enhanced, perhaps paradoxically, by the fact that it had a Supervisory Board. PR, by contrast, was intended to become part of the managerial way of life and thus employed minimal institutional arrangements. It was deliberately structured to create frugal resource demands. Both incorporated the notion of flexibility in that different members of the team would be directed towards different kinds of projects. PR depended on professional leaders or members of specialty advisory committees who were not, however, members of the team, except inasmuch as PRG staff stepped in to perform a professional leadership role on some occasions. MAS incorporated flexibility by secondment from the service of individuals with desired attributes, which were only partly cast in terms of NHS disciplines. Neither trial, however, found it easy to identify the networks or structures necessary for full and successful implementation of change.

6.36 The two trials began with different assumptions about the levels at which initiatives would be taken. MAS was primarily directed to the senior management at regional and district levels, a feature compatible with its focus on planning and information for monitoring performance and problem solving. PR was seen as relevant to management at all levels but the locus of responsibility for its operation was senior management at district level. MAS, however, might now be moving to include the unit management team in its work, as reorganisation begins to take effect. And, in the event, PR has taken place, in some districts, primarily at the unit level. Once again, convergence

between the two trials appears to be occurring. Schemes beginning high in the management system seek connections with operational development. It is, however, less clear that performance review is moving from the operational to the strategic. PR is firmly located within functional lines of management and for it to make the transition to the larger system it would have to enter more strongly into the corporate management scheme of things. Where districts have taken responsibility for PR they have done so in terms of a functional management approach rather than as part of overall corporate planning. Not only has PR tended to stay within its functional boundaries but within such an area as care of the elderly, it has evoked professional rather than all-service commitments. This, in its turn, has led to the endorsement of self-evaluation for self-improvement rather than more generally usable clinical audit. Managerial, let alone corporate management, aspects of such reviews have, therefore, as yet not been taken up. MAS is more clearly linked, both through its focus and through the nature of the studies undertaken, with corporate management. This, however, has not so far served to afford its work any particular emphasis. Indeed, critics argue that it lacks the sponsorship that might be provided by appeal to functional interests.

Time Scales

6.37 Both trials were acting within the same overall time scales implied by the DHSS announcement of an experiment. But they differed in the extent to which they were affected by the national framework. MAS was more aware of the implications of a massive reorganisation. It developed a fast through-put of projects which could be initiated, worked on, and published to be of reasonably immediate use and to demonstrate the existence of MAS. Since MAS was explicitly part of a time limited trial to be reviewed in a relatively short period, it had to make its mark quickly. The fact that its members were appointed on limited time contracts may have sharpened this imperative. There was a budget to be negotiated, within time constraints, with the DHSS. By contrast, PR, dependent as it was upon the commitment of the districts, and without the frames established by a more definite connection with the DHSS scheme, was not tied to externally determined time scales and at the beginning did not feel the pressure

of time scale and the achievement of explicit objectives within it. As the trial continued, however, the PRG became increasingly aware of the lead time necessary to initiate and carry through projects, and to produce perceptible results.

Knowledge and Technical Content

6.38 The acquisition and use of knowledge varied between and within the two trials. Both began by putting a premium on the use of existing knowledge. The MAS concentrated on collating and analysing existing data in the belief that it would lead to a process of change in management and planning. However, it did begin to evolve fresh analytic approaches, such as measuring policy outcomes. PR also began in the hope that existing data could be used but, because it was interested in identifying and improving service outcomes, became increasingly involved in creating new data. This was not fully compatible with the determination to keep the resource costs of PR to a minimum. Within PR some saw the creation of new and usable data as its most significant feature. Others saw this as a means to the principal end of achieving behavioural and organisational change.

6.39 In both trials there was the expectation that the region would provide expertise which the districts could not generate themselves. Districts wanted information and techniques which would help them with problems. As far as MAS was concerned, opinions were expressed that there was 'nothing new' in what had been provided yet districts/region did not have the resources to collate the information for themselves. A similar response was made to PR activities in terms of 'this is what we should be doing as managers anyway'. A contrary view was that the process produced unusably complex and multiple data which could be out of touch with the needs of management. These apparent criticisms should not, however, be taken at their face value or as cancelling each other out. They reflect the range of audiences addressed by MAS and PR. Moreover, the fact that collated data contained 'nothing new' or that an initiative reinforces or elucidates what managers ought to be doing as part of their general activities

may show that the initiative is successfully directed towards the problems that actually face managers and practitioners. There is a two fold problem in the use of data. First there is the problem of collecting relevant data. Secondly there is the problem of making its use active so that it does not stand simply as inert material collected for the sake of collection or display.

6.40 A further issue was the extent to which financial data and expertise were present. They were exploited in MAS but finance officers felt that they were less well represented, and less rigorously worked at, in PR.

6.41 Both projects raised the issue of what necessary expertise rested where. In particular, questions were raised, but not answered, on whether specific needs of districts could be met by each district's own capabilities (as some attempted to do); by a consortium of districts; by districts themselves seeking external support from consultancies; or through regional capabilities such as operations research, management services units, or a version of the PRG.

Generalisability

6.42 Two issues arose about the extent to which materials produced from the trials could be generalised and disseminated beyond their point of origin. First, would the knowledge and experience derived from a project be applicable to other districts or regions or functional or professional areas of work? The second issue was whether the approach or methods of either trial were transferable elsewhere. Participants in some PRs expressed doubt about the extent to which standards or criteria of performance could be generalised across districts. They were concerned with issues which were context bound and likely to be uniquely associated with the factors present in any one district or unit. Similar objections were raised in MAS projects. They were, however, written up to be immediately accessible to managers and practitioners not only in Oxford and South Western districts but in districts outside the region. It remains uncertain how far management will look for examples of good practice to emulate. In the

context of the MAS trial it appeared to lack the will to do so. MAS' emphasis upon, for example, participation in planning embodied aspirations of selling a particular approach to work. Similarly, in spite of the difficulties of clarifying objectives, the PR mode of working was seen by some as transferable by professions working within many services and by district managements across different service areas.

Some Conclusions

6.43 We have referred in earlier paragraphs to explicit products of the MAS/PR trials which became evident at the end of our two year evaluation. MAS' 27 studies and PR's 11 reviews produced information which could be used by management for its own purposes and not simply for purposes of accountability to other levels. The impact was perceived to be uncertain, and not easily disentangled from the effects of other contemporaneous initiatives within the NHS. At the same time, those concerned with initiating and carrying out the experiments, in the MAS team, and the Performance Review Group, felt that the trials were beginning to produce changes in attitude and in procedures.

6.44 The time initially set for the schemes participating in the trials was two years, and an additional year of support was later allowed by the DHSS. Inaugurating and evaluating beneficial organisational change, however, needs much more time than this. Whatever our hopes at the beginning of the evaluation, therefore, we could reach no conclusion on whether the trials had been 'successful' or 'unsuccessful' at the end of the 30 month period allowed for our work. We have attempted to draw attention to tendencies and trends in the preceding paragraphs. In the concluding sections of this chapter we sketch in some of the more general inferences that can be drawn from the MAS/PR experience.

More General Reflections on the Evaluation

6.45 The two trials evoke the question: how far can central government departments help to promote change in the NHS? The trials and their evaluation were inaugurated by the DHSS and financed by it. The relationship between the DHSS and the NHS has been typified by Hunter (1) as applying a top-down conception of policy and implementation in which the DHSS makes policy and the health authorities implement it. But the MAS/PR trials were an attempt to help health authorities to help themselves in changing organisational behaviour. How far was it possible, then, for the DHSS to put itself effectively behind such an initiative?

National Context

6.46 The DHSS' intentions were ambiguous from the beginning and changed in emphasis by the time of the start of the trials. They moved from a concern with setting standards, evaluating and identifying needs for change towards objectives of economy. The original impetus for the national trials came from a Minister endorsing devolution and the importance of dissemination of good practice between authorities. They were launched by another Minister aiming to strengthen central control over costs and standards.

6.47 The trials went ahead before it was clear that all of the intended regions would and could participate. The original MAS concept was in consequence never put to the test because one of the four regions decided not to participate. One of the schemes in the trial, the Wessex PR, not only was explicitly not a Management Advisory Service, but also was more ambitious in its objectives than was the national trial. It aimed to focus on and achieve changes in outcome. The Oxford and South Western MAS, once in action, also laid strong emphasis on influencing the implementation of change rather than simply identifying the need for it.

6.48 These were the circumstances in which the DHSS sponsored the national trial. It is rare for the Department to undertake a pilot scheme of this kind at all, let alone during a period of massive change within both the NHS and the larger political environment. It would not have been possible in such circumstances for a rigorous programme of 'systematic experimentation' to be established. However, what the DHSS seemed to envisage, a comprehensive evaluation of the strengths and weaknesses of each initiative, might still have been feasible. As it was, neither the experiments themselves nor the arrangements for their evaluation were adequately planned. No account was apparently taken of the nature of the enterprises being set in motion in the name of MAS and PR, in order to establish a time frame appropriate to the objectives and processes entailed. The argument that such a time frame would have been too long to be useful to policy makers is not necessarily conclusive. But the acceptance of such a frame would have meant a particular kind of evaluation project, in which policy makers, participants in the trial and evaluators worked in systematic interaction. We return to the question of time frames later. A second problem was the absence in the agreed evaluation of a region or regions not undertaking a MAS initiative to serve as experimental 'controls'. As more mechanisms were set in motion to cause change in the management of the NHS, this lack assumed greater significance.

6.49 If the trials began without adequate forethought, their evaluation was abandoned four months before their planned completion date: not the most predictable act of a Department apparently wedded to a philosophyof rational control and value for money.

6.50 Many would share Hunter's view that the centre cannot itself cause change but must rely on changes initiated in the working institutions. But in the MAS/PR trials the DHSS did not attempt to enforce change. It intended to enable others to cause change rather than to direct it itself. This attempt fell down on the ambiguities and lack of initial organisation of the scheme and on the DHSS' failure to see it through. It did not attempt to apply overwhelming authority which would have been a factor spoiling the chances of self-generated change in the regions and districts .

Nor is it inherent in the DHSS to behave in this way. The PR/MAS experiment still leaves over, therefore, the question of whether the DHSS, if it gave itself an adequate time frame in which to determine its objectives and arrangements for securing them, could act as an effective enabler of change by others.

Can Pilot Schemes Help?

6.51 If we take for granted, therefore, adequate sponsorship of pilot schemes, by the DHSS or some other external funding and legitimating body, what might make it difficult for pilot schemes to work and to be helpful in generating wide scale change? From the experience of PR/MAS it seems clear to us that there is a spectrum of difficulty in experimentation. At one end of the spectrum lie experiments in which progress will depend upon the clarification of technical issues, where objectives can be specified and agreed, and evaluation of outcomes more easily achieved. Such would be true of, for example, certain limited aspects of experimentation in catering procedures. At the other end of the spectrum, where opinions might be deeply divided between different professional disciplines, or between professions and client groups, or between different levels of authority, or between employer and employee organisations, consensus about the objectives of experimentation will be difficult to secure. The substance of the experiment might not be susceptible to clear analytic categories so that criteria of progress will be difficult to establish and measurement or identification of change difficult or impossible to achieve. It is factors such as these which make it difficult to experiment and identify changes in organisational and managerial behaviour.

6.52 A further factor affecting the success or otherwise of pilot experiments concerns their sponsorship. Although the DHSS did not intrude in the trials once it approved and financed them, issues of organisational behaviour are well to the fore of the DHSS-health authority agenda. The DHSS has, after all, taken a lead in three major reorganisations of the NHS within the working lifetimes of many now responsible for health service organisation. Changes in structure must be intended to affect organisational behaviour. This,

however, did not emerge as an issue in the two trials; instead, the regions carried the onus of being a point of authority from which the initiative was launched. But the identity of the client remained uncertain. Was it the region, or the districts, or the units, or the practitioners who were supposed to be the beneficiaries? Uncertainty on this point impeded the build up of commitment and consensus about the objectives and operation of the trials but perhaps derived from deeper seated uncertainties about the region-district relationship.

6.53 If then the objectives of a trial are not agreed, if the clients of an initiative are uncertain, and if there are groups involved in it with different values and priorities, can a pilot scheme be of any value? We think that it can, but that its tasks may be as much to identify issues, clarify assumptions and to map approaches to the complexities that emerge, as to resolve problems or produce solutions. But the evaluative methods required must then be congruent with such tasks.

Can Pilots Be Evaluated?

6.54 In Chapter 3 we drew attention to the range of evaluative frames from which choices can be made. In those experiments where the issues are technical and the objectives clear and agreed, an evaluation should be capable of reaching conclusions about outcomes. Indeed those involved in the experiment might themselves be able to perform such an evaluation. The MAS/PR trials were, however, far more complex and were, for the most part, concerned with behavioural and organisational change. In such circumstances, as Cope has argued (see Chapter 3), at most a quasi experimental frame can be adopted. And in such cases it seems to us that the mode of evaluation can most helpfully be formative, that is to say, designed to feed back to the participants information and judgements about the tendencies towards change created by the initiative and the multiple perceptions of those affected by it. In this role, the evaluators would take on an interactive and consultative rather than an objective and summative or distanced role. Under such circumstances, and given an adequate time frame for both the experiments and their evaluation, we believe that evaluation can be helpful.

6.55 The mode of experimentation and of evaluation proposed here is non authoritative and in line with the range of models offered by Weiss (2) of social research impact that are alternatives to direct, linear or instrumental models. They include the enlightenment model, where research permeates the policy making process not by specific findings but by its 'generalisations and orientations percolating through informed publics', so shaping the way in which people think about social issues. The interactive model allows for social scientists to enter the arena of policy development as one of a number of participant groups. The process is then 'not one of linear order from research to decision but a disorderly set of interconnections'. Weiss was discussing here social research in a broader sense than that applicable to the MAS/PR experiments. But the implications are similar; for our work as evaluators, and for the work of the protagonists in the trials themselves.

Time Spans

6.56 The time required for organisational experiment and its evaluation is patently more than two years. Whilst it is not possible to be specific about the optimum or reasonable period for an experiment it is possible to note the stages through which such an experiment must pass so that appropriate time allowances can be made. The time scale for an experiment will vary according to its nature. If, for example, a project involves not much more than collecting information and disseminating it, a few months or even weeks might be adequate. Again, if changes are to be proposed within a single professional discipline, problems of securing consensus and of developing a common language might make it possible to inaugurate and evaluate change within a period as short as two years. For the most part, however, the kind of experiment which MAS/PR was intended to encourage was to be interdisciplinary and, in some cases, trans-institutional. Such experiments must involve negotiation about conflicting values and objectives, the clarification of common language, decisions about the potential beneficiaries and the authority base of the experiment. The programme design has then sensitively to analyse the cases to be

tackled in terms of the many groups involved, to accommodate the political problems that might arise, as well as to tackle the issues of technical feasibility and the unintended consequences of change. One ambitious account of an implementation process specifies a formulating process and a carrying out process. Whilst it is by no means clear that all of the steps enumerated by Wolman (3) need to be pursued, his schema does give some idea of the potential extent of an experimental process leading to the implementation of change. The time scales involved would obviously be protracted. Wolman speaks of a formulating process including:

(a) problem conceptualisation;
(b) theory evaluation and selection;
(c) specification of objectives;
(d) programme design;
(f) programme structure.

The carrying out process includes:-

(a) resource adequacy;
(b) management and control structures;
(c) bureaucratic rules and regulations;
(d) political effectiveness;
(e) feedback and evaluation.

Incentives to Change

6.57 For the most part, the experiments did not face explicitly the issue of incentives. In one case, that of the Wessex Catering PR, the process of accreditation of hospitals was deemed to be an incentive in its own right and was incorporated in the review. Otherwise, it might have been assumed that MAS or PR would be a resource to districts helping them to cope with local problems and perhaps a source of recommendations that would influence the DHSS and the regions when considering proposals made in district reviews.

6.58 It is possible to conceive of two broad types of incentives that might have been identified. First, there is the merit of change and development for their own sake, part of the creed of the good manager and the reflective professional. In such a scheme of things, which incorporates the notion of normative re-education or self-education, the costs of participating in the work involved in

experiments are offset by potential improvement in the service that one can offer. A second model perhaps leads to the same benefits in the end but through a different route. It conceives of the health service as a system in which management and practice must become more efficient and effective. To some extent it responds to business models of efficiency and concerns itself with the saving of money and other resources, the improvement of work flows, and in the clarification of working systems. The incentives may be no different from those implied in the first model; for one thing it is unlikely that cash rewards will accrue to those who enhance efficiency. But the incentives to, say, a district or a unit might be tangible inasmuch as they might produce savings of money or other resources which it can employ in different ways. A wider margin of freedom is then created.

6.59 In the experiments as we observed them the concept of incentives was not prominent. The ethic was, however, primarily that of the public services in which efficiency and its concomitant virtues were their own reward.

6.60 Our evaluation of both MAS and PR suggests that only as they fully engage with the complexities of the service and gain multiple commitment are the changes that they seek likely to become established. It suggests that solutions relying too much on conceptual simplicity or concentration of control are unlikely to be sustained. The authors of the two schemes did not fall into that trap, but the frugal time and resource scales and the uncertainties of sponsorship, both national and in the districts, gave no leeway for a full working out and negotiation of the complexities.

REFERENCES TO CHAPTER 6

(1) D. J. Hunter, 'Centre-Periphery Relations in the NHS: Facilitators or Inhibitors of Innovation', in K. Young (ed), National Interests and Local Government, Heinemann Educational Books Ltd., 1983.

(2) C. H. Weiss, Using Social Research in Public Policy Making, D. C. Heath, Lexington, Massachusetts, 1977.

(3) H. Wolman, 'The Determinants of Program Success and Failure', Journal of Public Policy, Vol. I, Part IV, October 1984, pp 433-464.

APPENDIX A

'THE PROCESSION' OF MANAGEMENT INTERVENTIONS IN THE NHS

(Referred to in Chapter 2)

(1) HEALTH ADVISORY SERVICE

Origins

1. Hospital Advisory Services (HAS) for England and Wales were set up in 1969. They became the Health Advisory Services in 1976. (The functions and mode of operations of the two services are similar, except that the HAS England is not concerned with mental handicap). The Hospital Advisory Service for Scotland was set up in 1970 and is still in being. It includes mental handicap services.

Motives

2. In 1970 the formation of the Hospital Advisory Service reflected concern with care of the chronically sick in long stay institutions. In 1976 the broadening to the Health Advisory Service reflected shifts to community care and perceptions of the importance of inter-agency relationships to health.

Objectives

3. The Hospital Advisory Service was:

(a) to help improve the management of patient care in individual hospitals;

(b) to improve the hospital service as a whole by constructive criticism and propagating good practice;

(c) to advise the Secretary of State.

(Matters of individual clinical judgement were explicitly excluded).

4. The Health Advisory Service was to help maintain, and, within the available resources, improve the standards of management and organisation of patient care in the hospital and community health services by:-

(a) encouraging and disseminating good practice, new ideas and constructive attitudes and relationships;

(b) acting as a catalyst to stimulate local solutions to local problems (matters of clinical judgement were still explicitly excluded).

Methods

5. The HAS works through multidisciplinary teams (five or six members) drawn from the NHS and local authority social services departments. Team members, apart from the HAS Director, are seconded to HAS. They are senior or experienced in their particular field and their experience is current or recent.

6. HAS is examining services provided by the NHS and local authorities for the mentally ill, the elderly and children receiving long term care. They arrange their own programme but this does involve consultation with the authorities to be visited.

7. Before a visit, the Authorities concerned must supply information regarding the service to be seen, notifying their senior staff and asking them to work with the team. Studies are based upon recorded information, observation and discussion. Visits last one to two or three weeks. Members of the team give advice on the spot, although major matters will be discussed with the authority. The team will try and reach agreement on what can be done before they leave, discussing issues with representatives of authorities and with senior staff. Reports are sent in draft to authorities to agree the factual content and then in final form to authorities and the Secretary of State. Reports cover the issues raised, the agreements reached and areas where action could not be agreed because of: lack of resources; exclusion from the remit of the authority; disagreement.

8. The expectation is that the Secretary of State will consider any recommendations of national significance. HAS generalises its findings in an annual report to the Secretary of State. This report is published which may be a further stimulus to change. Supporting services for HAS are provided by the DHSS.

Implementation

9. Implementation of HAS recommendations is for authorities. It can be seen, however, that HAS has a number of levers - local agreements at the time of the visit, the report to authorities, the report to the Secretary of State and the Annual Report. HAS teams follow up the results of their visits, usually after six months has elapsed. The follow up may take the form of enquiries or a short visit. A report on the follow up may be issued directly to the Secretary of State.

Relationships and Authority

10. HAS is independent of the NHS and DHSS. It is accountable to the Secretary of State. It has authority to visit, to obtain information and to report conclusions. It gives local advice but also reports to higher authorities, including reporting on whether its advice has been taken. It has authority to monitor the NHS.

Evaluative Criteria

11. The HAS uses relevant national standards but also relies heavily upon emerging conceptions of practice, as promulgated by leading professionals.

(2) MONITORING

Origins

12. The concept of monitoring was introduced in Management Arrangements for the Reorganised National Health Service in 1972 (The Grey Book). (1)

Motives

13. Monitoring was seen by the authors of the reorganisation of the NHS as a means to achieve more systematic control of policies and performance in a situation where hierarchical relationships were not going to be acceptable or appropriate, and where maximum delegation and responsiveness to needs were to be encouraged.

Objectives

14. The need to decentralise local planning and operational responsibilities had to be balanced against the need for national and regional strategic direction or control over public funds. This would be achieved by means of a comprehensive and formal planning and monitoring process. (The Grey Book, Para 1.31). District Management, the AHA and the RHA were to have delegated authority to implement planning proposals agreed between them. Monitoring was to be one means of maintaining accountability in each case. (Para 1.32).

Methods

15. Objectives and planning proposals were to be agreed following an 'interactive dialogue between DHSS, RHAs, AHAs and their District Managements'. Operating authority for achieving the agreed objectives was then to be delegated and the performance of each level of the NHS structure was to be monitored by the level above against the agreed objectives. It became evident that clear objectives, criteria and measurements of performance were essential for effective monitoring. (2)

Implementation

16. The Secretary of State and the health authorities were to determine what action should be required of their management teams on recommendations made through monitoring.

Relationships and Authority

17. The authority of the monitoring relationship depended upon consensus about objectives and criteria and upon good working relationships between the different levels of management.

Evaluative Criteria

18. These were worked out between the management levels within the framework of the planning system. Recent interventions such as Regional Review and the development of performance indicators could be seen as means by which criteria might be generalised.

(3) PLANNING

Origins

19. The reorganisation of 1974 entailed a decision to set up a formal planning system. With the participation of NHS officers and following the institution of field trials, the full NHS planning system was introduced in 1976. (3)

Motives

20. It was part of the more general commitment by government in the early 1970's to move from piecemeal and ad hoc decision making to a more rational, technological and comprehensive approach to planning and policy implementation.

Objectives

21. 'To provide urgent review of policies designed to ensure that the overall cost of policies matches overall resources over the next five and ten years, and in the process to evolve comprehensive strategies and priorities for the development of the health and personal social services.'

22. 'Planning systems are seen as a principal means of achieving a clear line of responsibility for the whole NHS from the Secretary of State downwards to and within the AHAs, with corresponding accountability back to the Secretary of State through the Department.'

Methods

23. A clear distinction was made between strategic and operational planning, although the interaction between them was recognised, 'with operational planning providing a test of feasibility to strategic plans.'

24. A formal planning cycle was established involving the transmission of guidelines down through the authorities on resource allocation and priorities and the submission upwards of proposed plans based on them for integration at the higher tiers.

Relationships and Authority

25. The lines of accountability for carrying out the planning process were clear, but the processes for securing agreement on plans between the tiers were less clear cut.

Evaluative Criteria

26. Relevance to need. Relevance to resource availability. Compatibility between plans and time horizons. Flexibility. Comprehensiveness. Presumption that plans would be arrived at through a consultative process.

(4) NATIONAL DEVELOPMENT TEAM FOR THE MENTALLY HANDICAPPED

Origins

27. The National Development Team for the Mentally Handicapped (NDTMH) for England was set up in 1976.

Motives

28. Concern of Secretary of State (Mrs. Castle) for the care of the mentally handicapped, stimulated by critical reports and later by the work of the National Development Group for the Mentally Handicapped.

Objectives

29. The team itself is intended to promote national policies for the care of the mentally handicapped and to act as a catalyst for health and local authority services in the joint planning of services. During its visits it is available to provide advice upon specific local planning proposals and any facet of the operation of existing services within the framework provided by national policies and priorities.

Methods

30. The NDTMH works through a multidisciplinary team drawn from the NHS and local authorities. Apart from two full time Associate Director team members, including the Director, members are seconded to the NDTMH. They are experienced in their various fields and their experience is relevant to the current provision of mental handicap services. The panels are constantly reviewed to get individuals with new perspectives. It is also interesting that a team for a full visit will include a parent of a mentally handicapped person.

31. The NDTMH visits by invitation from the relevant authorities. Although the Secretary of State can ask for a visit to be made, this authority has not yet been used. Before a visit, the terms of reference are agreed with the health and local authorities concerned.

32. The team depends upon being given full and accurate information by staff participating. In addition to meeting staff from the health and local authorities it will meet with CHCs, voluntary groups and parents.

33. Full scale visits take from one to six weeks. Before they leave, the team will indicate their broad conclusions in a meeting with the authorities concerned.

34. Reports go to the relevant authorities who decide on distribution. Generalised findings and recommendations are set out in published reports. If, however, the team observed a matter of serious concern, this could be brought to the attention of the DHSS or the Secretary of State. The NDTMH also has close relationships with the DHSS. Periodic but regular meetings are held between the Directorate and members of the Mental Handicap Policy Branch.

35. Supporting services for the NDTMH are provided by the DHSS.

Implementation

36. Implementation of recommendations is up to the authorities. At the request of the Secretary of State, in 1978, the NDTMH will follow up the results of their visits usually after an interval of two years.

Relationships and Authority

37. NDTMH is independent of the NHS or DHSS. It is accountable to the Secretary of State. It has no authority to visit. Where it has been invited, it has the authority to obtain information and to report conclusions. It gives local advice but also has the sanction of report to the relevant authorities.

Evaluative Criteria

38. NDTMH uses relevant national policies and standards but also relies upon professional conceptions of good practice.

(5) REGIONAL REVIEWS

Origins

39. The 17th Report of the Public Accounts Committee 1980/81 (4) stressed the need to strengthen the accountability to Parliament of English health authorities. In January 1982 the Secretary of State's answer to a Parliamentary Question announced the intention of annual regional reviews.

Motives

40. To increase central control without apparently conflicting with delegation as set out in Patients First. Also derived from public expenditure constraints and changing policy priorities in the national health service.

Objectives

41. To strengthen the line of accountability from districts to the Secretary of State through the regions for more efficient use of resources within central government priorities and limits.

Methods

42. Annual meeting between Minister, regional health autohrity chairmen and regional chief officers at which progress made in achieving agreed plans and objectives for the year is reviewed and action required during ensuing year agreed.

43. Regional review paralleled by district reviews and oonsultation Regional chairman and regional officers and district chairmen (and authority members and district management team).

44. Use of performance indicators to make comparisons between districts and to measure progress within the region.

Implementation

45. Regions are accountable to Secretary of State for taking action themselves within planning, resource control and monitoring functions and for attempting to secure district compliance in actions required from them. Districts are left with primary responsibility for decisions on operational services.

Relationships and Authority

46. Regional reviews are conducted within the framework of authority relationships entailed in the NHS structure. The line of accountability from district to region to DHSS to Secretary of State is reaffirmed. Reviews entail 'top-down' assertion of authority relationships to gain commitment to objectives and compliance with national policies and standards, although objectives must be agreed and are based on consultation.

Evaluative Criteria

47. Basic assumptions are that regional norms can be agreed against national policies and standards and sustained, and that performance and progress can be measured. Evaluative mode is quantitative. However, performance indicators aim to generate dialogue and questions and are perceived as essentially multiple. Different patterns of indicators are considered likely to be relevant to different authorities.

(6) INDICATORS

48. In an initial exercise the DHSS worked with the Northern Region on the formulation of performance indicators. (5) The DHSS gave evidence to the House of Commons Social Services Committee (6) that the indicators to be applied were as follows:

> 'Average total cost per in-patient case; average cost of direct treatment services and supplies per in-patient case; average cost of medical and paramedical support services per in-patient case; average cost of general (non-clinical) services per in-patient day; proportion of all admissions classified as immediate admissions; proportion of all admissions classified as urgent involving a delay of more than one month before admission; proportion of all admissions classified as non-urgent involving a delay of more than one year before admission; average length of stay for hospital in-patients; average in-patient cases per bed over the year; proportion of all in-patients and day patients treated as day cases; average number of out-patients seen in each clinic session; ratio between new and returning out-patients; number of health visitors and district nurses per head of population; number of NHS administrative and clerical staff per head of population.'

49. It is clear that various kinds of measures and different ways of relating data are implicit in this exercise. The Department has been resistant to placing too much faith in indicators. As Klein has put it

> 'Indicators are a tool for generating questions. The performance indicators..... suggest that the DHSS is trying to apply a variety of different criteria to the evaluation of performance. One predictable concern is with costs, another is with the intensity of use.'

The DHSS Northern Region exercise was essentially concerned with using data already available which would help illuminate discussion on value for money. It was to be tied to the annual reviews. Rather than attempt to find a single indicator the intention was to construct a 'sieve' which would focus attention on areas where the study looked worthwhile. A central data set might enable health authorities to make comparisons within a national frame of reference. Both 'soft' and 'hard' information was tapped to set the findings in context. Through an interactive process, the group arrived at its first set of indicators. All indicators are concerned with process, resources, activity and costs: none with impact or outcome.

50. The approach was later adopted nationally. The first national set of indicators was published by the DHSS in 1983 (7). A Joint Group is reviewing the further development of performance indicators.

(7) THE ENGLISH HEALTH SERVICES INFORMATION GROUP

Origins

51. Discontent about the quality of data available to the resource allocation process and the national health service planning system persuaded the DHSS to set up a preliminary study of the problem. As a result of its findings, the Health Services Information Steering Group (ISG) or Korner Committee was established in February 1980.

Objectives

52. To conduct a comprehensive review of NHS management information systems; to ensure that national data systems are designed primarily to meet the needs of operational management and planning, rather than the demands of central government; to improve the content and quality of data; to create an environment which encourages the efficient collection, collation, processing and transmission of data; to promote the effective use of information to improve decision making.

Methods

53. The Korner Committee set up sub-committees to identify in the various activities of the NHS the need for data, applying criteria of desirability, feasibility and affordability, and to design a minimum basic data set for each authority. Proposals were developed in consultation with data providers and data users. Interim recommendations were made and tested in pilot districts before final reports were produced. There were six reports on information for hospital services, patient transport services, manpower, certain services spanning hospital and community, community health services and finance.

Implementation

54. Implementation is to be by the health authorities. However, the Korner Committee is responsible not only for recommending data systems but also for overseeing their implementation. The Committee's choice of methods of work was strongly influenced by its commitment to implementation and it has vigorously promoted the training of data collectors in the NHS, seeing this, together with the introduction of appropriate information technology, as the key to implementation. The proposed time period, endorsed by Ministers and Regional Chairmen, is three years from mid-1984.

Authority and Relationships

55. The Committee 'is a joint group between the NHS and the DHSS: it is chaired by a representative of the NHS'. (8) It is an advisory group, but the authority of the DHSS and the NHS has been thrown behind it. (9)

Evaluative Criteria

56. Criteria for the Committee's recommendations were that all authorities should develop minimum data sets, based upon the requirements of operational management.

REFERENCES TO APPENDIX A

(1) DHSS, Management Arrangements for the Reorganised National Health Service (The Grey Book), HMSO, 1972.

(2) M. Kogan et al, The Working of the National Health Service, Research Paper No. 1, for The Royal Commission on the National Health Service, HMSO, 1988, para 4.3.

(3) DHSS, The NHS Planning System, June 1976.

(4) Public Accounts Committee, 17th Report 1980/81, HMSO, 1981.

(5) DHSS, RA(82)34, Performance Indicators in the NHS. Progress Report on Joint Exercise Between DHSS and Northern Region.

(6) R. Klein, 'Performance, Evaluation and the National Health Service: A Case Study in Conceptual Complexity and Organisational Complexity', in Public Administration, Vol. 60, No. 4, Winter 1982.

(7) DHSS, Performance Indicators: National Summary for 1981, 1983.

(8) M. J. Fairey, 'The Korner Report and its Implementation', in Hospital and Health Services Review, Vol. 79, No. 4, July 1983.

(9) See, for example, DHSS Circular HC(84)10, April 1984.

APPENDIX B

EVALUATION AND INTERVENTION APPROACHES

Evaluation as Part of the Trials

1. Issues of evaluation became relevant to the MAS trials in two ways. First, the team had to decide which evaluative frame it might adopt and was thus led to review the possible range from which to choose. Secondly, it could have been expected that evaluation might itself form part of an MAS or PR activity undertaken by those in the field. In the event, evaluation did not emerge as the major feature of the intervention exercises. Some of the evaluative issues considered by the team are, however, recorded here as being at least in the background of our study. Notions of 'quality assurance' and 'accreditation' (in the catering PR) implied evaluative questions. The PR intention to measure outcome likewise involved complex issues of evaluative method.

2. Evaluation varies according to the nature of the change towards which the intervention is primarily directed: whether for example, it is impoovement in quality, reduction in cost, or equalisation of access which is sought. Further variation derives from whether it is concerned with evaluating the quality of the inputs, or the outputs, or the processes. Evaluative theory is an area in which there is considerable controversy and important dichotomies in the approaches adopted: the quantitative as against the qualitative, the illuminative as against the experimental are obvious examples. In practice, however, actual evaluations tend to contain mixed approaches.

3. Many attempts have been made to classify the different evaluative approaches which can be conceived of as a continuum, at the extremes of which there are two principal modes. The classic, experimental, 'scientific' approach which primarily depends upon the establishment, preferably by randomisation, of a strict control group against which comparative observation can be made. Randomised control equalises sources of variability that cannot be specifically controlled. The 'blind', or better, the 'double-blind' trial eliminates subjective bias. Thus, the nature of an existing state can be assessed, the effects of a clearly specified intervention can be evaluated and hypotheses tested. This mode is at the extreme of the continuum but is, nevertheless, important in practice. It encompasses, for example, clinical trials of new drugs and (without the blind element) such large scale genuine social experiments as the Rand study of alternative national health insurance programmes. (1)

4. The emphasis on randomised controlled trials (RCTs) has spread an appreciation of the problems of comparative evaluation into areas where such trials are not feasible. The 'scientific clinical model' has become an ideal, even in

areas where it is unattainable, against which other forms of evaluation now tend to be judged. At the other extreme there is evaluation of a situation where there is no control that is or can be specified and no testable hypothesis rigorously established. Two possibilities can then emerge. There can be no attempt to compare equivalent states over time. In one case, the evaluation involves collecting as much information as possible with a view to making judgements about the quality of the processes adopted and of the impact as perceived by those involved. Questions of milieu, of political interaction and negotiation, can also be accounted for in analysing reasons for particular outcomes. The evaluation attempts on that evidence to derive patterns and trends of action and impact. A second, and still non-experimental mode, not inconsistent with the first, attempts to uncover the internal logic of the activity, to see whether action is consistent with intentions, organisation compatible with objectives, and see whether the nature of the arrangements explains the outcomes.

5. Most inventories of evaluative frames include components of the two extremes which we have described. For example, Denis Lawton makes the case for evaluation being more than a measurement of the success of a particular intervention. (2) It might include, for example, whether that intervention was valuable as well as whether it was successful. He presents six models: two (the political and the professional) are essentially concerned with the political or institutional frameworks. The other four (the classical research model; the research and development model; the illuminative model; and the case study model) vary essentially on the extent to which control is present and is explicitly addressed, and the extent to which intervention is defined and circumscribed, so that its effect over time can be accurately measured or portrayed.

6. In the field of health service evaluation Cope discusses the experimental and quasi-experimental research designs which begin with a hypothesis, collect information and make observations to test the hypothesis. (3) In applying effective tests to establish internal validity (the process of eliminating rival causal explanations) and external validity (the generalisation of results), the experimental design again relies upon the ability to match the intervention with its effects over time on some controlled situation. A quasi-experimental research design differs from the experimental, in fact, in terms of the degree of control that can be established. Cope proposes, however, a non-experimental design in the field of organisational change where there is 'little in the way of effective theory' and neither internal nor external validity can be established. Similar attempts are described as 'social experimentation' by Freeman and Rossi. (4)

7. In planning organisational improvement, it is not realistic to attempt to produce a scientific input-output description but instead to introduce a continuing process of change. 'On this point of view, the most important evaluative criteria are not "before and after" measures but rather whether a process of change exists after an organisational survey and interventionist action, together with evidence that the direction of change is clearly towards the achievement of whatever objectives are currently in

force.' The method used is inductive which involves collecting a large amount of data and watching for a pattern to emerge. Some explanations will be eliminated and patterns may show themselves.

8. A way of using such non-experimental designs is to adopt the case study approach. Case studies might include diary type background information. Involved persons' interpretations of events and other accounts of them would be used. On this basis, Cope hoped to see which items were different as a result of intervention so that probable causes could then be assigned and evidence selected from them. Yin (5) set out to establish how case studies could be made part of more rigorous evaluative research. They could be controlled and structured so that, indeed, quantitative data could be brought in to reflect meaningful events and to build explanations which would, for example, ensure an accurate rendition of the facts, consideration of alternative explanations of the facts, and a conclusion based on a single explanation that appears most congruent with the facts. In cross-case analysis, the researcher or evaluator might construct an adequate explanation for each case singly and then identify the acceptable levels of modification in the original explanation as new cases were encountered.

9. Yin's approach attempts to bridge a gulf which has grown between those who maintain that activities involving interpersonal work should be evaluated primarily to expose their uniqueness attempt to generalise either the conditions or the outcomes of the initiative. Yin would seek to establish the generalisable and common aspects of unique experiences and compare them, through the commonalities, with other unique experiences. This approach makes it possible to achieve a rapprochement between Cope's type of non-experimental design and the use of a range of available instruments for measuring the impact of health interventions.

Evaluative Techniques

10. In approaching their task from such different perspectives, evaluators may draw upon a vast range of techniques. But they also have to decide first whether they will evaluate such specific dimensions as the cost consequences of an intervention, or the health outcomes, or the job satisfaction of employees.

11. Variations in evaluative techniques also depend upon the intellectual discipline being used (economic, medical science, social psychology, organisational studies and so on), the level of system to which they are addressed (for example, the human biological system as against the organisation of a whole region), and the nature and specificity of the data which are sought. Examples of techniques are as follows:

Methods of Securing Data

(a) various measures of input or resources used;

(b) descriptive measures of activity (such as numbers of x-rays or meals);

(c) descriptive measures of throughput (such as numbers of patients in different categories admitted and discharged);

(d) descriptive measures of outcome (for example, numbers of live births, still births, perinatal deaths). A recent review of instruments available for measuring the impact of health interventions has identified the following categories: individual; intermediate; index; indicators; and inferential (proxy outcome) measures of health status and health interventions; (6)

(e) measures of incidence, prevalence, use;

(f) surveys of attitudes of clients or employees;

(g) interviews;

(h) participant and non-participant observation;

Securing Control

(i) techniques for establishing experimental controls (such as randomisation, matching, double-blind);

Analysis and Synthesis

(j) development of indicators (for example, of need, access, performance);

(k) cost-based analyses relating cost measures to (a), (b), (c) or (d);

(l) analysis of content of meetings observed;

(m) analysis of organisations or formal organisational modelling.

12. The last group of headings concerns analyses and/or syntheses of data developed within different disciplines for the purpose of reaching evaluative conclusions. We discuss some of these techniques in the following paragraphs. Some of the techniques have, indeed, already appeared as DHSS initiatives and the reader will find a brief discussion of indicators in the Appendix A.

Cost Based Analysis

13. A range of evaluation tools are commonly used to identify the cost of the activity in question. They span two main dimensions: cost coverage, and the extent to which these costs are related to quantitative measurement of the impact or benefits produced by the activity. At the one extreme, only financial flows accounting costs met by a particular institution may be considered; at the other, the full opportunity cost of the resources employed may be valued. In terms of benefits, these may simply be ignored in a simple cost analysis, may be considered as constant or varying

in a single quantitative dimension in a comparison of relative cost-effectiveness; may be described and quantified in terms of a variety of dimensions in a programme budget or social impact analysis; or may be quantified and valued in monetary terms in a full cost benefit analysis. (7)

Analysis of Organisations and Organisational Modelling

14. Studies of organisations may range from analysis of authority and power structures to the effects of particular sets of relationships upon employee or client feelings and satisfactions. Studies may be normative and prescriptive and leading to proposals for and processes of change, or may attempt to discover underlying patterns of relationships which will contribute towards organisational or social psychological or sociological theory. Other studies of organisation may be concerned with the logical and work processes (operations research, for example) or with manpower and other costs of organisation.

US Attempts to Evaluate and Accredit Health Service Organisations

15. The following notes are intended to remind the reader that many of these techniques have been amalgamated in systematic American attempts to evaluate health and particularly hospital organisation. The two principal versions are Professional Standards of Review Organisation (PSRO) and Joint Commission of Accreditation of Hospitals (JCAH).

Professional Standards Review Organisation (PSRO)

Origins

16. The Medicare and Medicaid Programmes instituted in the 1960's had required the establishment of 'utilisation review committees' in any hospital requiring reimbursement under these programmes. In 1970 the National Centre for Health Services Research and Development (NCHSRD) funded a programme of 10 Experimental Medical Care Review Organisations (EMCROs) to be evaluated to provide a basis for future developments, but Congress pushed by the American Medical Association required a more immediate action to establish 'peer review organisations' in each state. In 1972 the Bennett Amendment established the system of Professional Standards Review Organisation.

Motives

17. The American Congress was primarily concerned to institute a system of cost-containment for publicly reimbursed health care. The AMA was concerned to ensure that a system acceptable to the medical profession was adopted and ensured that the review was to be performed by doctors, institutionalising the concept of peer review.

Objectives

18. The primary objective is to ensure that health services reimbursed under the Medicare or Medicaid schemes are medically necessary, meet professionally recognised standards of care, and are appropriately

provided in the most economical setting. They thus have dual, and possibly conflicting,concerns of economy and quality.

Methods

19. The legislation provides for DHEW to divide the country into areas, to contract with a physician organisation in each, and to designate that organisation as the local PSRO. Each PSRO is required by the legislation to review all institutional services provided to Medicare and Medicaid patients.

20. More specifically, and not surprisingly, priority has been given to reviewing acutein-patient care.

21. There are three inter-related components of the programme. Concurrent Review (CR) on which most PSROs have focussed, is designed to certify the necessity, appropriateness and quality of services during the hospital episode. As a whole, CR has concentrated on elimination of over-utilisation of in-patient services.

22. Medical Care Evaluation studies (MCE) take the form of an in depth assessment of the quality of the delivery and organisation of particular health care services. They are usually based on an analysis of the medical records (or specific abstracts from them) relating to individual patients.

23. Profile analysis is a form of retrospective monitoring in which aggregated patient care data is analysed to identify problems and patterns of service which require modification. This is then used to focus CR or MCE efforts.

Implementation

24. It is the responsibility of the individual institutions to take any necessary corrective action. Whilst the institution cannot be forced to do so there are strong potential sanctions.

Relationships and Authority

25. The PSROs are set up by the local clinicians subject to government approval of the arrangements. The PSROs are funded by appropriations from Congress.

26. The PSRO arrangements incorporate the threat of strong sanctions. First, if care is found by the concurrent review process to be unnecessary or inappropriate, payment under Medicare or Medicaid must be withheld. Secondly, repeatedly or grossly errant providers must be reported to DHEW. Nevertheless the PSROs look first to a variety of educational rather than punitive steps to change practice behaviour, and payment is seldom denied.

Evaluative Criteria

27. Each PSRO is required to use explicitly stated norms, criteria and standards established by the health professionals in the area. There is no set of mandatory national criteria. The approach is one of local peer review.

Joint Commission of Accreditation of Hospitals (JCAH)

Origins

28. The JCAH was created in 1952 as a successor to the Hospital Standardisation Programme of the American College of Surgeons.

Motives

29. Its establishment reflected a concern about the variability of standards within the American hospital system and the lack of quality controls.

Objectives

30. JCAH was attempting to ensure adequate standards. Initially the focus was on adequacy of inputs, of manpower and capital provision within hospitals. In the early 1970's the JCAH began to become much more oriented towards quality of care and performance evaluation.

Methods

31. Its principal evaluation tool is PEP (Performance Evaluation Procedure). PEP is a form of audit focussing on patient outcomes. The main questions PEP is designed to ask are how patients fare as a result of the care provided to them and to what extent are patient outcomes attributable to the performance of health professionals rather than to variables not under practitioner control. The routine data base is from medical records, supplemented by specific information relating to health outcomes, for example, from patient interviews. The JCAH initiative has been the main incentive for the widespread establishment of programmes of medical audits.

Implementation

32. Implementation is voluntary but encouraged by the presence of strong sanctions.

Relationships and Authority

33. Whilst participation in the Hospital Accreditation Programme is voluntary, American hospitals take very seriously the prospect of losing JCAH accreditation, not least because accreditation means that the hospital is automatically 'deemed' to be in compliance with the Federal Conditions of Participation in the Medicare Programme. It was widely believed that failure to implement PEP would lead to accreditation being withdrawn or granted only provisionally. Effectively, the accreditation requirements set a threshhold of minimum standards that the provider must meet to qualify for reimbursement.

34. Additionally the accreditation process acts as a stimulus to professional pride and competitiveness. Nurses for example, set and evaluate their own goals, and the JCAH process provides a means of identifying improvements in individual performance that can then be rewarded by salary supplements.

Evaluative Criteria

35. The format prescribed by JCAH in its PEP manual is highly detailed and involves the use of professionally determined minimum standards set externally to the institutions under review. Despite the intended emphasis on outcomes it is still felt to be focussed on the fulfilment of specified procedures and processes. There is a concern that the emphasis on raising standards of provision and on quality of outcome, rather than efficiency of process, may lead to more expensive care.

Application to the UK

36. A British team (8) arranged pilot reviews in two English districts to assess whether the UK could learn from the JCAH approach. They found great variation in existing quality measurement systems although there was great interest in seeking and defining quality. They concluded that there was a place for independent, voluntary assessment of quality in our own health services.

REFERENCES TO APPENDIX B

(1) See H. Freeman and P. Rossi, 'Social Experiments', Milbank Memorial Fund Quarterly, Health and Society, Vol. 59, No. 3, 1981.

(2) D. Lawton, The Politics of the School Curriculum, Routledge & Kegan Paul, 1980.

(3) D. Cope, Organisation Development Action Research in Hospitals, Gower, 1981.

(4) H. Freeman and P. Rossi, op.cit.

(5) R. Yin, 'The Case Study: Some Answers', Administration Science Quarterly, 26(1), March 1981, pp 58-65.

(6) E. Scrivens, D. Cunningham, J. Charlton, W. Holland, 'Measuring the Impact of Health Interventions: A Record of Available Instruments', unpublished, 1984.

(7) M. Carley, Rational Techniques in Policy Analysis, Heinemann, Educational Books, 1980.

(8) R. Maxwell et al, 'Seeking Quality', Lancet, January 1983.

APPENDIX C

EVALUATIVE FRAMEWORK

(Version 1)

The following is an attempt to demonstrate the scope of our project and to outline the questions to which we shall want to have answers by the end. We shall, by stages, be converting it to questionnaires to be put to different groups of participants at different stages of the project.

I - NATIONAL POLICIES

1. What are the origins/natural history of MAS?

2. What is the policy context in which it has been developed? And what are the central themes of this context (e.g. accountability, decentralisation, efficiency, effectiveness.....).

3. What objectives have emerged? Have they been consistent over time and are they mutually compatible?

II - REGIONAL MAS PILOT SCHEMES

1. History and Objectives

   (a) What are the origins/natural history of MAS in each region?

   (b) What is the local policy/political context in which it has been developed?

   (c) What are the objectives of the regional MAS? E.g. is it a tool for: operational management
   planning
   monitoring
   promotion of good practice
   promotion of individual commitment

   (d) From what problems are the objectives derived?

   (e) What priorities are derived from the stated objectives and problems?

2. Model

   We shall be concerned to characterise and identify the differences between the models of MAS adopted by the four regions as clearly as possible. Our identification of the models' components will be built up from a number of sources. Questions specifically asked on this subject might be:

(a) Does the region model its scheme, by example or by contrast, on any existing or past institution? (e.g. HAS).

(b) If not, do the authors of the scheme have a distinct model in mind?

(c) What is the relationship between the model for MAS and the region's conception of the role and function of RHA?

(d) Is it an advisory scheme or itself concerned with the implementation of change?

(e) Is it a customer/contractor or collaborative or quasi-autonomous system?

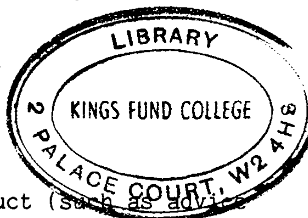
(f) Are activities evaluated to be compared with models of excellence or assessed within their own terms?

(g) What is the scope of the scheme? What boundaries were drawn:

- (i) in excluding clinical matters;
- (ii) in relationship to primary care and the personal social services?

(h) Is the scheme primarily conceived of as:

- (i) creating a product; or
- (ii) initiating a process?
- (iii) if (i), is it an instrumental product (such as advice or improved data) or an end product (such as improved service)?



3. <u>Institutional Arrangements</u>

(a) What are the institutional arrangements made for MAS in the region?

(b) What is the structural relationship between MAS and the RHA, the RTO and the district authorities?

(c) If there is a steering committee and/or a supervisory board for MAS, what is its membership, its authority and its function?

(d) What is the membership, structure, authority and function of the MAS team?

(e) Who was consulted about the setting up of and the institutional arrangements for the MAS? By what machinery was this done?

4. Creating a Process

(a) By what criteria:-

(i) was the composition of the MAS team determined;

(ii) were the members of the team appointed?

(b) By what criteria are services and/or districts selected for evaluation?

(c) Have priorities been influenced by factors such as the political context or the expertise of the MAS team?

(d) By what criteria and process did the team establish its methods of working, allocation of tasks and overall programme?

(e) Are there any standard procedures of consultation with or any standard requirements made of those whose work is to be evaluated?

(f) Who takes part in evaluations and how are they selected?

(g) Is MAS an internal exercise or do others have any part in it? (E.g. pressure groups, academics.....)

(h) Has there been any change over time in any of these components of the process?

5. Implementing a Process

(a) What is the process of advice or review?

(b) What is the nature of the advice and feedback? E.g. is it criticism, recommendations for changes in systems/practice, advice about how changes might be achieved.....

(c) In what forms and by what procedures are advice and feedback given? To whom are they given and for what purposes? How are they used?

(d) Does MAS have sanctions to impose advice itself?

(e) Does MAS have the right to make reports to management and, if so, at what level?

(f) Is there any follow up and, if so, how is it conducted?

(g) Has there been any change over time in any of these components of the process?

(h) What have been the main problems encountered in the process of implementing the MAS scheme as experienced by:

(i) MAS steering committee;

(ii) MAS team;

(iii) RHA/DHA members;

(iv) RTOs/DMTs;

(v) those who were the subjects of advice/review.

6. Evaluative Styles and Methods

(a) What evaluative styles are being adopted by MAS?

(b) What methods have been adopted in accordance with those styles?

More specifically,

(c) Have criteria, standards and norms against which performance can be evaluated and measured been established? If so, are they general and/or specific?

(d) Who has established them and by what process?

(e) What kinds of data collection have been determined as appropriate?

(f) Will the evaluative exercises enable comparisons to be made within the regions and between regions?

(g) Is there any collaborative work between the MAS team and those being evaluated?

(h) Has there been any change in evaluative styles and methods adopted over time?

7. Efficiency of Process

(a) Costs. What were the costs of providing a MAS:

(i) to those who were the subject of advice/review;

(ii) to RTOs, DMTs, RHA/DHA members;

(iii) to members of the advisory service itself.

(b) Costs might be calculated in terms of resources used (money, time, manpower, use of plant - e.g. computer resources), were there costs in industrial/professional relationships (e.g. man hours, etc.) and/or translated fully into financial costings?

(c) Could the exercise have been carried out with better use of resources?

(d) What commitment did it achieve to evaluation/performance review and to the objectives as specified by the region?

(e) What needs for change in management, practice, planning process did it identify?

(f) Did it establish usable criteria, standards and measurements of performance? If so, what were they and to what use have they been/could they be put?

(g) Has the system been capable of adaptations/response in the face of problems encountered?

8. <u>Efficiency and Effectiveness of Outcome</u>

(a) Has MAS produded more or improved data, information systems?

(b) Has MAS led to changes in operational efficiency and effectiveness? (E.g. more economic use of resources; improved response rate in delivery of services; changed working methods of existing institutions; new advisory or administrative structures and/or communication systems).

(c) Has MAS led to changes in planning systems and/or processes?

(d) Has MAS led to dissemination of good practice within and/or across professional boundaries?

(e) Has MAS led to changes in industrial and/or professional relationships (behavioural and expressive)?

(f) Has MAS led to changes in the perception of services by consumer or pressure groups.

(These kinds of criteria are likely only to be fully formulated when we know what the management advisory services in the regions are actually doing and which areas are going to be the subject of special investigation by our team.)

(g) In relation to all of these factors, what other events during the period of the pilot scheme might have had an influence on identified changes (reinforcing MAS, negating it, pre-empting it.....)

9. <u>Case Studies</u>

Elements of Sections 5 to 8 will be examined in more detail in selected activities of MAS.

Possible criteria for selection might include:

(a) What the regions themselves recommend.

(b) Studies susceptible to comparative work across the regions.

(c) Studies that will cover a range of work done by MAS.

(d) Time required to complete such studies.

(e) The stage in the development of MAS at which they are initiated.

We aim to incorporate into our project as wide a range of evaluative styles and methods as possible, given limitations of resources, time and our own expertise. We shall need to identify and test assumptions about how far the styles and methods which we adopt or would like to adopt are logically and operationally compatible and which, if any, must be regarded as alternatives. We shall also be testing the assumptions that the pilot schemes or parts of them are susceptible to comparative evaluation.

We are very conscious of the difficulties of our research. We have already recognised that some criteria of evaluation are ruled out by the nature (e.g. time scale) of the assignment. We cannot, for example, consider changes in health state that might be attributable to MAS. We recognise too that some criteria that we shall use (e.g. changes in relationships) are established by 'soft' rather than 'hard' evidence. There is also the problem of isolating MAS as one phenomenon distinct from concomitant developments and events, and we shall need to examine in what ways, if any, the MAS schemes that we are studying have been affected by the fact that they are pilot schemes.

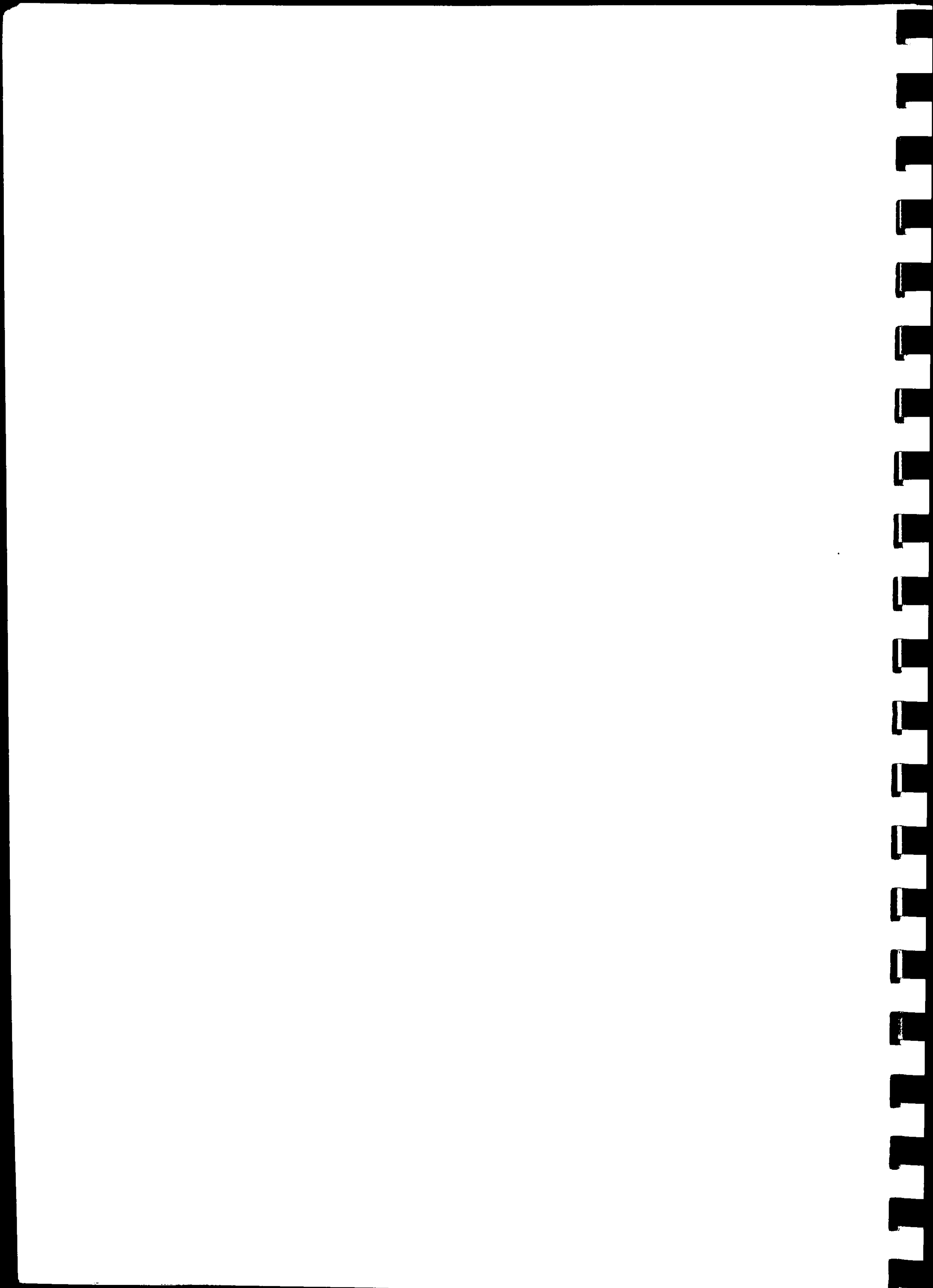
The framework as outlined is put forward on the assumption that it gives us space to pursue the following evaluative criteria and modes:

(a) efficiency of process;

(b) efficiency and effectiveness of outcome;

(c) internal logic and coherence in the conception of the scheme (we should also be able to undertake a comparative analysis of the models of the pilot schemees);

(d) internal coherence between values, objectives and actual processes, methods and outcomes of work.



48572 020000 048