Clinicians as leaders in local NHS governance bodies : the case of primary care groups

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Clinicians as Leaders in Local NHS Governance Bodies: The Case of Primary Care Groups

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Thesis submitted for the
Degree of Doctor of Philosophy.

Kings College London

2004

Abstract

Primary Care Groups were statutory governance bodies of the NHS in England that existed from April 1999 to April 2002. The membership policy for the Boards of Primary Care Groups was different from previous local governance bodies in that a) the majority of places were allocated to clinical professionals and b) nurses were given a joint leadership role alongside doctors. The political history of the NHS, sociological theory on professions and the division of labour in health care suggests that the Boards would become arenas of contested authority and power. Drawing on the research approach of critical realism, propositions are derived from theories concerned with: power relationships between interest groups, between professionals and bureaucrats and between doctors and nurses. These are used to explore the roles and experiences of the general practitioner and nurse Board members, drawing on data from eight Primary Care Group case study sites. The analysis suggests that leadership roles for primary care professionals are simultaneously supported, challenged and subverted. The relationships between doctors, nurses and managers in local policy decision-making are characterised by tensions and sometimes open conflicts. It is suggested that the sources of the tensions are multi-faceted, derived from both the hegemony of professional monopoly, challenges to that monopoly and contested sources of authority. However, among both the professional monopolists and the corporate rationalists there are those who are able to span the boundaries of the structured interests in order to collaborate to mutual benefit. Finally, it is suggested that the continued invisibility of nurses and nursing in the policy communities is not an accidental byproduct of the struggle between managers and doctors but rather it is a deliberately reproduced element of that struggle.

Acknowledgements

Although researching and writing a doctoral study is an individual endeavour, it relies on the participation of many people in many different ways. Foremost, I am grateful to all the anonymous informants in this study. The thesis would not have been possible without their interest, time and contribution.

Throughout the life of this thesis I have been encouraged and supported by work colleagues and friends, too numerous to list by name but my thanks to them all.

I am grateful to my employers, the Department of Primary Care and Population Sciences, Royal Free and UCL Medical School, and my sponsors, Camden & Islington Community Health Services Trust more latterly Camden PCT, for the time and funding to undertake this doctoral study.

In particular, I would like to acknowledge and thank my supervisor, Charlotte Humphrey, for her intellectual challenge, encouragement, good advice and patience over five years. I would also like to thank Claire Goodman for her willingness to listen and debate ideas.

Last but not least, I thank my long-suffering family, Dave, Lucy, Flora and Rona, without their support this thesis would never have been written.

For Adam and Flora Drennan

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Chapter 1: Introduction to the Thesis

1.1. Introduction

In 1997, the newly elected Labour Government produced a White Paper outlining its reforms for the NHS. A key feature was the introduction of new local governance bodies called Primary Care Groups (PCGs), which were to have "doctors and nurses in the driving seat" (Department of Health 1997:para 5.1). The announcement signalled a new phase in the organisation of the NHS. To one very familiar with the previous twenty years of political and internal history of the NHS, it indicated that a new chapter was augured in the relationships between professionals and managers, and in the relative power and authority base between interest groups. The strong policy pronouncements about a leadership position shared between doctors and nurses but not managers raised many questions of feasibility in the face of an academic literature and personal observation, which indicated not only the embedded power of the medical profession but also the aspirations for control and authority by general managers over professionals. These questions, derived from sociological theories on the nature and source of authority for leadership, led to this study of PCGs and thesis presented here.

1.2. The Context

Local governing bodies have been present since the inception of the NHS in 1948. Their constitutions and membership have reflected the wider health policy themes of the government of the day. The Labour government of 1997 announced the creation of new governing bodies, called Primary Care Groups (PCGs), as one element of its programme of reforms for the NHS (Department of Health 1997). A recurring Labour Party critique of Conservative health service policy over the previous eighteen years had been the imposition of unwelcome major changes without evidence of their effectiveness, or consultation with or agreement from those concerned (Webster 2002). The Labour Party pledged to

modernise the health service incrementally, after full consultation with those involved, and to allow diversity in response to local requirements and circumstances (Blair 1996). Within seven months of taking office, the Labour Government published its detailed plans in the White Paper 'The New NHS: Modern and Dependable' (Department of Health 1997). PCGs embodied the Labour Party manifesto pledges of a governing body that was both locally responsive and also consulted with all those concerned.

PCGs brought together all the GPs and primary care providers in a geographical area with a population of about 100,000 (Department of Health 1997). The PCGs, through their Boards, were charged with responsibility for improving the health of their designated population, commissioning health services for them and addressing primary care development (Department of Health 1997). Within that overall remit, PCGs could operate with different levels of responsibility. Increasing amounts of autonomy and independence characterized the different levels. At level one, the PCG advised the Health Authority on commissioning but remain a sub-committee of the Health Authority. At level two, the PCG had devolved responsibility for the budget for purchasing hospital and community health services for the population, but remained accountable to the Health Authority. At level three, the PCG was a freestanding body known as Primary Care Trusts (PCTs) with its own budget for commissioning services. At level four, the PCT assumed full responsibility for commissioning and the direct management of community health services. Shadow PCGs and Boards were formed in October 1998 with detailed guidance on their tasks and governance arrangements (Department of Health 1998, 1998a). They assumed their full responsibilities on the 1st April 1999. On that date, 481 PCGs were established in England with an average population of 100,000 (Audit Commission 1999).

The guidance for PCG Board membership emphasised a leadership role for primary care professionals, "The composition of Primary Care Group boards reflects the need to ensure that family doctors and community nurses will be in the lead" (Department of Health 1998b para. 13). This statement was repeated throughout the detailed guidance on the establishment of PCGs (see for example Department of Health 1998) and then PCTs (Department of Health 1999, 2000).

The White Paper emphasised the proximity of GPs and community nurses to patients but gave no more detailed explanation for the assignment of a leadership role (Department of Health 1997). The membership guidance for the PCG Board stated that it was to comprise : between four and seven GPs, one or two community nurses, a lay member, a social services member, a Health Authority non-executive member and a chief executive (Department of Health 1998b). The guidance reiterated the need to involve all stakeholders and local primary care professionals in the process of establishing the PCG.

1.3. PCG Board Membership

Many features of PCG Board membership were not new. Creating local NHS governance Boards with professional members was not an innovation developed by the Labour government. The medical profession had places on governance boards at the inception of the NHS (Webster 1988), although the subsequent health professional presence on Boards became more varied. Previous governments had also placed emphasis on clinicians as leaders in commissioning activities (see, for example, Department of Health 1995). Likewise, mechanisms for involving primary care practitioners in the commissioning of services were not new (Department of Health 1989). However, the PCG Board constitution differed markedly from prior NHS governance Boards in two respects:

- For the first time, a *majority* of places was assigned to clinical professionals.
- For the first time, doctor *and nurse* members of Boards were assigned joint leadership responsibilities,

One further notable difference from previous Boards with responsibilities across primary and secondary care was that the professional places on the PCG governing bodies were assigned to clinicians in primary care rather than in acute care or public health.

The White Papers of this period emphasised that clinicians needed education and managerial support to undertake leadership roles on Boards (Department of Health 1997, 2000a). Individual skills were seen as the key to successful

assumption of leadership roles. There was no acknowledgement that wider group, organisational dynamics or power relations might affect leadership roles within PCG Boards and the roles of the Boards themselves. However, analysis of the NHS demonstrates that the success of different groups has been influenced by factors beyond the skill level of an individual (Rivett 1997,Webster 2002). The underlying dynamics between groups were likely to be important in the assumption of leadership roles on the PCG Board.

Since the inception of the NHS, the hospital sector has had greater prominence on the national policy agenda than primary care not least because it absorbs the greater part of publicly funded health expenditure (Wanless 2002). General practice, together with pharmaceuticals prescribed in primary care and community health services, account for about a third of NHS expenditure (Kennedy 1999). General practitioners form approximately 30% of doctors working in the NHS (Department of Health 2003), while nurses and health visitors in primary care represent about 13% of nurses working in the NHS (Department of Health 2003a). Within medicine, general practice has long been viewed as less prestigious than acute specialities (Rivett 1997). In the wider health policy arena, despite government statements from the mid-eighties onwards asserting the importance of primary care (usually meaning general medical services), there was little shift in overall finances between the sectors (Wanless 2002). It was not until the later stages of the internal market reforms, when over 50 % of general practices were fundholders, that general practitioners gained some prominence in resource allocation (Peckham and Exworthy 2003). The pre-eminent position accorded to general practitioners on PCG Boards, while a continuation of the fundholding trend, contrasted with the accepted order in the medical and NHS world.

The creation of a NHS body with a majority of clinical members contrasted with the policy of general management leadership over clinicians in the NHS, which had been first asserted in the mid eighties (Department of Health and Social Security 1984). The growth of managerial control was a feature of the NHS during the years of the internal market (Ferlie et al. 1996) although the extent of its success particularly with the medical profession was disputed (Harrison and

Pollitt 1994). GPs as independent contractors had not encountered the expansion of managerialism in the same ways as those professionals employed in the NHS. However, the Conservative government had imposed the terms of the 1990 general medical services contract (GMS) on GPs without negotiation (Klein 2001). While relationships between Health Authority managers and GPs were portrayed very positively during the development of GP fundholding (Audit Commission 1996), there was also evidence of tensions and difficulties between the two groups in commissioning processes (Exworthy 1994, Flynn et al 1996). Against this background, the assignment of a leadership role to the professionals but not the managers appeared to be an unusual departure in policy. Moreover, the leadership role was not offered to the doctors alone, but was to be held jointly with primary care nurses.

In clinical care, medicine sees itself (General Medical Council 2001) and is seen by others as taking a leadership role vis-à-vis nursing, despite nurses' assertions to the contrary (Witz 1994). The archetypal nurse subservient to the archetypal doctor in charge remains a powerful image in the media (Hallam 2000). The construct of a gendered division of labour has been noted since the nineteenth century (Abel-Smith 1960). The extent of the structured divisions through gender, class and race between the two occupations in the UK has been observed since the late seventies. It has been documented by nurses (Carpenter 1977 and 1993, Salvage 1985, McKay 1989, Wicks 1998, Hart 2004) and by sociologists (Doyal and Pennell 1979, Oakley 1985, Stacey 1988, Walby et al 1994, Davies 1995). The empirical focus of attention has been on the relationship between doctors and nurses in clinical care activities. Although less noted, a similar imbalance can be observed in the contexts of Health Authority Boards (Department of Health 1990) and in the Department of Health (Rivett 1997). The emphasis on a shared leadership role for general practitioners and primary care nurses contrasted with their occupational relationships both in clinical care and also managerial settings.

In primary care there was a further nuance in the relationship that the new policy appeared to ignore. Unlike in the hospital sector, GPs are the direct employers of practice nurses, a group that by 1998 constituted nearly 40% of all nurses

employed in the NHS in primary care (Drennan et al 2004). There were two further characteristics of primary care that had the potential to alter some of the structured elements of relationship between the two groups. The first was that, in primary care, significant numbers of nurses and health visitors worked in quasi-autonomous community care and public health roles rather than caring for individual patients under medical direction (Community Practitioners and Health Visitors Association 1997). The second was that general practice was a medical speciality where women were present in significant numbers: 38% in 2003 (Royal College of General Practitioners 2004).

The events leading up to the establishment of the PCGs indicated some of the differing levels of power and influence in the policy arena between medicine and nursing. The actual detail of the PCG constitution was developed over the winter and spring of 1997/1998 against a backdrop of media concern about the lack of hospital beds to meet the winter demands and a scarcity of medical and nursing staff. During this period both the nursing unions and the British Medical Association demanded significant national pay increases for their members (Beecham 1997, Anon 1997). All the policy developed in this period has to be seen in the context of a government committed to containing the pay bill for the NHS (Dobson 1998) but needing to retain the support of all NHS staff groups, particularly the medical profession, for its modernisation plans. The initial guidance for PCG Board membership was published in April, leaving much of the detail to be negotiated at a local level (Department of Health 1998). The general practitioners were divided in their opinions about PCGs (Anon 1998). In May, the General Practice Committee of the BMA publicly demanded majority control of the PCGs (Anon 1998a). This was granted, along with the right of the medical members alone to nominate the Chair of the PCG (Anon 1998b). At the same time, the Minister for State for Health wrote to the leader of the largest nursing union, reiterating the importance of nursing representation but capping the nurse places at two on the PCG Boards (Milburn 1998). The final membership composition was announced in August 1998 (Department of Health 1998a), along with a sliding scale of remuneration for Board membership that reflected the differential incomes of doctors and nurses (Department of Health 1998b).

1.4. The Thesis

This thesis aims to explore the role of general practitioners and primary care nurses on local governing bodies of the NHS and the factors that influence that role, through studying Primary Care Group (PCG) Boards.

The political history of the NHS, sociological theory on professions and the division of labour in health care suggest that the Boards would become arenas of contested authority and power. Drawing on the research approach of critical realism (Robson 1993), propositions are derived from theoretical perspectives concerned with power relationships between interest groups, between professionals and bureaucrats and between doctors and nurses. The propositions are that:

- The doctors and nurses would not equally hold leadership roles. The dominant structural interests expressed in the Board activity would be medical and specific to the general practitioners
- There would be conflict between the professionals and the managers as to the role of professional leadership in the activity of the PCG. This conflict would be experienced differently for GPs and nurses
- The increasing numbers of women GPs would mean that gendered experiences of Board membership would be less clearly associated with occupational groups
- The nurses would have a differential experience of leadership according to a) their position in the bureaucracy of the community health services or general practice, and b) their clinical relationship to general practitioners

These propositions are used to explore the roles and experiences of general practitioner and nurse Board members, drawing on data from eight Primary Care Group case study sites in two Regional Health Authorities. Multiple data collection methods were piloted and refined. The main data collection drew on semi-structured interviews from a purposive sample of informants from within and outside the PCG Boards and on PCG Board documents. Observational

methods at public meetings were piloted but not pursued because, in Goffman's (1959) terms, the "front stage performance" at the meetings revealed very little of the relationships between participants. The methodological challenges of researching elite groups in a rapidly changing policy environment provides a recurring theme throughout the study. The data collection period stretched over two years from March 2000 to February 2002. A template approach to data analysis (Crabtree and Miller 1992) was undertaken assisted by computer software, the QSR N5 programme. The template codes were developed from both the theoretical propositions and converse propositions. The thesis presents the evidence that supports or contradicts the propositions, as well as the absence of evidence.

The thesis then turns to consider the significance of these empirical findings in the context of the political history of the NHS, sociological theory on the professions and the division of labour in health care. It discusses the empirical findings in the context of Edelman's observations on the symbolic nature of policy (Edelman 1985). It concludes by applying these observations to the current and emerging iterations of local NHS governance Boards.

1.5. The Structure of the Thesis

The thesis commences with a review of the empirical evidence on the factors influencing professionals' roles on local governing bodies in UK health care. The NHS has passed though a number of re-organisations of governing bodies since its inception in 1948. Chapter 2 provides a detailed review of studies of local governing bodies from 1948 to the present day. The studies are grouped by time period and a brief summary of the local governing bodies and the membership policies is provided. The final part of the chapter draws together the analyses from empirical studies. It is noticeable that many were descriptive studies devoid of explanatory frameworks. Those analysts who did use theoretical frameworks found the framework used by Robert Alford, which was derived from political science, of particular utility (Alford 1975). He argued, from his analysis of health policy development in New York, that three types of interest groups are present in the health policy arena:

- Those whose interests are structured into the existing institutions and organisational arrangements (the dominant group),
- Those whose interests are to change the structures that support the dominant interest group (the challenging interest group),
- Those whose interests are never represented except with enormous and exceptional energy (the repressed interest group).

A number of the analysts drew on Lukes (1974) theories of the third dimension of power. In this, the dominant group has so shaped the perceptions of those around that they see the existing order in favour of the dominant group as natural and unchangeable.

Chapter 3 provides an overview of theories of power in general and specifically the application of these theories in the analysis of health policy and policy communities in the UK. It examines the extent to which empirical studies have identified structured dominant elite groups or a plurality of groups with equal influence in the health policy arena. Commentators explaining health policy development in the UK have offered insights that suggest both a plurality of groups involved in policy making but also a structured hierarchy in status and power. Nowhere is this contention more apparent than in the almost complete absence of nurses and nursing from analytical texts of the NHS policy development and indeed from Alford's seminal work. Strong and Robinson (1988) offered the first empirical study to document the invisibility of nurses and nursing to those influential in policy making and implementation.

Against this background, nurses but not managers were offered a joint leadership position in the PCGs with doctors. The thesis then moves on to consider sociological theories concerning both leadership and the relationship between professionals and managers in a bureaucratic organisation. Weber (Gerth and Wright Mills 1970) provides the starting point with his theoretical consideration of authority for leadership. The development of theories on contested authority between professionals and bureaucrats derive from Talcott Parson's translation of Weber (Parsons 1949). Chapter 3 examines the empirical evidence of conflict

between professionals and managers in the NHS, again contextualising the studies within the prevailing organisational milieu. The evidence points to an analysis that requires the internal divisions and hierarchies within each occupational group to be made explicit. The chapter concludes by examining the internal hierarchies of the occupations of medicine and nursing. The examination of relationships however is not complete without consideration of the interaction between medicine and nursing.

Chapter 4 reviews the empirical evidence on the relationship between the two occupational groups in institutional settings and then in primary care. Medicine views nursing as subordinate in patient care (General Medical Council 2001). Case law in the UK supports this view (Montgomery 2003). The chapter uses theories from sociology and anthropology on subordinate and oppressed groups to explore nurses' response to medicine and to each other. It notes that the majority of empirical studies focus on the relationship in hospital environments and argues there are important contextual differences that may be important in examining the relationship on PCG Boards.

Chapter 5 provides the detail and critique of the study methodology as well as information on the PCG sample. The research approach drew on ideas of critical realism (Robson 1993), which views social structure as both the product and the medium of motivated human action. Critical realism is focused on developing and testing theories to *explain* social reality. The propositions that this investigation utilised were derived from the review of the literature and empirical data in Chapters 2, 3 and 4. A multiple case study approach was undertaken in eight PCGs in two Regional Health Authorities. The methodological challenges of researching elite groups recur throughout the process of choosing data collection methods, gaining access, undertaking data collection and analysis of the data. The data collection period stretched over two years from March 2000 to February 2002. The chapter then turns to critique the research methods; identifying a number of limitations and considering how these could have been avoided. Chapter 5 concludes with a detailed account of the policy context during the data collection period, the sample PCGs, the informants and the PCG documents.

The thesis findings are presented in the next four chapters. Chapter 6 considers the roles of the GP and nurse Board members in the early stages of the PCG. It explores first of all their motivation to become Board members, before examining the differences in selection processes between GP and nurse members. It then examines GP and nurse experiences of Board participation in the first months. It considers how the local Health Authority context of the PCG affected the types of roles Board members undertook. The chapter then concludes by comparing and contrasting the motivations, expectations and roles of the GP and nurse members in the establishment phase of the PCG.

Chapter 7 examines the leadership roles of the GP and nurse members. The chapter explores this concept from the GP and nurse members' own perceptions and then compares that with evidence from other sources and informants. It examines the sources of authority that the clinical members drew upon on, considering in turn the clinical members: as representatives of a group of health professionals, as holders of expert medical knowledge, as holders of knowledge of the patient experience and health care needs, as experts in the business aspects of health care provision, and finally as members of the medical profession. It turns to examine the issue of lack of bureaucratic authority between the PCG and the constituent GPs and finally considers issues of authority between peer members of the same occupation. The chapter concludes with an examination of one of the thesis propositions against the empirical evidence. This was that the doctors and nurses would not equally hold leadership roles.

Chapter 8 presents the factors that supported and detracted from the GP members undertaking a leadership role. First of all, it examines the relationships between GPs, identifying a number of sources of tension. It explores a number of factors that impact on these relationships including: past involvement in commissioning, adoption of population perspectives, and conflicting business interests. The chapter then considers evidence as to the relationships between GPs and managers, differentiating between those internal to the PCG and those external to it. It examines the sources of tension in the relationships, first from the GPs' perspective and then the managers. It reviews the thesis proposition that there

would be conflict between the professionals and the managers as to the role of professional leadership in the activity of the PCG. The chapter concludes by identifying the inadequacy of the neo-Weberian theory of conflict between professionals and bureaucrats in explaining the empirical data in the thesis.

Chapter 9 considers the factors supporting or detracting from the nurse members undertaking a leadership role. It explores the relationships between the nurse members and three different groups: the other nurses in the PCG, the managers and finally the doctors. In the same manner as with the GPs it examines the relationship with managers internal and external to the PCG. It offers the evidence from the viewpoint of the nurses, the doctors and of the other informants. It concludes by considering the remaining thesis propositions in the light of the empirical evidence. These were that: conflict between the professionals and the managers would be experienced differently by GPs and nurses; the nurses would have a differential experience of leadership according to their position and employment; that the increasing numbers of women GPs would mean that gendered experiences of Board membership would be less clearly associated with occupational groups.

Chapter 10 reconsiders the three theoretical explanations explored in the literature section of the thesis to account for the tension in relationships documented in earlier chapters. The first was the interplay between structured dominant, challenging and repressed interests in policy determination. The second was the contest of authority between professionals, who derived it from expert knowledge and profession membership, and officers of a bureaucracy, who derived it from their position in the tiers of the bureaucracy. The third was the response of nursing and nurses to medicine's subordination of their occupation. Each of these is considered in the light of the study findings. The thesis suggests that each of the theoretical perspectives offers an inadequate explanation for the empirical data derived in this study. The concept of leadership roles for professionals was simultaneously supported, challenged and subverted. The relationships were sometimes collaborative but more often characterised by close to the surface tensions and sometimes open conflicts. The complex relationships of nurses to both GPs and managers suggests that their

invisibility in the policy processes is not just an accidental byproduct of the relationship between doctors and managers, but a significant element of the contest for power and authority between those two groups. All of these relationships are interwoven with issues of gender, race and class that are so structured into the fabric of the interactions that they rarely become visible to the participants. Further study of such governance bodies with these factors at the forefront of the research design would help reveal their extent in the warp and weft of decision making in the NHS. The chapter then turns to consider the implications in the light of new and emerging governance arrangements, in which the underlying policy themes of the PCG Boards can be identified.

The thesis concludes by examining a final question: whether the findings of the thesis were just an example of the real, but imperfect, world of policy implementation (Hogwood and Gunn 1984) or whether it was ever really intended that doctors and nurses should lead the PCGs.

Chapter 2: Local Governing Bodies in the NHS

2.1. Introduction

The purpose of this chapter is to provide an account of NHS local governing bodies and their membership in the first fifty years of the National Health Service. The account draws upon both national policy, as derived from legislation and its ensuing guidance, and empirical studies of governing bodies. The account is divided into periods related to the organisational arrangements of the NHS. This allows the empirical studies to be placed in their specific policy and organisational context. The concluding section considers the analysis of the empirical work and the elements of value in examining the roles of members of current day local governance bodies.

2.2. Constituting Governing Bodies

Acts of Parliament and subsequent statutory instruments provide the legislation from which local NHS governing bodies are constituted. These legally constituted bodies are responsible for the provision of local health services as specified in the National Health Service Act 1946 and its successors, within the allocated public monies. They are accountable for their decisions and fulfilling their remit to the government minister for the health services.

The names given to governing bodies are varied. In the business sector, they are known as a "Board of Directors". "Board of Governors" is the term more familiar in the education sector, while "Management Committee" is used in voluntary organisations. In local government the terms "Council", "Local Authority" and "councillors" are used. Members of any governing body can have either executive or non-executive responsibilities. Those who have executive responsibilities are employees of the organisation and are responsibility for carrying out (i.e. executing) the decisions in the day-to-day activities of that organisation. Those who have non-executive responsibilities are not employees of the organisation and their activities are only within the

governing body. Eligibility criteria for membership are specified in the governing document of an organisation. These are variously known as constitutions or company articles (as specified in company legislation). In the provision of statutory organisations, their governing document will be specified in the Acts of Parliament of Health and statutory instruments. Non-executive membership criteria will often be either as a representative of others or as having particular knowledge or expertise.

The nomenclature for local NHS governing bodies have changed throughout its fifty-year history. Executive Councils, Hospital Management Committees, and Local Authority Health Committees changed into Family Practitioner Committees, Area Health Authorities and District Management Teams with the 1974 re-organisation. Area Health Authorities and District Management Teams were re-organised in 1981 to become District Health Authorities. The 1991 re-organisations created Area Health Authorities, Family Health Service Authorities and Trust Boards: all with Directors rather than members. The Family Health Service Authorities were dismantled in 1995, their responsibilities absorbed by the Area Health Authorities. These transitions and subsequent ones are detailed in Appendix 1.

It is worth a brief reflection on how the names for governing bodies mirror wider government policy and intent. For example from 1948 to 1974 medical teaching hospitals had Boards of Governors while all other hospitals came under the jurisdiction of Hospital Management Committees and Regional Hospital Boards. The terminology perhaps only reflects past divisions. The Local Authority governing bodies used the term "committees" so named to reflect the democratic tradition of local government. The independent charitable hospitals had Boards of Governors, a name with the cultural overtones of both the business world but also with benevolent and altruistic direction. The different names, it could be argued, also reflected the continued differential treatment of the elite group of consultants in the teaching hospitals. It is particularly noticeable that the first time local NHS governing bodies were called Boards of Directors was under the NHS and Community Care Act 1990 re-organisation. The underlying ethos of this re-organisation was to introduce business and commercial principles into the

organisation and financial management of the NHS (Department of Health 1989a).

The following section considers the studies of governing bodies in the NHS and their memberships in historical order and then draws together cross cutting themes. The studies are preceded by a brief description of the organisational structures in the NHS for that time period.

2.3. Local NHS Governing Bodies 1948-1974

2.3.1 The Structures

The first twenty-seven years of the NHS saw stability in organisational structures. The tripartite structure of separate management for hospitals, community health services and independent providers of primary health care services, meant that there were three types of governing bodies. These were:

1. Hospital Management Committees reporting to the Regional Hospital Boards in the non-teaching hospital sector, and the Board of Governors for teaching hospitals reporting direct to the Ministry of Health. It should be noted that the teaching hospitals indicated the presence of medical schools. All hospitals had schools of nursing.

2. Executive Councils were the governing bodies for the provision of services contracted from the independent professionals in the community. These were general practice, dentists, opticians, and pharmacists.

3. The Health Committees in the local authority were the governing bodies for health services provided in domiciliary and community settings. This included including district nursing, health visiting, the school health service, home help services and environmental health officers.

The membership criteria for each of these bodies were different (National Health Service Act 1946). Lay members in all cases were in the majority. However, the

lay representatives in the Local Authority Health Committees were elected councillors and in the other bodies were appointed by the Minister of Health. In the Local Authority Health Committees, there were no health professional members. It was only under the Local Government Act 1958 that they were encouraged to co-opt professional members such as doctors, health visitors and midwives (McEwan 1959). The Medical Officer of Health was the council officer who managed the health department in the Councils. The Executive Councils had to have one representative elected from each of the Local Medical Committee, the Local Dental Committee, the Local Pharmacists Committee and the Local Opticians Committee.

The Regional Health Boards and the Hospital Management Committees were to have a quarter of places filled by Local Authority representatives, a quarter by people with experiencing in governing hospitals in the voluntary sector and no more than a quarter consultants and university representatives from the medical schools (National Health Service Act 1946). Other places should be filled as the chairman deemed fit (Webster 1988). Webster (1988) reports that in many instances over fifty percent of members were medical professionals and the Regional Boards were made up of a majority of people who were also members of Hospital Management Committees or Boards of Governors. No other health professionals had a designated place in the governing bodies.

Bevan was adamant that the medical membership in governing bodies would be an "expert voice " (Klein 1995 p20) not a syndicalist representative. From the beginning there was ambivalence as to the place of health professionals in governing bodies. The independent contractors providing services for the NHS had very different relationship to the governing bodies from other professionals. In this first phase of the NHS, the presence or absence of professionals on the hospital committees and local health committees may also have reflected custom and practice of the pre-NHS structures. The custom of Councils was to have a clear separation between the elected members' position in decision making and that of its officials.

2.3.2 Studies of Governing Bodies Before 1974

In this period there are two studies concerning the activities and working of governing bodies in the NHS: the report of the Farquarson – Lang Committee (Scottish Home and Health Department 1966) and Christopher Ham's critical history of the Leeds Regional Hospital Board from 1947-1974 (Ham 1981).

The Farquarson – Lang Committee (Scottish Home and Health Department 1966) was a Scottish Home and Health Department sponsored investigation into the working of the Hospital Management Committees. A nominated Committee of Inquiry took evidence from knowledgeable key individuals in the Scotland hospital sector as to how the system of Hospital Management Committees was working and how they could be improved. It noted that there was confusion in the way Board members understood their roles. The report recommended that, as in business, Board members should focus on broad policy and objectives setting, leaving the day-to-day operational management to the officers. This recommendation was singled out for implementation in England (Department of Health and Social Security 1968). The report also highlighted the tension between the role of the hospital administrator and the senior medical officer in advising the Hospital Management Committee and executing decisions. It commented on these tensions without providing an analysis of the cause. It went on to recommend that there should be only one senior executive post to which all other executive posts reported. In essence it was the forerunner to the Griffith Report (Department of Health and Social Security 1983) and the implementation of general management (Department of Health and Social Security 1984).

Christopher Ham's critical history of the Leeds Regional Hospital Board from 1947-1974 was commissioned at the point of the Board's dissolution (Ham 1981). Ham focused on addressing two issues: firstly, the dynamics of public policy making and secondly, the evolution of the NHS. He drew his conclusions from examining the Minutes of the Authority and interviewing individual members who were still alive and willing to contribute. He discussed the problem of the selectivity in that issues that did not appear in the Minutes are then neglected. However, he justified his approach as the interviews failed to

identify any major issues that were not in the Minutes. He identifies six roles that the members played. Five of these were representing particular interests; local interests, patients' interests, a special interest, a professional interest (seen most clearly in the medical membership), a particular organisation's interest. The sixth was as the manager and allocator of resources (Ham 1981).

Ham identified that the officers to the Board, which included the senior administrative medical officer, were very influential in the decision making of the board. Their role of bringing issues, presenting information and offering options for decisions to the Board placed them in a powerful position to influence the work and opinions of Board members. He also documented the conflict between the senior administrative medical officer and the senior administrative officer in the late 1950's. He analysed this as conflict over domain of influence and conflict over seniority. He argued that the medical officer assumed seniority by virtue of his profession but that the administrative officer refused to accede to this. He cited this as evidence of the tension referred to in the Farquarson –Lang report (Scottish Home and Health Department 1966) but pointed out that the conflict was not apparent when other individuals took up these posts. He suggested that in situations where principal officers were enjoined to work together equally, personalities had a significant bearing on working relationships.

Ham examined particular issues such as the allocation of resources for the lower status medical specialities such as psychiatry and geriatrics over the time period. He observed that very few additional resources were given to these services and little change occurred. He contrasted this with the major developments that the Board supported in acute specialities and acute hospitals. As he pointed out, this lack of attention and investment was all the more surprising when the central policy pronouncements during the sixties insisted attention be paid to hospitals for mental illness and mental handicap. These central government policies followed public inquiries into the levels of care in psycho-geriatric and mental handicap hospitals (for example Department of Health and Social Security 1969).

Ham observed that it was the medical interests that frustrated the changes required to implement central government policy. He commented that it appeared much easier to prevent change than to achieve it (p197). He noted that the non-medical members of the Board often did not pursue their challenges to medical opposition or dominance of views (p198).

Ham considered his findings against several interlinked theoretical frameworks of power in policy making, including that of Alford (1975). These theories are discussed in detail in chapter three. Ham concluded that none of the interest groups represented in the Board had the power to impose their will on another group; "collective decision making took the form of bargaining in a system of bureaucratic politics resulting in small changes in the status quo "(Ham 1981 p197). He concluded that conflicts between interest groups were not visible as a struggle but as suggested by Alford (1975) the medical interests were dominant and systematically benefited by the status quo. He argued that his evidence supported more closely an explanation of power held by an elite group, rather than by a number of groups as in pluralist theories of power. He identified a number of structural factors that contributed to the power of the medical profession in the activities of the Board. The first factor was that they, unlike other professional groups, had membership of the Board. The second factor was that the Board gave significant weight to the views of the Medical Advisory Committees. The Medical Advisory Committees to Regional Hospital Boards and Hospital Management Committees were specified by statute. No other professional group was required to organise a collective advice-giving structure to the governing bodies. The third factor was that the medical members, as actual service providers to patients, carried the additional force of current experience. The fourth was that other members of the Board accorded deference to medical views on any subject. While Ham identified the medical profession as a powerful group he also noted an internal hierarchy of influence. Consultants in acute specialities were the most powerful in their influence, while doctors below consultant level and doctors in the non-acute specialities appeared less influential. These influential consultants established the pre-emptive importance of medical research and medical teaching interests to the extent that this assumption was never challenged or questioned in any of the discussions of the

Board (Ham 1981 p 205). Ham argued that this was an example of the latent third dimension of power as theorised by Lukes (1974).

Ham's study provides a valuable base line of analytical discussion to consider other studies of governing bodies in the NHS. His analysis used both Alford's and Lukes' theories, which were published at the time of his study. His analysis is fixed within the NHS organisational context of its time. It is also firmly anchored on the consideration of the medical interests; the other professional groups are notable by their absence. The next section considers the succeeding governing bodies in the NHS.

2.4. Local Governing Bodies in the NHS 1974 -1991

2.4.1 The Structures.

The 1974 re-organisation saw the dismantling of the tripartite system of provision of hospitals, community health services and the independent contractor services (The NHS Reorganisation Act 1973). The Local Authorities no longer provided the nursing and school health services. Area Health Authorities (AHAs) now governed community health services together with all the hospital services. AHAs were responsible to Regional Health Authorities (RHAs). This set of reforms introduced, for the first time, a separate body to represent the views of patients and residents known as the Community Health Council. A central policy theme of the Labour government was of consensus in decision making (Klein 1995). This policy increased the participation of multiple interest groups in the governance of public services.

The Area Health Authority (AHA) was the local governing body. The "grey book" guidance for this reorganisation was very prescriptive in stating that members should "devote their limited time to major issues of planning and resource allocation,...Officers have executive authority to implement policies and plans delegated to them after agreeing with the Authority specific targets and measures of performance,... the Authority should monitor and control performance in relation to the agreed measures of performance" (Department of

Health and Social Security 1972 section 1.29). The Board membership was between 16-19 people with stipulated places for representatives of different interest groups. The Local Authority could nominate up to 6 councillors. The medical profession had one place for a consultant, one for a general practitioner and one for the Dean (or representative) of the Medical School. For the first time the membership was widened to include one designated place for a nursing, midwifery or health visiting representative and one for a Trade Union Representative. This broadening of involvement of different groups was mirrored in the operational management. Every AHA was divided into a small number of Districts. Each District had a management team (DMTs) who were the executive officers for the hospital and community health services. The DMT comprised of the district administrator, the district finance officer, the chief medical officer and chief nursing officer, who each managed their own function of the service. This team were jointly responsible for the management of the services by consensus (Department of Health and Social Security 1972 section 2.44).

In 1981 the organisational tier of Area Health Authority was dismantled (The Health Services Act 1980). The governing body was then located at already existing district level and known as the District Health Authority (DHA). The membership criteria for the DHA Boards remained the same as for the previous Area Health Authority. The opportunity was taken, however, to re-iterate that the central role of district health authority members was one of policy and strategic decision making (Department of Health and Social Security 1981)

The governing body for the independent contractor services also changed. In 1974 the Executive Council was renamed the Family Practitioner Committee. It too expanded its membership to between 20-30. The policy guidance stipulated that there were to be equal numbers of professionals and lay members (Department of Health and Social Security 1972). The professional membership continued to be representatives of the professions independently contracted to the NHS but now included one place for a nurse. The lay membership expanded to include up to 4 councillors representing the Local Authority. These changes

represented the widening of participation in the governing of the public services. This governing body was untouched by the dismantling of the AHAs in 1981.

Although the membership of each body increased at this point, the actual numbers of governing bodies decreased substantially. In Scotland, Hunter stated there was a reduction from 150 previous organisations to 15, with a decrease of 1,224 places for lay people, although he did not give his source for these figures (Hunter 1979)

Three significant changes from the previous membership arrangements for governing bodies are notable. Firstly, the majority of the membership was seen as representative of a particular interest group or organisation rather than as an expert or having particular individual knowledge as previously. The second change was that service providers other than the medical profession were given membership of the governing body as non-executive members. The third change was that the executive group expanded to include a chief nurse and finance officer. The inclusion of other service providers was echoed in the mandatory professional advisory committee structure (Department of Health and Social Security 1972 section 1.2 d) with which Klein describes the organisational arrangements as being "festooned" (Klein 1995 p 90). Nurses and midwives, dentists, pharmacists and opticians now also had the authority to convene professional advisory committees; in the first instance to the Area Health Authority and then with the 1981 changes to the District Health Authority (Department of Health and Social Security 1981).

The age of consensus in operational management was short lived. The Griffiths Report (Department of Health and Social Security 1983) condemned both consensus and unidisciplinary management. In 1984 general management was introduced into the NHS (Department of Health and Social Security 1984). This was a significant and highly disputed organisational change (Rivett 1997). A hierarchy of accountability to one person, the general manager, was implemented for all employees of the District Health Authority. The general manager, rather than the district management team now became the executive member of the governing body (Department of Health and Social Security 1984).

2.4.2 Studies of Governing Bodies 1974 – 1990

During this period a wider interest in the roles and relationships of Board members is evident through an increase of empirical studies focused directly and indirectly on Boards. There were five studies of hospital and community health services governing bodies and their membership in this period. These were: a national study of the working of the NHS (Royal Commission on the NHS 1978), an ethnographic study of the interest groups and decision making of one AHA in rural Scotland (Taylor 1977), a study of the decision making processes in resource allocation in two AHAs in Scotland (Hunter 1979), an action research study supporting the development of members roles in two DHA (Ham 1986) and a study of the work of DHAs (Haywood 1983 and Haywood and Ranade 1985) which investigated the motives and behaviours of board members in 6 Health Authorities (Ranade 1986). For the first time, there was also a study investigating the work of the Family Practitioner Committees (Alsop and May 1986). Additional sources of information came from two postal surveys requesting demographic information of English NHS Board members. The first reported that the majority of members were from management and business backgrounds (Elcock and Hayward 1980), while the second reported that women and people from minority ethnic backgrounds were under-represented in the membership in general and most noticeably in the chair positions (Kings Fund 1990). Two studies focused on the introduction of general management provided incidental findings on perceptions of Boards and their membership (NHS Training Authority 1987, Robinson et al 1989). In order to aid understanding these studies will be considered in two groups: before and after the implementation of general management

2.4.2.1 Studies Prior to the Introduction of General Management

The national study of the working of the NHS (Royal Commission on the NHS, 1978) considered the effectiveness of all the administrative structures that had been established following the 1974 re-organisation. Multiple methods of enquiry were used across the four countries of the UK, seeking opinions from

representatives at every level of the NHS. Semi-structured individual and group interviews were the main data collection method. Research Paper Number One included a small section on authorities and member involvement (Royal Commission on the NHS, 1978 section 10). It described the perceptions of Authority Board members, officers and staff of the role of the Authority and the relationships between members and officers. Overall, they concluded there was a lack of certainty in the role of the members. It should be noted however that a key finding of the whole report was that "uncertainty in role" was the prevailing feeling in an "over-elaborated organisation" (Royal Commission on the NHS 1978 p 224 section 8).

The report did not differentiate between the types of Board membership except to note concerns expressed that the dual role of Local Authority councillors as Health Authority members created conflicts of loyalty and interest. Some Board members reported confusion between their role and that of the newly established Community Health Council. Tension between the role of officers and the role of members was described in some areas. Officers were reported to perceive the members as too involved in the operational running of the service with insufficient technical knowledge. However, both officers and members pointed to examples of Boards failing to take up roles in broader policy making and objective setting. Instead, Boards tended to receive and "rubber stamp " decisions offered by the officers. The impact of the members on the service was perceived to be slim (p75 section 10.13). The researchers concluded that the variation in roles and relationships of members and officers that was reported was the result of local political traditions. It was not the consequence of the increased opportunities for professionals to be involved in decision making or of consensus management. It is not clear how they reached this conclusion from the data they presented. They did not offer any examples to demonstrate their methods of analysis or show comparisons between different areas.

In contrast to the broad study of the Royal Commission, Rex Taylor (1977) provided a very focused investigation. He studied one small Area Health Authority over twelve months in rural Scotland, focused on identifying potential interest groups and their influence on resource allocation decisions. Data

collection methods included interviews, observations of public board meetings, public Council health committee meetings, the Area Medical and Nursing Advisory Committees and field work which involved "lingering and loitering" (Taylor 1977 p583) in doctors surgeries, in Health Centres, hospital corridors, offices and car parks. The analysis was framed by reference to professional – lay and managerial-professional conflicts, although these central themes are not explained.

Taylor identified three "potential interest groups" within the Area Health Authority Board: the elected members who obtained their positions through popular vote, the professional members who obtained their position through workers' syndicalism and the appointed members who obtained their position through patronage. He argued that they were only mobilised as interest groups when the routine business was transformed into controversy. Taylor identified five occasions when the professional members made a controversial proposal. This resulted in the elected members, and to a lesser extent the appointed members, forming a group in opposition. He used one of the controversial proposals (the replacement of a resident island GP with a nurse and visiting GP) to illustrate his analysis. He noted that the management team had a difficult relationship with the Board, particularly with the elected and professional members. He argued that this was a function of the smallness of this particular study site. He hypothesised that in larger areas with more local interest groups the officers to a Board could play these off against each other, allowing more centrally determined polices to be pursued. Taylor made the case that the source of the conflict between professionals, lay people and managers stemmed from the different definitions of the "public good"(p591). He argued that for professionals the definition had been shaped by years of professional training, for managers by the needs of ongoing service structures and for lay people by sectional and local interests. This part of his report was very thinly argued. He seemed to be arguing for homogeneity in the views of each of these interest groups. However, the material he presented indicated that this was not the case, particularly for the "professional interest group". He described at some length how the Area Medical Advisory Committee (AMAC), an extremely influential body in this instance, was dominated by one section of the local medical profession. He was also clear

that the views of other professional advisory committees were not sought over any aspect of resource allocation.

Taylor provided a useful descriptive case study, however it was weak in its defence of the analytical statements and puzzlingly devoid of reference to other contemporary studies (for example Alford 1975) or contemporary sociological debates on managerial-professional conflict (for example Green 1975). David Hunter (1979) has provided much stronger analytical material in a study contemporary with Taylor's and also undertaken in Scotland.

Hunter (1979) examined the processes in decision making in allocating ring fenced funding for new developments in two Scottish Area Health Boards over two financial years. He collected data through semi-structured interviews with key informants, examination of documents and attendance at some meetings. Hunter argued that there was a "policy triad" (p 634) in the new re-organisation formed of a) Board members, b) officers and c) the professional and lay advisory bodies. His study reported on the difficulties within this triad. Both members and officers were reported to have great difficulty in identifying exactly what the member role was. Some members contrasted it with the role in the previous organisation, which they viewed as more intimately involved in the management of the services. He quoted Board members as describing the work of the Board as a "rubber stamping agency"(p231) with decision-making now in the hands of the officers. This observation echoed the findings of the Royal Commission reported above. He went on to describe the relationship of members to officers as "verging on the parasitic rather than the symbiotic" (p263), referring to the members' dependence on the officers for information and knowledge about the services. He contended that the officers were powerful in relation to the Board members as they had by statute to form a group. Issues on which they had already reached consensus were then presented to the Board members. He argued that the professional advisory bodies appeared to have little influence but conceded that the proposals for the development funds did not represent radical change in service provision from current services. Like Ham (1981) he gave an example of development fund allocation to the acute hospital sector, in the shape of a new orthopaedic surgery unit, which appeared to completely ignore the

contemporaneous injunctions from central government to invest in long term and community care (p635).

Hunter used Lukes' (1974) theory of the three dimensions of power to explain his observations and made reference to Alford's (1975) theories on three structured interest groups. He stated that while the officers appeared the most active element of the policy triad, this should not be confused with being the most influential. The officers' assessment of the allocation exercise was that they were reacting to pressures as and when they surfaced rather than being proactively in control of the decision making (p635). Hunter argued that this was an example of Lukes' third dimension of power; a structural element in support of one interest group that precludes any other issues from even being raised. Hunter contended that the process of resource allocation in the health service stemmed from the appointment and then the decisions of individual medical consultants. All resource consequences for the health services, from buildings to staffing, flowed from these two acts. (p.636). He viewed this as a subtle process rather than a form of medical conspiracy, "The medical profession may be said, then, to set the agenda for development fund allocations if only by their preventing or hindering, by their very existence, the emergence of an alternative policy agenda" (p.639).

Hunter's study was focused on the issues of the acute health care sector, in itself providing an academic example of the structural dominance of this sector over other parts of the health service. While he argued that there was a policy triad of Board members, Health Authority officers and professional and lay advisory committees, his empirical evidence showed that his third arm of the triad was formed of multiple interest groups who had differential levels of influence. It would be more appropriate in the light of his conclusion on the structural influence of individual medical consultants to expand the notion of a triad, disaggregating his third group into its component parts. It is hard to see how Hunter's policy triad fits with his reference, in his concluding chapter, to Alford's three interest groups. He does however provide more evidence for uncertainty regarding the Board members' role and for the differential influence

between officers and members of Board. However, he makes no comment as to the effect of the different source of Board membership.

2.4.2.2. Studies after the Introduction of General Management

There are three empirical studies of governing bodies in the period after the introduction of general management in the NHS: Haywood and Ranadé (1985), Ham (1986) and Alsop and May (1986). The context of these studies is of a changing environment in the roles and relationships among senior officers, and between officers and members of Boards. It is also set at a point when the central government cut public expenditure in all areas and the Department of Health implemented changes in determining the financial allocations to individual DHAs (Webster 2002).

Haywood (1983) investigated how the new District Health Authorities (DHA) were working in six areas, using semi-structured interviews with a sample of members. His conclusion was that the officers dominated the work of the Health Authority, confirming again the findings from the Royal Commission. He declared no theoretical frameworks in analysing his work but argued that the members lacked the pre-requisites of power as they had no electoral legitimacy or "caucusing" behaviours. This argument is flawed as the Local Authority members had been elected as councillors and certainly operated in political environments.

Haywood followed this with a more detailed study in the same DHAs: "concerned with ways in which chairmen and members can carry out their responsibilities to ensure they make a real rather than symbolic contribution to the work of the Health Authority" (Haywood and Ranadé 1985 p1). The motives and behaviours of members were particularly explored. The data collection was through eighty interviews with Board members and district management teams, combined with observation of the DHA meetings and recording member contacts with the chief officers. Ranadé (1986) argued that the terms of reference for membership of the DHA meant there was ambiguity as to whether member

loyalties were to the administration of the NHS or the group they represented. She devised a typology drawing on an incentive analysis framework used in the study of British Local Authority councillors. She used the typology to predict which type of members were most likely to achieve individual influence within an Authority and to "diagnose" some of the reasons for the observed differences in the corporate influence between the six Authorities. She proposed that there were five types of members; strategists, specialists, loyalists, back benchers, and representatives (Ranadé 1986). This is very different from Ham's analysis of roles where he identified only representative roles (Ham 1981). Ranadé typified the Strategists as having entered public service as a personal challenge, with a personal interest in health services and a clear sense of purpose. The Specialists had also entered public service as a personal challenge, with a personal interest in health services or with a very specific purpose in mind but then used their expert knowledge to carve out a role in the Authority. The Loyalists became members for compensatory reasons to make up for not finding their main work roles challenging enough. She argued the Loyalists were the most active and enthusiastic members. Backbenchers had not thought through their reason for membership, neither having a specific purpose or representative role. Within this group she identified a group of professionals that included doctors and nurses who thought they had to be members as part of an organisational or professional duty. Backbenchers were characterised as being inactive members. Representative types were portrayed as maintaining a watching brief on behalf of those they represented. Their activity on the DHA was highly specific. Their loyalty to a sectional interest was viewed as greater than to the DHA and often resented by other members. Two people fell outside of these five categories and these she named the mission types. These two people were described as judging " everything against the light of their ideological principles" (p 185) and quickly politicised discussions, speaking a lot in all discussions. Other members disliked these two individuals. Ranadé argued this was primarily because the other members considered the mission types main loyalties to be outside the health service, their representative group and their organization.

The study then asked the six chairman and the district administrators (reported as the two most powerful positions in the DHA) which three members they viewed as having the most influence in the DHA discussions. Although Ranadé reported that "they sometimes said groups of people like clinicians''(Ranadé 1986 p 193), she dismissed this and focused on her own typology " but it was clear that the most influential members came from the strategists and specialist types '' (p193). She stated that they were more likely to be seen as influential if they took the initiative rather than just reacted. Ranadé did not consider other theoretical frameworks. Her analysis focused on personal motivation rather than structural interests. The evidence she provided, particularly with regard to the backbenchers and the representatives could be interpreted as examples of different types of interest group behaviour.

Christopher Ham (1986) provided a different perspective through an action research study in the same period. He was employed as a consultant to the members of two newly formed DHAs. He worked with them through development seminars and individual interviews over eighteen months to explore their perceptions of their roles and develop solutions to address the identified issues. He also collected data on the activities of the DHA through observation at meetings and documentary analysis. He concluded that the influence of members over policy making was limited, although less so in one of his sites and less so with the passage of time.

Ham identified five factors that influenced the contribution of the members to the work of the District Health Authority (DHA):

- Individual attributes, both in time available for DHA work and skill at committee work.
- Preparation and training, both the offer and take up was very uneven.
- The organisational structures of DHAs; in particular consensus management meant major differences had been argued through so that the officers only presented single policy options to the DHA.
- The organisational cultures of the DHAs: in both study sites Ham identified that the officers and the Chairmen perceived the role of the

members as providing a means of accountability rather than determining policy as envisaged by the central guidance. This influenced how they involved members in the work of the DHA.

- The power structure in the NHS: he argued that ministers of health developed a more interventionist stance in the local implementation of central policies during this period. This curtailed the possibility of greater member involvement in strategic policy development. In one of the case studies, members perceived their role in policy making as further reduced by the need to implement service cuts as a result of central decisions to allocate resources to DHAs differently.

Ham reported that the chief officer and the chairmen were perceived as the most influential members. However, he made no comment on the various types of members, treating them as homogeneous. While he made reference to Haywood and Ranadé's study (Haywood and Ranadé 1985) he did not draw on Ranadé's typology. Instead he reviewed his observations against Alford's constructs of dominant, challenging and repressed interest groups. He argued that while it could appear that the managers as the challenging interest group had moved to a dominant position through placing issues on the agenda for discussion, none of these issues presented challenges to the prevailing system of consultant led hospital health care. This, he argued, demonstrated the structural nature of the dominance of the medical profession in the health care system. It is not clear why Ham did not view proposed service reductions at the DHA as proposals that challenged medical interests. Ham also argued that the community interest groups remained repressed: citing little evidence of influence in the DHA work from the Community Health Councils (CHCs), community organisations, trade unions, the Local Authority or the Family Practitioner Committees. The latter organisation seems to indicate a very liberal interpretation of the idea of groups representing "community interest". It may be a true reflection of repressed interests but they are very diverse, including health care professional groups.

The argument that the members of DHAs were not viewed as influential in decision making was supported in two other studies whose primary focus was the

introduction of general management. The Templeton Series reported on a series of interviews with district general managers (DGMs) across England on the implementation of general management. The researchers noted that the DGMs viewed the Board members of the DHA as peripheral and unnecessary in the decision making process (NHS Training Authority 1987). However, they saw the presence of a Board as important in terms of public accountability. Robinson et al (1989) investigated the impact of general management on the nursing profession. Their data collection included a postal survey of 193 chief nursing advisers across the UK. One small part of this requested perceptions of the level of influence nurse members held in the decision making of the DHA: 40% perceived the nurse members were not influential while 17% considered them very influential.

Alsop and May (1986) also used Alford's theoretical framework in the only investigation into the work of the Family Practitioner Committees (FPCs) in the thirty seven year history of the NHS. There were no studies of Executive Committees. This study was based on a postal survey of the 90 English and Welsh FPCs requesting examples of innovative and developmental work by the Committee, supplemented by an unspecified number of interviews and discussions with FPC administrators (i.e. the chief officer of the FPC), members and practitioners. They described in detail the tension for FPCs as a result of not managing the independent contractors but still needing to ensure a certain range and standard of care was provided. They depicted this as "responsibility without power" (p170). While the study portrays the work of the FPCs with all the contracted independent practitioners, it is the work with the general practitioners that provides the bulk of the material. They observed how the general practitioners were particularly well organised in electing their representation through the Local Medical Committee. Their members were present and active in all Committee and sub-committee business. Alsop and May (1986) recorded the difficulties for the FPC in the absence of a specific contract for General Medical Services between the NHS and general practitioners. They showed how some FPCs failed to fully use the authority available to them in ensuring standards in deputising, practice premises and practice administration. They argued that the capability of a FPC to improve standards in general practice was reliant on

developing a good working relationship with the Local Medical Committee and the individual practices. The net result was the FPCs developed their policies around practitioners, not around populations or communities (p167). Their lack of accountability to the population was demonstrated in the "astonishing "(p169) lack of information produced by the FPCs for the public, including in a number of instances failure to even produce an Annual Report. Alsop and May (1986) used the term "amateurish" (p170) to describe many of the FPCs.

They proposed that the FPC was the focus for the interplay of various interest groups and applied Alford's (1975) concepts of dominant, challenging and repressed interest groups to their findings. They viewed the change from the Executive Committee to FPC, with its increased non-professional membership, as an attempt by the corporate interests of central government to control both the FPCs and the practitioners from the centre. However, they argued that the professional interests remained dominant in the work of the FPC while the community interests were repressed. In each FPC area, they observed that while the individual practitioners were concerned with their own personal goals and security, the collective professional interests were well organised and represented. In comparison, the community interests were unlikely to be so coherently represented as the lay members were neither elected nor had a clear constituency to represent.

The studies in this period are characterised by the use of theoretical frameworks, in the main concerned with power relationships. It was a period characterised by membership through representation. The end of the decade brought a review of the NHS that augured a radical shift in the organisation of the NHS and consequently the membership of governing bodies.

2.5. Local NHS Governing Bodies 1991 – 1997

2.5.1 The Structures

The NHS and Community Care Act 1990 introduced internal market principles to the administration of the NHS. The White Paper (Department of Health 1989a), which preceded the Act, and its subsequent twelve working papers spelt

out the government major objectives. It split the NHS into two types of organisations either purchasing health care services on behalf of the population or providing the health care services. The District Health Authorities (DHAs) carried out the purchasing function. Family Health Services Health Authority (FHSAs) replaced the old FPCs. The Health Authorities Act 1995 removed the tier of Regional Health Authorities, dissolved the FHSAs and passed their responsibilities to the new Health Authorities (HA). The provision of services was through freestanding organisations that were called Trusts and the independent family practitioners: general practitioners, dentists, pharmacists and opticians.

The 1990 Act introduced the option of fund holding for General Practitioners. This meant that practices with large patient lists could both provide and purchase services for those patients. The late eighties had seen increased attention paid to primary care, and general practice in particular by central government (Department of Health and Social Security 1986, 1987). A managerial role was given to the new FHSAs with the introduction of the 1990 contract for general medical services (Rivett 1997). This contract addressed some of the deficits Alsop and May (1986) had identified. It provided explicit levels of service and clinical care statements for the first time and introduced financial incentives for achieving target levels of public health work such as childhood immunisation and cervical screening. GP fund holding however created a very different role for one section of the medical profession in the administration of the NHS and signalled a new policy emphasis on leadership from primary care (Department of Health 1991). Klein described that rapid rise in the power of the GP fund holders to influence the hospital consultants as "nothing less than a revolution" (Klein 1995 p241). General practices provided with public funds to purchase services for their patients were not required to have a governing body. The reduction of finance available to District Health Authorities through the rapid increase of GP fundholding led to a range of "locality commissioning "initiatives in many health Authorities. These were intended to persuade GPs they need not become fund holders in order to influence commissioning (Mays and Dixon 1996).

The governing bodies of the new Trusts, DHAs and FHSAs were intended to be very different from the past. The White Paper argued that previous bodies were ineffective through their size and their omission of senior managers (Department of Health 1989a). It also argued that it was problematic for members to reconcile roles for both responsibility for a service and also representation of the community. The governing bodies of all the new organisations were called Boards and their members Directors. The emphasis in the guidance was the recruitment of non-executive members for their experience and skill in complex management and contractual issues rather than as a representative. Membership was restricted to a maximum of eleven people with lay membership in the majority. The professional membership of these bodies was radically curtailed in comparison to the previous structures. The executive membership on Trust Boards had to include a medical and nursing director. The non-executive membership of the FHSA Boards had to include a nurse member (with no clinical or managerial responsibilities in the geographical area), a GP, a pharmacist, and an optician, all appointed through the Regional Authorities rather than elected by their peers. The executive membership of the DHA Board stipulated only one health professional: a Director of Public Health (NHS & Community Care Act 1990, Section five).

2.5.2 Studies of Governing Bodies 1991- 1997

This period saw a change in the types of empirical studies undertaken. The Department of Health took an interest in gaining greater knowledge about the work of governing bodies. This was the result both of the criticisms of previous Boards within the White Paper (Department of Health 1989a) but also the aspirations to fundamentally change the governance and management of the health services. In the early period, three studies were commissioned in order to address the development needs of Board Directors. The NHS Training Directorate funded the largest study in this period (NHS Training Directorate et al 1993) for the clear purpose of improving the development of Board participants. The Audit Commission conducted two investigations (Audit Commission 1993, 1996) in order to produce organisational development material: as did South East Thames Region (Stern et al 1995).

Despite the aspirations of the government policy to introduce a new type of person to the governing bodies of the NHS, Ashburner et al (1993) revealed that there was actually a strong degree of continuity in non-executive membership in FHSAs and Health Authorities. Their study aimed to examine the practical operation of the new Authorities and to identify the development needs of members. It was undertaken in order to produce a resource manual, which included summary papers of the research findings with training and development materials (NHS Training Authority et al. 1993). The empirical work consisted of a postal survey of all members of NHS governing bodies in England in 1991 (response rate of 69%) and twelve case studies in two regions, Trent and North East Thames. Data collection involved a series of interviews with Board members of 2 RHAs, 4 DHAs, 4 Trusts and 2 FHSAs over two years, as well as observation at some Board meetings.

The national postal survey provided evidence that the number of Board members who were women or people from minority groups had decreased after the 1990 reforms (Ashburner et al 1993). The researchers argued this was a direct result of the recruitment of people from the business sector. The postal survey was undertaken at a very early point in the establishment of the new organisations. The study papers did not discuss the theoretical or empirical work that informed the development of the questionnaire. However, commentators on Board roles, such as Christopher Ham in the health sector and Lorsch and MacIver (1989) in the private business sector, were cited in the discussion sections. The conclusions from the survey were that while about half of the informants agreed that the executives held the balance of power in decision-making, there was also strong agreement from the executive members that they did not put forward proposals that they thought the non-executives would have difficulty in supporting. A third of the members agreed that a substantial part of the Board work was rubber-stamping managers decisions. FHSA non-executive members were least likely to agree that executive members had more influence in decision making (Ashburner et al 1993).

The case study element of this study was also presented without a theoretical framework (Ashburner et al 1993a). It is of particular interest as it included data on two FHSAs and as such was only the second study to do so. The researchers noted that the patterns of discussions were different in the FHSAs Boards from the other bodies. In all the other Boards, the Executive members dominated the discussion. In the FHSAs, the discussions tended to be dominated by the lay non-executives, which the researchers explained through two factors. Firstly, there was only one executive member, as opposed to a group of executives in the other organisations, and secondly, the FHSA practitioner non-executive members spoke primarily to their own professional area and some rarely spoke in meetings. Some further insight into this situation comes from a separate paper in which the researchers observed that in the inner city FHSA case study the majority of members were unclear and dissatisfied about their role (Ashburner 1993a). The members viewed the executive member as the most influential in the work of the Authority although some of them saw the Authority itself as having little effect on strategic development because they viewed policy as centrally imposed. These Board members believed they could influence the rate and pace of development rather than the direction. The researcher gave two examples when major decisions were made by the executive and the chairman outside the authority meeting and presented as a fait accompli to the members. On both occasions, major arguments arose and the members delayed the decisions until later meetings after they had fully discussed them. The first occasion was concerning a decision on the commissioning strategy: the second, the decision to merge with the DHA.

Ashburner et al (1993a) argued that although the involvement of professionals in overall numbers had dropped from the previous structures, the positions the professionals held as executive members increased their influence. From their observations, the researchers argued that "the majority of medical professionals were held in high esteem" (Ashburner et al 1993a p14) and suggested this demonstrated a greater scope for corporate influence than in the past. The Trust medical director was particularly noted as a pivotal position on the Board. They stated, "It is less clear that the nursing director roles are seen as equally important. This may be partly accounted for by the incumbents, who in some

instances seem less confident of their corporate role. For example, in a number of the research sites, the nursing directors made the least frequent contributions of all the directors" (Ashburner et al 1993a p 15).

The production of educational materials was a strong theme from the studies in this period. The Audit Commission (1993) visited seven FHSAs and talked with members. It concluded that the business skills of the non-executive members were not being utilized. It promoted good practice examples of FHSAs involving non-executive members. A later study, based on visits to ten Trusts and Health Authorities, concluded that non-executive skills were poorly used and produced best practice practical guidelines on how to utilise the skills and talents of non-executive directors (Audit Commission 1996). A South East Thames NHS Region sponsored study investigated the induction and development needs of non-executive directors through a postal survey to 50 directors (Stern et al 1995). It concluded that providing knowledge of how the NHS worked was important so that the directors could participate more effectively. It produced recommendations on induction programme content.

The one study of Board members during this period that did not have as an end point training and development materials was carried out by Edward Peck. Peck (1993) studied the establishment and first eighteen months of one first wave Trust. He observed that the chief executive was very influential in the selection of non-executive directors to the Board (Peck 1993). The chief executive worked to ensure that non-executive members were people that he felt able to work with and who could help further Trust relationships with other significant external organisations. This was in direct contrast to central government requirements that the sole criteria was business acumen for non-executive membership

The main part of Peck's investigation examined the aspirations and perceptions of Board members in the NHS Trust (Peck 1993a). He used structured interviews to ascertain members' aspirations for the Board and then eighteen months later a second interview to obtain their perceptions of the functioning of the Board. He also observed fifteen Board meetings during this period. His observations were structured through classifying (and timing) each member's contribution to nine

categories of behavior on all agenda items. The categories ranged from the very passive such as receiving information to the very active such as challenging the chief executive or chairperson. Peck observed that over sixty per cent of the time in Board meetings was used to receive information and reports from the executive members. The chairman and chief executive contributed most to the meetings both in frequency and in amount of time. The non-executive members mostly asked questions. Peck did however acknowledge that he was not allowed to observe an unspecified number of confidential meetings and sections of meetings of the board. His conclusions were only based on the meetings the chairman and chief executive permitted him to attend. He noted that while one of the most frequently mentioned aspiring roles for the Board had been to develop a strategic direction; this was not one of the roles mentioned in reviewing the successful roles of the Board eighteen months later. He concluded that the Board had failed to make any significant impact on the major issues occurring during the year. Peck drew on a typology of Boards of Directors developed by Molz (1985). Molz (1985) categorized Boards into seven types determined by the method of control exhibited by the Boards of Directors. It was presented as a continuum:

- Managerial control,
- Review and approve control,
- Control by exception,
- Normative control,
- Strategic control,
- Shareholder control,
- Social control.

Peck concluded that this Board of Directors could be classified as under "managerial control". Peck pointed to the recruitment process as one explanation although the extent to which other chief executives had been as influential in selecting their non-executive members was not explored.

The studies in this period had a strong descriptive element and appeared to draw very little on the analysis of the studies of the preceding decade. The majority

of them were funded in order to address specific organizational development needs and contrast sharply with preceding studies in that.

2.6. Governing Bodies 1997 onwards

2.6.1 The Structures

The demise of the conservative government of eighteen years brought further reorganization to the health service. The Labour Party took power in May 1997 with a mandate to remove the internal market and GP fund holding in the NHS. It introduced a wave of reforms that included PCGs (Department of Health 1997). PCGs were a feature of the English NHS. Under devolution, Scotland, Wales and Northern Ireland had decided on slightly different local arrangements. The PCGs were described in detail in section 1.2. The PCG Board (level 1and 2) was composed of 4-7 GPs, 1-2 community nurses, a lay member, a social services member, a Health Authority non-executive member and the chief executive (Department of Health 1998b). The membership policy for the PCGs boards was designed to place "doctors and nurses in the driving seat in primary care groups" (Department of Health 1997 paragraph 5.1). This statement was repeated in the constitution of the Boards for level 3 and 4 PCGs (known as PCTs) prior to secondary legislation (Department of Health 1999) and in the announcements of PCT pilot sites (Department of Health 2000).

PCGs were in existence for only three years. The composition of Boards for PCTs introduced a number of changes from the level 1 and 2 PCGs Board (Department of Health 1999). The Boards were to have : a lay member majority (including the chairperson), the chief executive, the finance director plus three professional members from a new body called the Professional Executive Committee which had to include at minimum one GP and one nurse. The new Professional Executive committees introduced places for professionals other than GPs and nurses.

2.6.2 Studies of Governing Bodies 1997 onwards

The major reforms brought a number of studies, funded in different ways, concerned with evaluating the changes. Central government funded three of the studies in England. The first was an evaluation of the forty short-lived, GP commissioning pilots, which were precursors of the Primary Care Groups (Regen et al 1999). This study then focused on twelve primary care groups (Smith et al 2000, Regen et al 2001). The second was a survey of Health Authorities prior to the formal establishment of PCGs (Audit Commission 1999) and after the first six months (Audit Commission 2000). The third was a three year longitudinal survey of seventy two Primary Care Groups (Wilkin et al 1999,2001,2002). The British Medical Association General Practice Committee also undertook a national postal survey of all 277 PCGs to monitor the progress and development of PCGs and PCTs after six months (British Medical Association 2000). In addition, primary health care academics were particularly interested in the innovation. They used the PCGs as a focus for a variety of population based studies (for example Majeed et al 2000, Lucas and Bickler 2000) and a plethora of studies on the education and training needs of members of PCGs (see for example Bate et al 1999).

The Audit Commission reported on two investigations. The first was a postal survey to all English Health Authorities (Audit Commission 1999) just prior to April 1999. The detail of the questionnaire, the completion rates and the objectives of the investigation were not given. The report included material from other sources in the Department of Health. The report was a mixture of description, judgments on the observations e.g. "This may prove a sensible approach" (p 8) and general injunctions for Health Authorities and primary care groups. The report provided baseline information on the PCGs such as populations served. Of the 481 PCGs, 17% were starting at level 1, and 83 % at level 2. 97% had elected a GP as chair. One third of PCGs had co-opted non-voting members such as pharmacists. 75% had appointed a chief executive, of these 61% had previously been employed by health authorities, 12% employed in general practice and only 5% employed outside the NHS (Audit Commission 1999). The report observed, "The GP and practice nurse board members are not

representative of all general practice. Former fund holding practices, training practices and those serving more affluent areas are more likely (in relations to the prevalence of these types of practice) to contribute a member to a PCG Board than others" (para.10). Detailed figures were not offered to support this statement. The questionnaire itself was not provided in the report and consequently it is difficult to assess the veracity of this information.

The Audit Commission followed the postal survey six months later with a further survey of 57 PCG chief executives and an unspecified number of interviews with PCG Board members and staff "elsewhere" (Audit Commission 2000 p3). The investigation focused on "organizational development, early progress on objectives, and the resources available and future plans" (Audit Commission 2000 para. 5). The report described its findings, provided examples of PCG activity it considered good practice, commented on observed problems and then provided recommendations for action for PCGs and Health Authorities. The report noted that some PCGs had not opened the Board meetings to the public, while those that did also had closed meetings. The report commented on observed board meetings although this activity had not been declared in the methodology. The authors noted that little effort had been made to assist the public either in attending or understanding the proceedings once there. They also observed that the GPs were most vocal in the meetings but that few decisions or actions seemed to be taken. The majority of PCGs in the survey had co-opted a member of the Community Health Council to the Board. It described the trend for PCGs to establish a range of sub-committees to undertake its work and that these often co-opted people from outside the Board e.g. practice managers. 60% of the 57 PCGs in the survey had appointed a nurse and GP as joint lead members for clinical governance: while in 7% of PCGs a nurse member had sole responsibility (Audit Commission 2000). The report did not attempt any theoretical analysis or explanation for its observations. A significant part of the report provided recommendations on managing the transition to PCT status.

The BMA surveyed by post all the chairmen of the PCGs in September 1999 and received information on 277 (British Medical Association 2000). The intention was to provide baseline information very similar to the Audit Commission postal

survey. However, it did provide insight into particular aspects not covered in those reports. The GP members were exclusively elected to the Board The PCG Board links to the Local Medical Committee (LMC) were well developed, 70% of the PCGs reported formal links with the LMC and 40% had formal representation on the LMC. The survey also revealed great variation in the remuneration to chairmen and GP Board members. Health visitors were the most frequently reported nurse members on the Boards, with over a third of the total places.

The Department of Health commissioned two other studies. The first evolved out of an evaluation of the forty GP commissioning pilots established in April 1998 (Regen et al 1999). The speed of the implementation of PCGs overtook these pilots and the evaluation continued but changed to focus on twelve PCGs. The authors provided no theoretical frameworks but used a non-attributed structure, process and outcome framework. The report provided description without offering explanation. It suggested aspects which were likely to be found in other developing PCGs, e.g. the reported enthusiasm of nurses to be involved, and highlighted issues that were likely to be problematic for PCGs e.g. engaging non-lead GPs.

The evaluation team then focused on twelve PCGs from the cohort of previous GP commissioning pilots (Regen et al 2001). The aim of this phase was "to identify lessons that might emerge from the operation of this set of twelve case study PCG/Ts for the further development of PCG and PCTs" (Regen et al 2001p5). Data collection was undertaken twice with a twelve month interval. It was composed of semi-structured interviews with board members and senior health authority personnel, focus group discussions with Board members, observation of some PCG/T Board meetings and a postal survey of all "grass roots" GPs in the twelve PCTs.

The two subsequent reports (Smith et al 2000 and Regen et al 2001) provided a detailed account of frequently observed phenomena but no explanatory theoretical frameworks. The emphasis in both reports, like the first (Regen et al 1999), was on recommendations for the emerging new bodies, this time PCTs.

The researchers observed that the PCG boards initially spent a great deal of time on PCG organizational issues. At the second data collection period the focus had changed to service development issues, and the formation of the new PCTs (Regen et al 2001). Regen et al (2001) reported that typically in Board meetings the chief executive would make the most contributions, followed by the chair (in each of the case studies this was a GP) and then some of the GP members. Much of the Boards' activity was reported to be in ratification rather than decision-making. PCG chairs and chief executives as a pair were viewed as the locus of power on the Board. In the second year, one or two other GPs were seen to join the locus of power. The researchers attributed this to these GPs taking lead responsibilities for issues such as prescribing, clinical governance, and commissioning. The nurse members were viewed as less influential than the GP members but more influential than the lay members. Despite the nurses having taken lead responsibilities in areas such as clinical governance and health improvement, the research team reported perceptions of a reduction in the level of nurse member influence by the second year (Regen et al 2001).

The third centrally funded evaluation was the national tracker survey of a representative sample of 72 PCGs (Wilkins et al 2000 and 2001). It aimed: "to describe how PCGs and PCTs tackle their core functions, evaluate achievements against national and local policy goals, identify features associated with success"(Wilkins et al 2000 p 1). Data collection was undertaken annually in the autumn in 1999, 2000 (only 71 PCGs at this point) and the spring 2002 (Wilkins et al 2001, 2002). Two data collection methods were used. The first was face-to-face interviews and telephone interviews with chief officers, chairpersons and Health Authority leads. The second was a postal questionnaire to members with lead responsibility for clinical governance, prescribing, information management and technology, the social service representatives (year 1 and 2), one GP and one nurse member on each board (year 1 only), and CHC representatives (year 2 only). The large research team also published articles on additional data collection not declared in the main methodology (for example: a survey of clinical governance leads in London PCGs, Heywood et al 1999, a survey of primary care investment plans, Leese and Gillam 2001). The reports from the

first two data collection periods were descriptive. The first report provided a description of the establishment of PCGs as organizations. It confirmed the establishment of sub-committees but also the existence of formal and informal executive committees (Wilkins et al 2000). As in the Regen et al (2001) case studies, members ranked the chair and chief executive as most influential members in decision making followed by the GPs. "Most PCGs have succeeded in welding a disparate group of professionals and lay people into an effective corporate unit. They have established clear policies and priorities to carry them forward, and they have begun to implement changes to deliver better services" (Wilkin et al 2000 p1). It observed that many of the PCGs were concerned with mergers and forming PCTs. It provided recommendations for organizational development. The second report was also descriptive (Wilkin et al 2001). It noted that all the PCG/PCTs had extended the range of primary care services available while progress on commissioning, health improvement and partnership working with local Authorities was much slower. Managerial capacity and information management and technology were reported to be inadequate to achieve the priorities and targets of the PCGs. The third report focused on the development of PCTs (Wilkin et al 2002). It was apparent that this longitudinal study, like the evaluation of the GP commissioning pilots Regen et al 1999) had been overtaken by the speed of implementation of the new organizational arrangements.

2.7. Discussion

This review of empirical studies of NHS governing bodies reveals a number of themes. This section comments on:

- The nature of these studies,
- Recurring themes regarding the role of the governing bodies,
- Recurring themes regarding the role of different membership groups within the governing bodies.

It concludes by identifying how the present study addresses the gaps identified in the empirical knowledge base.

2.7.1 The Nature of the Investigations into NHS Governing Bodies

A number of features are evident from the review of empirical studies:

- The absence of interest during the first thirty years of the NHS,
- The high incidence of descriptive studies from government funded researchers,
- The use of theoretical frameworks in analysis in the decade between 1977- 1986 and their absence at other times,
- The paucity of material considering the governing bodies for independent contractors,
- The focus on the production of educational materials for non-executive members from NHS funded studies following the reforms of 1991.

It would appear that there was a very low level of interest from both the government and academic community in the governing bodies throughout the first thirty years of the NHS. The Scottish Health and Home Office sponsored the first documented investigation (Scottish Home and Health Department 1966) and even that was commissioned nearly twenty years after the establishment of the NHS. It is puzzling as to why academics in political science were not more interested in these bodies.

The impetus for the first group of studies (Taylor 1977, Royal Commission for the NHS 1978, Hunter 1979, Ham, 1981) clearly came from the first major administrative re-organisation of the NHS. This pattern is evident in the next twenty years where studies following successive re-organisations of NHS administration. Studies conducted in the decade following the 1974 reforms explicitly used theoretical frameworks from political science and sociology applied to medicine (Taylor 1977, Hunter 1979, Ham 1981, Haywood and Ranade 1985, Alsop and May, 1986). This was also a period of prolific theoretical development in political and social sciences applied to health care (see for example Freidson 1970, Illich 1975, McKeown 1976, Alford 1975, Larson 1977, Navarro 1976). It is noticeable that the central government funded

investigations provided descriptive studies with little use of theoretical frameworks for analysis (for example Royal Commission, 1978, NHS Training Directorate et al 1993, Regen et al 2001, Wilkins 2000). The emergence of post-modern theory in these years was not referred to in the studies and consequently cannot explain the absence of theoretical frameworks. It is particularly noticeable that prior to the implementation of the 1997 reforms there were only two studies investigating governing bodies concerned with the independent practitioners (Alsop and Mays 1986, Ashburner 1993a) and that there were no studies concerned with the Local Health Authorities. This is an indication of the low level of importance placed on primary and public health by funding bodies and academics in comparison to the hospital sector. The introduction of Primary Care Groups prompted three large government funded studies (Audit Commission 1999, 2000, Regen et al 2001, Wilkins et al 1999, 2001). These studies provided description only and were intended to provide organisational development materials for the new forms of health service organisation. There was also an absence of theoretical analysis in these studies.

2.7.2 Issues Concerning the Role of the Governing Bodies

From the earliest study (Scottish Home and Health Department 1966) a tension was reported in the role of the governing body between making policy decisions and the execution of decisions. Boards in general and non-executive members in particular were reported to be confused in their role (see for example Royal Commission 1978, Hayward and Ranadé 1985). Hence successive governments, at times of both stability and also change, have stated that the role of the Board was one of strategic policy making and not operational (for example Department of Health and Social Security 1968, Department of Health 1990). However, the studies provide evidence as to the difficulty in separating these two activities. Hunter (1979) described the Board members as "verging on parasitic" in their relationship with officers in order to gain enough operational detail from which to inform decision making. Ashburner et al (1993a) described the creation of "quasi" executive roles for non-executive members e.g. in placing them on appointments panels, internal grievance panels or serious incident investigation

panels. Another observation from non-executive members challenged the view that local level policy making was possible at all in a centralised state run service (Ashburner 1993).

Evidence would suggest that chief executives have not perceived the role of the Board or Board members as one of policy making (NHS Training Authority 1987, Peck 1993). The district general managers interviewed in the Templeton studies (NHS Training Authority 1987) viewed the Board's main role as one of ensuring public accountability, while in Peck's case study the chief executive saw the primary purpose of the non-executives as aiding relationships with significant external organisations. The studies of Primary Care Groups have not considered the issue of the role of the Board in policy making or the perceptions of chief executives to the role of the Board.

2.7.3 Themes in the roles and relationships of different membership groups on Boards

A complicated picture emerges on the roles and relationships between different types of members, not least because the studies are set in periods with different constitutions. One constant through the different constitutions of governing bodies has been the presence of executive and non-executive members on Boards. The relationship between these two groups has in the main been portrayed as one where the executives are very influential in decision making in comparison to the non-executives. From the Royal Commission on the NHS (1979) onwards, reference is made to a perception by many non-executives that their role is one of "rubber stamping" i.e. just providing the official agreement for decisions already made by the executive members (Hunter 1979, Haywood and Ranadé 1985, Ashburner et al 1993). This observation has been made about the governing bodies for the hospital and community services as well as the bodies for the independent contractors (Alsop and May 1986, Ashburner 1993). While this supports the argument that executives or managers dominate the activity of the Board there is evidence to the contrary. Some of the studies observed that it was the chief officer and chairperson jointly who were viewed as

most influential in the work of the Board by other members (Haywood and Ranadé 1985, Alsop and May 1986, Ashburner et al 1993, Regen et al 1999, Wilkins et al 1999). Some studies reported that the managers only offered the policy options they believed the Board would be able to agree (Hunter 1979, Ham 1986, NHS Training authority 1987). During the period of consensus management, it was argued that usually the process of reaching consensus by the officers left little for the Board to challenge (Royal Commission on the NHS 1978). Hunter (1979) warned that it was important not to confuse high levels of activity with high levels of influence. The managers in Hunter's case studies reported that they were not in control, merely responding to demands usually precipitated by consultant activity. Taylor (1977) supports this view in his case study in which he analysed situations of conflict. He portrayed the management team as the lacking any influence in the process of decision-making. He did however speculate that this was a result of the small size of the service and population; in larger communities increased numbers of interest groups would allow the managers to gain influence by playing off different interest groups against each other.

The studies on Primary Care Groups have not examined issues of conflicts of interests or the impact of having professionals who provide the services also being non-executive Board members.

The constitutions of governing bodies have, in fact, always provided for the presence of three different interest groups. These can broadly be categorised as the managers, the professionals and lay people. The categories, professional and lay people, however do not convey the extent of the variation. The lay people on the Board have had different characteristics at different periods of time. Some were clearly representatives of the local population, such as the elected local councillors. Some had skills and experience to contribute at particular points such as previous governors of charitable hospitals in the first years of the NHS or business acumen with the instigation of the internal market. However, even at the point where non-executives had been recruited for their business acumen, a

majority believed their role included being the voice of patients, particularly in the FHSAs (Ashburner et al 1993).

Before the 1974 reforms, professionals meant almost exclusively medical professionals although dentists and pharmacists had representation in the Executive Committees. After the 1974 reforms, nursing also gained representation although their presence fluctuated afterwards in successive re-organisations. Medical and nursing professionals have held executive and non-executive positions at different periods. It is, however, the medical profession that is considered influential in all the studies. Nurse members are rarely referred to and, when they are, it is to describe but not explain their lack of influence (Hunter 1979, Taylor1977, Ashburner 1993, Wilkins et al 1999, Regen et al 2001).

Ham (1981), Hunter (1979) and Alsop and May (1986) draw on Alford's (1975) theories arguing that medicine was the dominant interest group in the governing bodies while the officers were the challenging interest group, and the interests of the community were not heard. Surveys, which reported demographic details of governing body members, indicated under-representation of considerable sections of the population (Kings Fund 1990, Ashburner et al 1993). Lay members have been perceived as the least influential, particularly at points when they have been in the minority (Wilkin et al 1999, Levenson and Joule 1999). Taylor (1977) provided a rare example of conflict in which the lay representatives organised to oppose and defeat the proposals of the medical members. However, Hunter (1979) and Ham (1981) noted that open conflict was not evident in their studies although there was evidence of tension between the medical membership and managers (Scottish Home and Health Department 1966, Ham 1981, Taylor 1977, Ashburner 1993). Hunter (1979) and Ham (1981) argued that the interests of the most powerful section of the medical profession were served through an unchallenged acceptance of the status quo by the governing bodies. Their work directly exposed the different interest groups within the medical profession, an observation that was supported in later studies. Ranadé's (1986) analysis suggested that the sole motivation for Health Authority

membership by many medical professionals was to protect the interest of the group they represented. The case studies of FHSAs agreed with this view (Ashburner 1993a). The studies of the PCGs have not addressed motivation for Board membership.

The policy guidance for the PCGs placed the general practitioners and primary care nurses jointly in leadership roles. The descriptive studies of the Primary Care Groups described perceptions that the GPs were more influential than the nurses, and that the chairperson together with the chief executive were seen as the most influential in Board business. However, they do not offer any explanations. These studies have treated the GPs and primary care nurses as homogeneous groups. Yet empirical studies of the professional groups, together with the variation in recruitment practices would suggest there is heterogeneity within these groups. The published studies of PCGs have not drawn on explanatory theories from political and social sciences to direct either their data collection or interpretations. This present study draws on theories of authority and power and the structured nature of occupational relationships to explore the leadership role of general practitioners and primary care nurses in local governing bodies of the NHS through studying the experience of Primary Care Group Boards. It is these theories that will be considered in the next chapter.

Chapter 3: Power and Leadership in Health Policy Processes

3.1. Introduction

PCGs were simultaneously: a local decision making body for the allocation and monitoring of public funds to health care provision with its own bureaucracy, and an element of a national bureaucracy for the administration of a state health service. The members of the Board were given equal status but at the same time the clinical professional members were given specific leadership roles. This chapter is therefore concerned to identify theoretical and empirical work: firstly, on the nature of power and influence in policy making and implementation, particularly in health policy, i.e. at the macro level and secondly, on the nature of leadership in organisations, particularly health service organisations i.e. at the meso level.

3.2. The Nature of Power in Public Policy Making

"*.... A discussion of the public policy process needs to be grounded in an extensive consideration of the nature of power in the state*" (Hill 1997 p18)

The starting point of this chapter is a brief consideration of the definition and nature of power itself. Definitions of power have always been given through the relationship between individuals or groups, not as an attribute in isolation. Weber defined power as, " the chance of a man or number of men to realise their own will in a communal action even against the resistance of others who are participating in the action" (Gerth and Mills 1970 p180). Weber distinguished between *coercion* as an illegitimate form of power and *authority* as legitimate form of power. Dahl refined Weber's definition to, " A has power over B to the extent that he can get B to do something B would not otherwise do "(Dahl 1961 p203). Bacharach and Barataz (1962) critiqued this definition as it implied that power was always visible through decisions. It did not address covert mechanisms or subtle cultural processes. They argued that "power is also exercised when A devotes his energies to creating or reinforcing social and

political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A" (p 948). They argued that power was covertly exercised when A was able to resist issues of significance to B from even becoming a matter for decision-making: a form of non-decision making. Gramsci (1971 quoted in Ritzer 2000) offered a further form of covert power in his theory of "hegemony" or cultural leadership, in which a set of beliefs became so pervasive in society that they legitimised the dominance of one group over another. Lukes (1974) went on to build on all these ideas and argued that the exercise of power could be observed in three dimensions. The first dimension was the exercise of power in observable conflicts of interest where A prevailed in getting A's preferences followed over B. This is the basis for studies that examine the actual decisions made. The second dimension was the exercise of power in covert conflicts in which A was able to prevent issues in B's interest reaching the political process or B anticipates the negative reaction of A and fails to raise them. The third dimension involved the exercise of power "to shape perceptions, cognitions and preferences so that they accept their role in the existing order of things because they see or imagine no alternative or because they see it as natural and unchangeable" (Lukes 1974 p24). Consequently there is neither overt nor covert conflict but what Luke's described as latent conflict. In Lukes's view, latent conflict exists when there would be a conflict of preferences between those exercising power and those subject to it if the latter were to become aware of their interests.

Given that the exercise of power is in the interaction between individuals and groups, how can power relationships in a democratic state be understood? A brief summary of the main explanatory frameworks derived from political sociology and political science is given below, before considering the application to health policy making. These theories can be categorised into two broad groupings: those based on ideas of power being held by a minority through social structures at the expense of other groups (structural dominance theories) and those arguing that power is shared between competing interest groups (pluralist theories).

3.2.1 Pluralist Theories

Classical pluralist theory argues that power is dispersed through different groups in a democratic society: that multiple interest groups have equal opportunity through the democratic process to exert power and influence. The complexity of the modern liberal state prevents one single group, class or organisation dominating society. Power is dispersed among many groups rather than cumulative in a ruling group or elite (Smith 1995). Dahl, a leading proponent of pluralist theory argued that there were multiple centres of power which meant that political decision-making was the peaceful resolution of conflicting interests (Dahl 1961). This position was heavily criticised: a) for failing to account for the different dimensions of the exercise of power (as discussed above), b) for focusing on the process of the decision making rather than the consequences of the decisions, and c) for ignoring the differential power levels between different interest groups (Walt 1996). The challenge that there were differential levels of power between groups came from structural dominance theories. These challenges led to a revision of pluralist theories. Hall et al (1975) suggested a notion of 'bounded' pluralism, in which the issues of economic policy are decided within an elitist framework (see below) but that most domestic policies on health, education, transport and housing are likely to developed through pluralist processes. However, Ham (1999) was able to identify only two studies of the NHS in the 1960s as rooted in a pluralist framework of analysis. Analysis of the power relationships in decision making in the UK health service have drawn on other theories as outlined below.

3.2.2 Structural Dominance Theories

In this broad grouping, it is argued that a dominant but small group within society exercise power in their own interests. Different schools of thought provide different explanatory theories as to the source of this domination.

3.2.2.1. Marxist Theory

Marxist theory contends that the dominant minority is defined by its control of the means of production in society. Economic domination is therefore the source of political domination (Giddens 1973). The economic relationships are reproduced, legitimated and reinforced through the structures and institutions of a society such as the legal system and the education system. Marxist theory argues that the ruling class creates recruitment mechanisms to positions of political authority that ensure the monopoly by ruling class members. Decision-making and the exercise of power through the political system are then made in ways that support the interests of the ruling class. Gramsci (quoted in Ritzer 2000) in the mid-twentieth century proposed that the ruling class exercised cultural leadership or hegemony: this meant that a set of beliefs became dominant in society that legitimised the power relationships in society The notion of a hegemony resonates in Lukes's (1974) ideas of a third dimension of power discussed earlier. Challenges to the pivotal role ascribed to a group determined by economic position alone came from theorist of dominant elite groups.

3.2.2.2. Elite Theorists

Elite theorists also support the notion of a dominant minority group in a state but rejected the notion that this group is an economically determined class. Elite group theories originate from the work of Italian political scientists Mosca and Pareto in the early twentieth century (Bottomore 1964). They argued that the dominant minority group ensured that decision-making was in its own interest, but that it was an autonomous and independent social force, which could recruit from any part of society. These ideas were taken forward in the mid- twentieth century by empirical work in the UK and USA, which focused on networks of power elites. C Wright Mills described a power elite in the USA formed from the command positions in federal government, business and military institutions (Wright Mills 1956). He argued moreover that the political, military and economic elites all exercised a considerable degree of autonomy and were often in conflict (Evans 1995). Bottomore (1964) analysing British society argued that

"elites" were mainly occupational groups that had high status for whatever reason in society. More contemporary commentators have argued that family groups, state executive members, executive members of multi-national corporations now form the membership to elite power groups (Dowding 1996).

A separate group of theorists have addressed not the determination of the dominant group but the socially structured position of subordinated groups. Feminist theorists argued that both Marxists and elite theories of the distribution of power failed to adequately explain the inequality experienced by women in society. Feminists argued that patriarchy i.e. the primacy of the male over the female, was a dominant ideology present in all economic, social and political institutions (see for example De Beauvoir 1953, Millet 1971, Mitchell 1971, Firestone 1973). Therefore, the consideration of the distribution of power was incomplete unless it incorporated the differential experience based on gender. Minority group theorists have argued that there has been a failure to account for the subordinate position of other groups. People from groups visibly different from the majority of the population, whether by race, disability, religion or sexuality have had their position as a subordinate group institutionally structured (Ritzer 2000).

3.3. Health Policy and Policy Communities in the UK

Policy making has been described as messy set of negotiations and iterative activities between levels of government and interest groups (Sabatier 1999). Analysts of public policy making in general, rather than specifically health policy, point out that the interplay of interest groups, agendas and contexts ensure that the process is not rational, linear, or ordered (Sabatier 1999). Edelman (1985) first drew attention to the fact that politicians often promulgate policy that is purely symbolic: symbolising to the electorate a set of aspirations rather than defined enforceable actions. Pressman and Wildavsky (1973) demonstrated that even when central policy intentions were for action, the nuances of policy were worked out at a local level for implementation, where different sets of interests are likely to have influence. This section examines

health policy development in UK through the theoretical perspectives outlined previously.

3.3.1 Analysis of Health Policy Development in the UK

There have been a number of analyses of the policy making in the NHS using structured dominance theorists. Analysts using a Marxist framework have argued that policies are made in the interest of the dominant, capitalist group in society (Doyal and Pennell 1979, Mitchell 1984, Iliffe 1988, Widgery 1988). The persistent differential experience of morbidity and mortality and provision of health care services is explained through reference to the conflict of interest between the social classes. Challenges to this view have come from perspectives that argue for the need to understand other dynamics that cannot be explained by class conflict alone. It has been argued that the pervasive gendering of NHS has a significant effect on the differential experience of women and men as producers (Davies 1995, Riska and Wegar 1993) and consumers of health care (Clarke 1983, Porter 1990, Doyal 1995). Likewise, the differential experience of people from minority ethnic groups in participation in the policy making process and receiving differential services has been used as an analytical framework, independent of social class (Torkington 1985, McNaught 1988,Watters1996).

Other policy analysts have sought to use structured dominance frameworks that acknowledge the professions as elite groups in the development of health policy. Many have been drawn to the work of Robert Alford (1975) and as such it is worth exploring this in more detail. Alford examined the apparent inertia and lack of change in the New York City hospitals from 1950 to 1970 despite twenty major inquiries. Each inquiry followed a declaration of crisis in the provision of health care for those without or with low levels of insurance. The inquiry reports described increasing costs, inaccessible and complicated clinic and hospital structures, and expanding government agencies. In order to explain this situation, Alford differentiated between "interest groups" in the conventional sense and those structural interests present or not present in the institutions of a society. He classified these into dominant (i.e. currently present), challenging (i.e. being created by the changing structure of society) and repressed (i.e. not

present). A defining difference for Alford was that the dominant, unlike the repressed, structural interests did not have to continuously organise to promote or defend those interests. Alford argued that the professional monopoly of medicine over the production and distribution of health services was the dominant interest, structured into health care institutions. Those who shared this interest were the "professional monopolizers". In his analysis, the 'challenging interest' was "in breaking the professional monopoly of physicians" (Alford 1975 p15) and gaining control over the production and distribution of health care. He argued, this was a shared interest held by those employed in various bureaucratic organisations involved in the provision and funding of health care, including medical schools. He labelled those who shared this interest "the corporate rationalizers". The "repressed interest" was the provision of health care to those who had no current financial mechanisms of securing it. This group Alford labelled "the community" but in fact he meant very specific sections of the population. He included: " *white rural and urban poor, ghetto blacks, the neighbourhoods just poor enough that no doctor wants to establish his practice there, middle class families rendered newly medically indigent by sharply escalating costs and those occupations affected by job-related diseases, and many more"* (p 15). Alford argued that his concept of structural interests did not preclude groups holding conflicting interests within a dominant structural interest and that *"the concept leaves open the extent to which and the conditions under which coalitions form and constitute 'interest groups' in the usual sense*" (p14). However, one of his central theses was that *"the developing structural interests in corporate rationalization contradicts and challenges some fundamental interests of professional monopolies and that this contradiction accounts for much of the sometimes muted, sometimes blaring, conflict between doctors and hospitals, fee for service and prepaid practice, and health planning and the health market.*" (p 15) .

Alford provided a framework that acknowledged multiple interest groups in the health care arena (thus providing a pluralist foreground) but differentiated some groups by virtue of the presence of their interests within the structural fabric of the health care institutions (providing a structured dominance background). Although Alford does not refer to Lukes' (1974) theoretical constructs of power,

he provides an illustration of Lukes' third dimension of power, through identifying the hegemonic nature of the power of medicine in the health care arena in the USA in the same period.

Alford's analysis was critiqued at the time of publication for failing to consider the dominant class basis of the medical profession in the USA (Navarro 1976). However, this is just one type of unifying structural interest that Alford has ignored. There is no discussion of relative social values placed on different genders, ages, ethnicities and the structured presence of these values in health care supply, provision or institutions. Alford's empirical data is located in a very specific period and health care system. His analysis, located at a slightly later time period, was concurrent with a period of upsurge in feminist as well as minority rights activism in America. Alford only discussed the medical profession and the officials in bureaucracies as holding a unifying structural interest. The majority of the health care labour force, including the nurses, do not feature in either his presentation of the empirical data or his analysis.

Alford's framework has been used in the analysis of decision-making by local NHS governance bodies (Hunter 1979, Ham 1981, Alsop and May 1986). Each applied the framework in a looser manner than Alford but identified the hegemonic nature of the interests of the medical profession, and the absence of representation of the community views. Ham (1981) pointed out that it was the structural interests of a very specific group of acute medical and surgical consultants, rather than all doctors, that were pervasive and unquestioned. Government policy shifts in the organisation of the NHS have led analysts to question further the 'fit' of Alford's typology in the UK. Policy shifts to an internal market in the NHS was another point where the applicability of the Alford typology was examined. Using empirical data from a doctoral case study of commissioning, North argued that Alford's typology fitted at a national level but became problematic at a local level (North 1996). She argued that the internal market shifted the orientation of groups of local managers so that those employed in purchasing or providing organisations pursued very different objectives. She also questioned, in the configuration of responsibilities in that period, whether GP fundholders should be categorised as 'corporate rationalizers' rather than

'professional monopolists' (North 1995). In this she provides an example of how many UK analysts have come to use Alford's typology as shorthand in which "professional monopolizers" equals doctors acting in the interests of themselves and thereby their medical profession and "corporate rationalizers" equals those acting in the interest of a particular bureaucratic organisation. The shorthand version dispenses with Alford's definition of the corporate rationalizers as those who would break the monopoly of medicine. Using the typology in this way has meant that analysts have been able to identify that some doctors act as corporate rationalists within the medical profession in their engagement with the UK state funded system (Elston 1991).

A recent empirical study examining the role of health consumer groups in the UK argued that policy shifts had ensured that the interests of users of the health service were now recognised and represented in the policy process (Baggott et al 2004). They argued that the interests of the patients are therefore not repressed in Alford's terms; although they conceded that medical concepts remain dominant and the "institutional bias against health consumer groups is still evident (Baggott et al 2004, p329). In this, the authors provide a pluralist perspective in policy making that retains a structured dominance. This has been a recurring theme in UK health policy analysis.

Many analysts have pointed to the influence of "policy communities" and "issue networks " made up of multiple interest groups but noted a hierarchy in their status and power (Walt 1996, Ham 1999). Cawson (1982) argued that the inclusion of the provider interest groups in health policy making was a form of corporatism rather than pluralism. Heclo (1978) used the term "iron triangle" to describe policy making which included a small number of participants who never changed in contrast to "issue networks" where a greater number of interest groups were present in less stable relationships. Haywood and Hunter (1982) demonstrated the existence of "iron triangles" in the development of policies for the care of older people.

Klein (1983,1995,2001) throughout his analyses of health policy in the UK acknowledged the structural dominance of the medical profession but situates it

alongside the structural dominance of successive governments mandated to fund a national health service. At the point in time of Alford's analysis, Klein (1974), characterised interest groups as chess pieces in a multi-dimensional board where alliances, sacrifices, conflicts and agreements are part of a more complicated overall strategy than the individual elements would suggest. He elaborated:

> *"One needs to conceptualise policy-making as a sort of multi-dimensional chess.... In a field like the health services, it is the inter-relatedness of areas and issues that seems to be the norm. If the medical profession adopts a particular stance on issue X, it may well be because section A of the profession wants to enlist the support of section B on issue Y. Similarly, government may well give in to the demands of the medical profession on issues Z, because it wants to conserve its political and administrative resources for the coming conflict over issue W." (Klein 1974 p 236).*

However, he was clear that the chess pieces were overall aligned in two opposing groups: the medical profession and the government of the day. Klein (2001) described the internal political history of the NHS as "the history of relations between the government of the day and the medical profession". He characterised it as a union between "technocratic paternalism and professional self interest"(p231) creating an unwritten agreement in which the state provided ring fenced finance and the medical profession had clinical autonomy to decide how to use resources within the ring fence. Klein demonstrated that there have been shifts in the balance of power between the government and the medical profession when the wider socio-economic climate has altered. He used case studies of policy making in the face of concerted medical profession opposition (for example, the introduction of the limited list for prescribing in 1984, the Working for Patients reforms in 1989 and the GP Contract in 1990) to demonstrate the impact of a changed political and economic climate from the nineteen eighties onwards. He concluded that the medical profession was not in a dominant position when faced with a determined government and that history suggested, "*The power of the medical profession is in inverse relationship to the size of the stage on which a specific health care issue is played out.*" (Klein 1995: 55-6).

3.3.2. Nurses and Nursing in the Policy Communities

While policy commentators point to the power of the producer interest groups in health policy making, it should be noted that rarely is any other group than medicine referred to. Alford (1975) made no reference to any other health care provider profession. An analysis of the indexes of well-known texts on UK health care policy demonstrates the low visibility of nurses for health policy analysts (Ham 1999, Levitt et al 1995, Walt 1996, Barker 1996). They provide only one or two references to nurses and nursing in comparison to multiple references to the medical profession. Salter (1998), who was later appointed as a Dean of a Faculty of Nursing, provides a rare example of an entire chapter within a UK health policy book that addresses nurses and nursing.

Nursing has always had a presence in the policy communities since the establishment of the NHS (Baly 1980). However, the extent and influence of its presence has fluctuated. Dingwall and colleagues (1988) described the development of the Nursing Division in the new Ministry of Health in 1941 but pointed out that the Chief Nursing Officer was initially placed in a very low status civil service rank and never achieved parity with the Chief Medical Officer. White (1986) noted in the mid eighties that the size of the Chief Nurse's department and her portfolio of responsibilities had grown and shrank at successive re-organisations. The repetition of this pattern led Jane Salvage, an Editor of the Nursing Times in the eighties and Nursing Director at the Kings Fund and the European Office of the World Health Organisation in the nineties, to write in 2003 of an overwhelming sense of déjà vu at reporting that " *a fierce battle has been raging to keep England's chief nurse at the top table in the latest Department of Health reorganisation, following leaks that her post would be down graded*" (Salvage 2003 p19). In the 1991 re-organisation, the chief nurse was denied a place at the policy board of the NHS and her responsibilities and staff reduced. A change of Minister of Health enabled her to reclaim her place (Rivett 1997). The Department of Health re-organisation in 1997 initially saw a reduction in the Chief Nurse's department and responsibilities, unlike the Chief Medical Officer (Webster 2002). While the Chief Nurse's portfolio then grew,

the announcement of further decentralisation in the NHS (Department of Health 2001) also marked the further reduction of her directly managed department. During 2003 the size of the Chief Nurse's Department was further reduced from a directly managed team of twenty-five to two (O'Dowd 2004). Leaks of information to journalists in 2004 about a further reorganisation suggested further down grading in of the Chief Nursing Officer post so that unlike the Chief Medical Officer post, it would be within the domain of the Head of Human Resources of the NHS Executive rather than directly accountable to the Chief Executive as previously (O'Dowd 2004). This move would suggest that the value of the Chief Nurse to the NHS Executive was related to ensuring sufficient supply of nurses to the workforce rather than an expert in health care or health service delivery. The example of the Chief Nursing Officer position demonstrates that while the interest of nursing is technically structured into the organisation, those supporting the interest repeatedly have to behave in ways that Alford (1975) described as repressed in order to ensure the interest is represented.

Nurses' representative organisations have had a presence in the policy communities although the extent of the involvement has also fluctuated. In their analysis of the establishment and first two decades of the NHS, Dingwall and colleagues argued, "There is then no logical pattern to the participation of nurses in the health policy process whether at the centre or the periphery. What is also striking is the lack of evident action by nursing organisations on policy questions, especially when contrasted with the strenuous BMA to lobby on behalf of its constituency" (Dingwall et al 1988 p 109). Unlike medicine, nurses have not had one representative organisation but have been split in their membership to a number of professional and trade union organisations throughout the history of the NHS (Hart 1994). The presence of most of these organisations has been most obvious at points of negotiations and disputes with the Department of Health as an employer on pay and conditions of employment (Webster 2002, Rivett 1997). Members of nursing organisations, particularly the Royal College of Nursing, have participated in policy communities on issues wider than nursing, as evidenced through member lists of official committees and reports to House of Commons committees, throughout the history of the NHS.

However, documented accounts of nursing organisations' activity in policy fields are most readily available from first person narratives on issues concerned with the organisation of nursing such as the shift of nurse education into the auspices of higher education (Clay 1987) and the legal right of nurses to prescribe medicines (Jones 2004). Dingwall et al (1988) argued from an analysis of the first decades of the NHS that the aspirations of nursing organisations succeeded in becoming policy when they were convergent with a wider policy agenda of the government of the day. Strong and Robinson (1988) undertook policy ethnography of the introduction of general management. In this they recorded the invisibility of nurses, nursing organisations and nursing activities in the world of the policy makers, managers and doctors at regional and district levels of the NHS. In their analysis, the doctors treated the nurses as occupational and gender subordinates and the managers' attitudes reflected this (Strong and Robinson 1990). Klein (2001), in his analysis of the political history of the NHS, observed that the nursing profession, despite its numeric dominance, was invisible in the health politics of the NHS. Klein gave no explanation for this observation. Others have explained this invisibility in part through an occupational socialisation process that makes nurses unwilling to voice their opinions (Clay 1987). Other commentators have argued that the position of nurses and nursing is a socially structured reflection of both the low status of women and the cultural definitions of nursing as women's' work (Salvage 1985, Colliere 1986, Robinson 1992).

Davies (1995) has argued that the invisibility of nurses in the UK policy arena has been sustained not because the problems lie within nurses and nursing but because the social institutions that they operate within are gendered to assert the primacy of the masculine over the feminine. She has made the case that the gendered nature of the organisations of the NHS, both the bureaucracy and the profession of medicine, actively devalues the feminine work of nursing and diminishes those who both undertake the work and represent it in the public world. Davies suggested that introduction of the contract culture would involve a "*clash of masculinities*" (Davies 1995 p 184) between the profession of medicine and the managers in the bureaucracy, which could offer an opportunity for nursing to make alliances and become more visible in the debates on public

policy. Latimer (1996) has suggested that this analysis is based on an ideal type of nursing and nurses. The focus purely on gender fails to account for the experience of male nurses in the mental health services or the inclusion of some nurses in policy communities at different periods. Other commentators have pointed to the contrast in social class, (with all its nuances of difference in education, financial security, culture, social networks) between the majority of nurses and the doctors and policy elite of the civil service (Carpenter 1977,1993, Faugier 2004). While there a number of studies and analysis considering the position of the ostensibly repressed interest group, the community or patients, in the UK policy arenas (see for example Illsley 1980, Brownlea 1987, Rigge 1994, Beresford and Croft 1993, McIver 1996, Harrison and Mort 1998, Berrow 2002), the empirical studies and analysis considering the position of nurses are relatively few.

Having considered the relevant theories and empirical evidence in the nature of power in health policy in the UK, it is now necessary to consider the issue of leadership against this background.

3.4. Sociological Perspectives on Leadership

The concept of leadership has an extensive literature in sociology, in social psychology, and the related applications of organisational development and management theory. The Shorter English Oxford dictionary offers the definition of leadership " the dignity, office or position of a l.; also, ability to lead" (p1189). A leader is "one who leads "(p 1189). It also offers multiple definitions of "lead" including; "to give direction by going in front", " of a commander, to direct the movement and action of others ", "to guide, direct to a place", "to guide by persuasion", "to guide with reference to opinion", " to direct by ones example", "to have the foremost position in an organisation", "to have the official initiative in the proceedings (of a deliberative body)".

The nuances in the definition of leadership help explain the different focus of academic interests, for example, social psychologists focus on theories of leadership concerned with individual traits (Kirkpatrick and Locke 1991), styles

of decisions making (Vroom and Jago 1978) and the inter-play between individual characteristics and contexts (Fiedler 1978). This study, however, addresses the sociological concerns of the nature and sources of authority that confers leadership and ensures that followers will be influenced.

3.4.1 Weber and Leadership

Weber defined *authority* as a legitimate form of power, in which *"there is the probability that certain commands will be obeyed by a given group of people"* (Gerth and Wright-Mills 1970 p29). He postulated three modes of claiming authority: traditional authority, charismatic authority and rational/legal authority. Traditional authority was that inherited or conferred by a higher authority e.g. monarchy. Charismatic authority rested on the appeal of leaders with extraordinary personal characteristics. Rational - legal authority was enacted in law or contractually established, often characterised by position in a hierarchical organisation. Weber considered the *"bureau"* as the archetypal organisation based on rational-legal authority. Legitimisation for authority in a bureaucracy, he argued, was conferred through position in the hierarchy and its accompanying rules and regulations of behaviour. Officers were educated and therefore expert in the administration of the business of the bureaucracy. Weber viewed the bureaucratisation of society as a threat to individual liberty and postulated that politicians provided the important counter balance to this process (Gerth and Wright-Mills 1970).

3.4.2 Sources of Authority and Conflict Theories

Talcott Parsons in his translation of Weber highlighted in a brief footnote the potential for conflict between professionals, who derived their authority from expertise recognised in their membership of a profession, and bureaucrats who derived their authority from their position in the bureaucracy (Parsons 1949 cited in Blau 1974). Consequently, professionals in a bureaucratic organisation drew on authority for leadership from sources other than position in the hierarchy. It was argued by Parsons (1954) and other contemporary sociologists such as Gouldner (1954) and Blau (1956) that this alternate source of authority

created an inherent tension and conflict between professionals and managers in any bureaucratic organisation. The expert knowledge medicine has access to and control of, is highly valued both by society and the state (Turner 1987). Sociologists found empirical support for the "conflict theory" in the late fifties and sixties particularly focused on law and medicine (see for example Scott 1966). In the same period business management theorists also began to write about the "problem" that professionals caused for businesses and managers. This was based on their perceived allegiance to the values of their profession rather than the values of their business organisation (see for example Drucker 1955).

By the mid nineteen seventies, theorists argued that the polarisation, through the use of ideal types (in the Weberian sense) in the conflict theory was an oversimplification, which was weak in its explanatory powers. These challenges arose from a) critiques of the prevailing attribute theories of the professions particularly medicine, and b) from empirical studies. New scrutiny of the nature of professions contended that professions:

- Were not always a source of public good (for example Illich 1975),
- Served the interest of dominant groups in society such as the bourgeoisie (for example Navarro 1976) and men (for example Ehrenreich and English 1973),
- Were concerned with self–interest rather than with service (Freidson 1970).

Larson (1977), through a historical analysis of the development of medicine, argued that "professionalisation" was an occupational strategy for a) ensuring particular expert knowledge was required by the public and then b) controlling the supply and nature of their expertise. Larson pointed out that that the medical profession derived the authority of its expert knowledge through embodiment in the laws of the state. During this period, other theorists pointed to the extent of state legitimisation for the medical profession to have professional autonomy i.e. to determine its own rules and regulations.

Professional autonomy has been broadly classified into three areas (Freidson 1970, Turner 1987):

- Economic autonomy, the right to establish remuneration levels in the market place,
- Political autonomy, the right to assert the expert opinion on health matters at a public policy level,
- Clinical (or technical) autonomy, the right of the profession to self-regulation as well as the right of the individual doctor to exercise clinical freedom in the care of patients.

Starr (1982) differentiated between "social authority" i.e. control through giving commands as described by Weber and "cultural authority" i.e. the probability that medical definitions of reality and medical judgements would be accepted as valid and true. This definition reflects Gramsci's theory of hegemony (Ritzer 2000). A few analysts at this point began to point to evidence that medical authority might be lessening (see for example Armstrong 1976, Elston 1977). Haug (1973) argued that the knowledge gap between the general public and doctors was narrowing, resulting in a more critical public attitude that diminished the medical professions claim to authority based on expert knowledge.

Empirical studies of the time both built on these critiques and questioned the idea of overt conflict. Green's observational study (1975) of three hospitals in Scotland found little evidence of a clear-cut conflict between medical professionals and administrators. Green reported that the managers and the majority of doctors never came into contact with each other. The conclusion was drawn that the relationship could be more satisfactorily explained by other theories such as a negotiated order of status in hospitals (Strauss et al 1973). Green argued that issues of hierarchy within medicine were as relevant as postulating a medical versus administrator conflict. Alford's policy study of New York (Alford 1975 and section 3.3.1 above) was published at the same time. He described covert tensions rather than overt conflict between the medical profession and the officers in bureaucracies. He used a theory of an underlying structural interest over professional monopoly rather than draw on the theories of conflict between professionals and bureaucrats. However, his empirical data

demonstrates tension and conflict over the authority to make policy decisions between the officers in the bureaucracies and the representatives of the medical profession.

Davies (1983) used case studies of the history of organised nursing in Britain and the USA to argue that issues in hospital order related to social divisions in the wider society such as gender rather than relations between bureaucrats and professionals. Davies (1995) later drew on the analysis of Bologh (1990) and Jones (1993), amongst others, to argue that both bureaucracy and profession are gendered ways of organising social institutions that emphasise the superiority of cultural notions of masculine rational action and actors. In analyses the conflicts become ones of "clashes of masculinity" (Davies 1995 p 184) rather than sources of authority.

3.4.3. Revisiting the Evidence to Support the Conflict Theories: The Introduction of General Management

In the UK, empirical studies of the eighties shifted position from the previous decade, informed both by the debates in political science about the nature of power and by the introduction of the concept of general management into the NHS. General management was the term used to describe management of professionals and health services by people without clinical qualifications (see section 2.3.1). It was an early example of what came to be described as the new public management (Hood, 1991). For UK policy analysts of the time it exposed the conflict in authority between clinicians and managers (Day and Klein 1983). Harrison and colleagues (1992) investigated whether the general managers asserted their authority over health professionals in six District Health Authorities. General managers revealed that they rarely raised issues with doctors that they considered might be contentious, specifically in order to avoid conflict. The authors concluded that general management rarely challenged the medical domain. An observational case study in the mid-eighties of the implementation of general management at a district and unit level noted that staff relationships at ward /clinic level were completely untouched by the turmoil at a higher level in the organisation (Cox 1991). In contrast, Pettigrew and

colleagues (1992) described in great detail the conflict, sometimes overt, of authority and leadership between managers and medical consultants in their case studies of strategic change in eight English District Health Authorities. They described the relationships between clinicians and managers as fragile and ever changing. They note that a "federal"(p177) system of clinical teams, led by a consultant, reinforced professional diversity, autonomy and organisational independence. The relations were likely to be easier either where the managers had been previously administrators and "semi-immersed in the world of the clinicians" (Pettigrew et al 1992 p283) or where the clinicians were managerially minded. They observed, "the relationships could quickly sour but were slow to build up " (Pettigrew et al 1992 p283). These three studies did not consider any another professional group outside medicine. It should also be noted that they focused on the acute sector. In contrast, the community health services, which were predominately nursing services with a few of doctors in community medicine, family planning and child health, continued to have a management structure in which the professions were more likely to be represented (Ottewill and Wall 1990).

In contrast to their dealings with the medical profession, general managers were frequently successful in asserting authority over nursing and nurses by virtue of removing the senior nursing management structure. Two empirical studies from this period provide detailed evidence of the how nursing management and leaders were removed from positions of authority. Robinson and Strong studied the impact of the reforms on nursing through two rounds of interviews and observations of meetings in seven District Health Authorities and a national survey of Chief Nursing officers (Robinson and Strong 1987, Strong and Robinson 1988, Robinson et al 1989, Strong and Robinson 1990). Owen and Glennerster (1990) undertook detailed case studies over three years of the relationship of general management with the nursing profession in four District Health Authorities in the North West Thames Region of England. Both studies recorded the removal of the nursing management hierarchies and positions for nurses at the top (and often) middle management level in organisations. Some general managers appointed nurses to senior positions as advisers in the organisation but without the authority to directly control the nurses or the activity

of nursing. Many of those who remained in senior positions were given roles concerned with quality assurance of services other than medical. The studies demonstrated the precarious position of the senior nurses, the frequent overt and covert conflict with the general managers, and the managers' perception that the senior nurses had little expert knowledge. Strong and Robinson (1988) came to the conclusion that nursing had been caught in the cross fire of set of reforms which were intended to assert authority over the medical profession.

As the eighties progressed, managers were developing a new strategy for exerting authority over the medical profession. Harrison and Pollitt (1994) characterised this as "incorporatism" i.e. incorporating doctors through appointment to managerial positions and assigning managerial responsibilities such as budget control. Empirical studies of the late eighties and nineties in the hospital sector demonstrated the growth of new medical manager roles (Lorbieki et al 1992, Packwood et al 1991). However, a major impetus for accepting these roles came from a desire to protect clinical autonomy from lay managers (Parkhouse et al 1988).

3.4.4. Revisiting the Evidence to Support the Conflict Theories: The Introduction of the Internal Market in the NHS

The NHS reforms, introduced with the NHS and Community Care Act 1990, and the 1990 GP contract, demonstrated the continuation of two strategies for exerting authority over professionals: 1) the management of professional activity by non- professionals and 2) the incorporation of professionals to positions in the management structure. The reforms also included a third strategy that of accountability to others in clinical activity. Elston (1991) argued at the time of the introduction of the reforms that they were likely to fail in attempting to incorporate doctors into NHS management. She provided a detailed analysis of the situation in the UK, which pointed to an adjustment in relationships but not a generalised waning of either medicine's technical autonomy or its cultural authority. She concluded that new forms of institutionalised professional control were more likely to succeed in influencing individual clinical behaviours.

Incorporation of professionals in the management processes was signalled by the return to medical and nursing representation to Boards, this time as executive Directors (NHS & Community Care Act 1990 Section 5). However, most Medical Directors of Trusts reported they saw their role as one of representing their medical colleagues rather than managing their activity (Baker 1994). Surveys of clinical directors (i.e. medical directors at the unit level in hospitals) reported their disinclination to have direct authority or attempt to exert authority over their consultant peers (Mole and Dawson 1993). Attempts at direct management of medical consultant activity produced conflict as evidenced by the consultant bodies in two Trusts passing votes of no confidence in the chairmen of their Boards, John Spiers and Roy Lilley, leading to their resignation from post (Court 1994). In contrast, an interview study of Nurse Directors, commissioned by the Chief Nursing Officer one year after the reforms, emphasised their role in leading the nursing workforce and exerting authority over nurses and nursing as well as contributing to the corporate agenda (Noons et al undated).

General practitioners and consultants experienced these sets of reforms differently. The central government strategy of involving professionals in the contracting process of the internal market (Department of Health 1989b) provided an example of conflict between managers and consultants. The Joint Consultants Committee reported to the Minister of Health that there was widespread exclusion of consultants by managers in the contracting processes at a local level (Department of Health 1993). In order to pacify the consultant body, a ministerial Task Force was established, followed by an injunction from central government to the local managers to involved professionals in commissioning, the newly adopted term for contracting (Department of Health 1995, 1995a).

In contrast 'GP fundholding' was a completely new strategy by which a section of the medical profession, which had previously been semi-detached from the rest of the NHS through its independent contractor status, was fully incorporated into the internal market processes. GP practices were delegated finances and responsibilities for purchasing health care on behalf of their registered patient population (see section 2.4 for details). GP fund holding was viewed as a success and quickly extended (Department of Health 1992, Department of Health

1994) but later evidence indicated it made little difference except at the margins of health care (Le Grand et al 1998). However, one empirical study demonstrated that it transformed the relationship between hospital consultants and general practitioners. Hospital consultants had to consider GPs as important customers for the first time, re-orientating their attitudes (Ferlie et al 1996). The introduction of GP fund holding was followed by the introduction of other models of GPs involvement in the commissioning process (Department of Health 1997a). Involvement in fund holding had the effect of increasing the number of managers directly employed by GPs (Marnoch 1996); this was in contrast to the relationship between doctors and managers in the acute sector. A second consequence was that the tensions in the relationships between general practitioners and community health service managers over the availability of community nurses and therapists to individual practices became more visible. Flynn et al ((1996) studied the contractual process for community health services in three areas. They recorded the adversarial and confrontational attitudes of GP fund holders to community health service managers in contracting meetings. Goodman (1998) reported similar attitudes in nine case studies of GP commissioning and purchasing of district nursing but noted that in one area the GP fundholders worked more co-operatively to the point where they agreed to use their fundholding monies to address Trust overspends.

This set of reforms also brought a drive to make the medical profession more accountable to the organisation for their performance. General managers for the first time were included in the process of drawing up of job plans for consultants and in the process of deciding which consultants should receive distinction awards, which was a system for rewarding clinical excellence with increased salary (Department of Health 1989c). In practice, Salter reported that two thirds of merit awards remained at the discretion of a national body, whose membership was predominately medical (Salter 1998). These reforms also required that every doctor should take regular systematic audit of their practice (Department of Health. 1989d). The challenge to the authority of the medical profession was subverted however as medical audit was undertaken in a variety of ways (Kerrison et al 1993). Studies of the period suggested that the medical profession successfully appropriated audit as an internal professional process rather than one

of external managerial scrutiny (Pollitt 1993, Humphrey and Berrow 1993). In contrast, the nursing profession had already started to engage in more public auditing of its practice, promoted by nurse managers (Reid 1988). The Department of Health now promoted a system wide approach to nursing audit (NHS Management Executive 1991). The adoption of systems for auditing nursing quality was widespread and usually led by nurse managers (Redfern and Norman 1994). Audit of nursing practice was therefore open to scrutiny by managers in contrast to medical audit.

3.4.5. Revisiting the Evidence to Support the Conflict Theories: The Retreat from the Internal Market

The re-organisation of the NHS under the labour government demonstrated a continuation of the strategies to incorporate professionals in the management of the NHS (Department of Health 1997). However, the most significant arena in which the authority of the medical profession was challenged was in the self-regulation of clinical practice. The 1990's saw a series of major scandals in medical practice that shook public confidence in the medical profession and provided the politicians with a "policy window "(Ham 1999) to push through a raft of reforms, previously not attempted for fear of the scale of medical opposition. The three highest profile of these scandals were:

- The high rate of deaths of children undergoing heart surgery in Bristol Royal Infirmary because of inadequacies of the surgeons (Department of Health 2001a),
- The illegal retention of organs from children removed at autopsy at Alder Hey Hospital in Liverpool (Department of Health 2001b),
- The sentencing of Harold Shipman, a general practitioner, for the murder of 15 healthy elderly patients (O'Neill 2000).

The medical profession acquiesced to a set of reforms that made the performance of the individual doctors open to a level of scrutiny, which had never been attempted before (Salter 2001). For the first time the chief executives of NHS organisations were responsible for clinical quality as well as

financial probity (Department of Health 1999a). Clinical governance, an organisational system to link all aspects of quality assurance with clinical risk management (Department of Health 1998e) was introduced. Every Trust and Primary Care organisation were set target dates to implement systems for monitoring clinical performance and ensuring that national determined clinical standards (such as in the National Service Frameworks) were being met. All doctors were required to take part in audit: it was no longer voluntary. The reforms also introduced state, rather than professional, mechanisms for directing and scrutinising clinical quality (National Institute of Clinical Excellence and the Commission for Health Improvement). The government questioned the current professional self-regulation mechanisms (Department of Health 2000a). Reforms were made to the state mechanisms for dealing with doctors whose clinical practice gave rise to concern (Department of Health 1999b). The medical profession responded to these challenges to medical self-regulation by the acceptance of the principle of re-validation for consultants by the Royal Colleges for the first time (Salter 2001). In the case of nursing, the government introduced legislation for major changes in the professional registering body. The Nursing and Midwifery Council (NMC) replaced the United Kingdom Co-ordinating Council for Nursing Midwifery and Health Visiting (UKCC). The legislation ensured that non-professionals were the majority of members on the NMC Board and its business committees (Department of Health 2002b).

The late twentieth century history of the NHS demonstrated repeated challenges to the authority of the professional by managers within the bureaucratic system of the NHS. The medical profession successfully resisted these challenges in contrast to nursing. The last years of the century, however, saw the establishment of a number of bureaucratic measures to assert the authority of the managers over the doctors, potentially curtailing the clinical autonomy of the individual doctor but not the profession. Conflict theorists however have addressed the professions as though they were homogeneous. Clearly there are differences between the professions but there are also internal divisions within professions. It is helpful to understand the internal divisions in the professions in order to comprehend the variety of relationships between managers in the NHS bureaucracy, medicine and nursing.

3.5. Medicine and Nursing: Divided Professions

Medicine is a stratified occupation with subdivisions holding differing levels of power and prestige (Elston 1993). Specialists (i.e. the consultants) have been accorded greater prestige than the generalists (i.e. the general practitioner), which Honigsbaum (1979) traces back to social class divisions. In 1995 general practitioners constituted 50 per cent of the UK medical workforce but fewer than 20 per cent of medical graduates positively opted for a career in general practice (Health Policy and Economic Research Unit 1998). The differential positions of prestige and influence held between consultants and general practitioners is also evidenced by the scant attention paid by policy analysts to general practitioners up until the introduction of GP fundholding. Aside from the hierarchy of status associated with speciality and medical schools, medicine organises itself in a nationally recognised hierarchy from newly qualified doctors to consultants. Each consultant has a "firm" i.e. a hierarchically organised team of doctors working for them with differentiated job roles. The differential position between junior doctors and consultants is reflected in salary, different levels of authority and status symbols in the hospital environment.

The structuring of the medical profession is a reflection of wider social structures although beyond Honigsbaum's (1979) historical analysis there appears to be little empirical evidence as to the influence of social class on current generations of doctors. While originally a fiercely defended male occupation, the twentieth century saw a gradual increase in female entrants (Elston 1993). By the nineteen nineties, half of all entrants to medical school were female (Pringle 1998). Despite this shift, the medical profession is a gendered occupation, with men more likely to be in higher status positions and higher status specialities than women (Allen 1988, Elston 1993). Women now form about fifty percent of general practitioners (Royal College of General Practitioners 2004). However, analysis in the early nineties identified that women GPs were more likely to be part-time and employed in ways that meant they had reduced income and influence in group practices (Elston 1993). Medicine is also structured by ethnicity. Doctors from minority ethnic groups,

particularly of Asian and African origin, are over represented in less prestigious specialities, in less prestigious hospitals and in general practice in areas of multiple deprivation (Coker 2001). There are few empirical studies that compare and contrast the relationships between doctors and managers whose positions are socially structured in different ways.

Nursing, like medicine, is not a homogeneous occupation. While medicine is recognised as having power differentials between its specialists and generalists, the claims for differentials between the occupational groups of nurses, midwives and health visitors has largely been unrecognised by others outside the nursing profession. Clay (1987), as General Secretary of the Royal College of Nursing, recounted that the factional fighting between general nurses, midwives and health visitors, completely bemused the politicians and almost resulted in the loss of the legislation for a university based nurse education and reformed nursing registration body. Nursing has always been organised hierarchically. However, it lost its nationally uniform frameworks with the introduction of general management. As a result, titles like senior nurse and clinical nurse have different roles and responsibilities dependent on the local context (Cameron and Masterson 2000) unlike medicine in which consultant, registrar and other titles correspond nationally. Even recently introduced positions such as nurse consultant and matron vary according to local contexts (Guest et al 2001). Nursing, like medicine, has also been structured in less obvious ways. Rosemary White in a series of historical studies of the mid-twentieth development of nursing in the UK demonstrated further divisions within the nursing profession that are particular relevance in considering the application of professional and bureaucrat conflict theories in nursing (White 1985, White 1986). Drawing on work from managerial studies as well as the sociology of occupations, she argued that three groups could be determined that held different motivation, reference values and aspirations. These were the generalists, the professionalists and the nurse managers:

- The generalists emphasised the nursing as a practical skill, learnt as a craft, which could be broken into task elements and divided for efficiency. The generalists were primarily interested in material rewards and a functional status.

- The professionalists aspired to the occupational strategies of a profession, seeking control on entry to their ranks, a defined knowledge base transmitted through a profession controlled education system located in higher education, and market monopoly.
- The nurse managers adopted the values and knowledge base of the bureaucrats in managing the organisation rather than their occupational group. They preferred nurses who were generalists and did not challenge their authority or the status quo. They suppressed the development of professionalists because they challenged the authority of the managers (White 1985).

Carpenter has pointed to the stratification in nursing by social class, arguing that the generalists were more likely to be from working class backgrounds, while the professionalists and senior nurse managers were more likely to be from middle class backgrounds (Carpenter 1977). He has also pointed to the class and gender divisions in the recruitment of nurses to different types of hospital. London teaching hospitals (i.e. with medical schools) actively recruited its student nurses from middle class backgrounds throughout most of the twentieth century. Carpenter identified the dominant representation of London teaching hospital nurses in many of the nursing professional organisations (Carpenter 1977). Nursing has always recruited men in the UK, predominately to specialities such as mental health nursing and learning disabilities (Carpenter 1980). The recurring nursing workforce crisis from the inception of the NHS saw active international recruitment of qualified nurses into jobs and people into UK student nurse training. People of colour were actively directed into less prestigious areas of nursing and less prestigious hospitals (King Edward's Hospital Fund for London 1990). The over representation of male nurses in senior clinical and management positions (Jones et al 1981, Davies and Rosser 1986, Finlayson and Nazroo 1998) and the under representation of nurses from black and minority ethnic groups in those positions (NHS Leadership Centre 2002) provides evidence that even in a predominantly female occupation, the structural stratification of the wider society is replicated in ways that are not immediately obvious. Carpenter has argued that a social division analysis is important in considering the occupation of nursing, in which arenas of employment, work

roles and levels of seniority have been stratified through gender, class and race (Carpenter 1993).

3.6. Conclusion

This review indicates the structured dominance of the medical profession in the health policymaking process in the UK. However, it is evident that the power of the medical profession to influence policy is reduced when the issue is of wider concern in the government than the Department of Health. Treasury pressures and public outrage at medical scandals has provided the authority to create policy even in the face of opposition from the medical profession. While other groups are present in the policy communities, the medical profession has pre-imminence both in its contribution and the recognition of its powerful position by others in the policy community. There is little evidence that the profession of nursing has influence, or is viewed as influential by policy analysts. In considering leadership within health policy making and its implementation, there is evidence of ongoing conflict and challenges between managers and the professionals. The conflict is not necessarily overt but it clearly forms an important backdrop in understanding the development and implementation of health policies. It is evident that the medical profession has been repeatedly successful at resisting the challenge to its authority from the managers within the NHS. However, nursing has rarely been considered in its relationship with the managers of the NHS. The few empirical examples that exist demonstrate both conflict and accommodation to the authority of the managers. Nursing and nurses are more frequently considered through their relationship with medicine and it is this relationship that will be discussed in the next chapter.

Chapter 4. Doctors and Nurses

4.1. Introduction

The policy guidance for the Board membership of the PCG prescribed a joint leadership role for doctors and nurses. However, the roles and relationships in clinical care, suggest that this would not be a straightforward relationship in a decision making body. The depiction of the omnipotent male doctor supported by the subservient female nurse provides a stereotype of roles that belies the complexity of the relationships across the breadth and history of health care provision in the UK. This chapter reviews the empirical evidence in the relationship between the two occupational groups in institutional settings and in primary health care.

4.2. Perceptions of the Relationship Between the Occupations of Medicine And Nursing

It has been argued that the gendered nature of both politics and the health service has rendered nursing, tacitly defined as women's work, of low value and invisible (Stacey and Price 1981, Witz 1994, Davies 1995).

The medical profession has held and continues to hold a clear view of the subordinate position of nursing in patient care. This relationship is explicit in the language of the documents of the registration body for medicine, the General Medical Council. Doctors 'delegate' tasks to nurses and only 'refer' patients to other doctors.

> *" **Delegation** involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf..... **Referral** involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical*

practitioner. If this is not the case, you must be satisfied that any health care professional to whom you refer a patient is accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient" (General Medical Council 2001 paragraphs 47 & 48)

Despite delegation of tasks to nurses, the GMC asserts that it is always a doctor who always holds the responsibility for continued management of patient care.

Armstrong (1979) made the case, through examination of government reports on nursing and professions allied to medicine in the 1970s, that there was a dwindling of the medical hegemony prevalent at the inception of the NHS. However, common law demonstrates the continued medical hegemony as well as invisibility of nursing to successive governments and the judiciary (Montgomery 2003). Most famously, the House of Lords ruled that nurses administering prostaglandin to induce abortion were not contravening the 1967 Abortion Act, which stated that only medical practitioners could undertake abortions. It was ruled that doctors, not nurses, undertook the abortion as the nurses only acted on the orders of a medical practitioner, (Montgomery 1992). English case law in medical negligence suits reveals that nurses are not deemed negligent if they are carrying out the orders of a doctor, irrespective of the inappropriateness of the order (Gold v Essex County Council 1942 AII ER 237 cited in McHale and Tingle 2001).

4.3. A Brief Overview of the Development of an Occupational Hierarchy in Health Care

The division of labour in health care in the UK has a history that demonstrates how one occupational group, medicine, has organised to gain state sanction for securing the pre-eminence of its knowledge and skill based services in the health care market (Johnson 1972, Larson 1977). More than that, it demonstrates that

the gender divisions in society were replicated in establishing a hierarchy of authority and reward in labour processes (Stacey 1988). The process of occupational monopoly depends on state sanction for three dimensions:

- Occupational control of entry to its ranks that requires acquisition of its knowledge base through a university system of education,
- Access to a client group that precludes or subordinates other occupational groups,
- The right of autonomy at the point of using or applying the occupational knowledge and skills (Turner 1987).

In analysing the power of the medical profession in the USA and UK, Freidson (1970) concluded that when one occupation had state sanctioned autonomy in a division of labour, that sanction implicitly included the domination of other occupational groupings. Turner identified three modes of dominance by an occupational group to other occupational groups: subordination, limitation and exclusion (Turner 1987). The relationship between medicine and nursing over time demonstrates all three modes.

The history of the development of nursing as a paid, trained, state sanctioned occupation in the UK demonstrates its dependence on the sponsorship of the medical profession through acknowledging its subordinate position to the medical profession (Abel-Smith 1960). A defining feature of this hierarchical relationship has been its gendered nature. The construction of a predominantly male profession, sanctioned in state legislation during the late nineteenth and early twentieth century, was simultaneously supported by the construction of a much larger predominantly female occupational group to undertake the tasks necessary to support medicine in its growing power base of the hospitals. Abel-Smith's history was one of the first to focus on the social stratification between medicine and nursing (Abel–Smith 1960). It took until the later part of the twentieth century for a critical analysis to begin to reveal the reproduction of gendered relations and wider male hegemony in the assertion of medicine in the

division of labour between medicine and nursing (Ehrenreich and English 1973, Gamarnikow 1978, Versluyen 1980).

During the nineteenth century, the profession of medicine both gained a state sanctioned register of medical practitioners with a university education (Cartwright 1977) and secured sole right for its members to perform certain acts within the state, such as death certification and medication prescription, to the exclusion of other occupational groups. Fifty years later midwifes also attained a state sanctioned register, followed by nurses in the Nurses Registration Act of 1919 (Baly 1980). However, the entry criteria to the Register depended on training in "schools" in hospitals rather than an institution that was part of organised education (Davies 1980). Any rights gained by nurses in other legislation were either shared with medical practitioners, such as the Midwifery Act 1902, or limited so that they were only at the specific direction of the medical profession (for example in administering medicines controlled under legislation through the Therapeutic Substances Act 1925).

4.4. The Response of Nursing to a Subordinated Position

Members of subordinated groups in any society display a number of common behaviours. Clarke et al (1975), in considering social class and culture, argued that the relations between a subordinate and dominant group are always intensely active and always oppositional. They made the case that working class culture was created through a continuum of "negotiation, resistance and struggle" against the dominant class culture (Clarke et al 1975 p103). They suggested that the subordinate class had a repertoire of strategies and responses that include ways of coping as well as resisting the dominant culture. Cohen (1980), described a cultural repertoire of responses to subordination that included "learning how to get by, how to make the best of a bad job, how to make things thoroughly unpleasant for 'them' " (Cohen 1980 p 161). Roberts (1983) argued that nursing demonstrated "oppressed group behaviour". She drew three sources

to argue her case: the work of anthropologist Memmi (1965) studying colonisation, the writings of the leaders of the American Black Liberation movement of the early seventies and Friere (1972), a liberation educationalist. She argued that nurses as an oppressed group displayed aggression and violence horizontally in their own group, not vertically to the dominant group. She proposed that nurses in position of authority to other nurses assimilated the norms and values of the dominant culture and actively participated in repressing the subordinate culture. The subordinate nurses resisted this assimilation and resented the super-ordinate nurses who promulgated it. Considered together these theories suggest that members of subordinate groups:

- Accommodate, normalise and mediate their situation,
- Resist and challenge the dominant group,
- Create their own, sometimes counter, culture to the dominant culture,
- Treat with suspicion those members who assimilate to the dominant culture,
- Are more likely to display overt aggression to their own group than to the dominant group.

These theories will now be considered against the empirical evidence.

4.5. The Nurse and Doctor Relationship in Institutional Settings: Accommodation, Normalisation and Mediation

The twentieth century history of cyclical labour shortages for nursing and high drop out rates from nurse training in the UK (see for example Ministry of Health et al 1947, Department of Health and Social Security 1972a, Seccombe and Smith 1996) provides evidence that large numbers of young women are not prepared to work in a subordinate occupation. However, there are nearly half a million qualified nurses employed in the English NHS (Department of Health 2003). The sheer scale of the numbers of women employed as nurses, midwives and health visitors in the public and private sector suggests that a degree of

accommodation, normalisation and mediation occurs, underpinned by a range of motivators and incentives.

While Gamarnikow's (1978) seminal historical analysis of the development of nursing, revealed an analogy between doctor/nurse/patient relationships and that within the Victorian family of father/mother/child, the analogy repeated in contemporary populist and academic literature is that of nurses as "handmaidens" i.e. female servants to the doctor. Empirical evidence from the twentieth century suggests a complex relationship in which nurses mediate their position. Stein (1967) argued for a modification of the stereotype of subordinate nurse, describing "the doctor –nurse game". In this "game", the nurse preserved the appearance of subservience while actively involved in the decision-making in patient care and treatment. The doctor preserved the appearance of omnipotence through seeking information and opinions from the nurse without actually asking for it. The nurse was therefore a covert participant in clinical decision making not merely a recipient of the doctor's orders. Stein's arguments were not supported by any empirical evidence beyond his experience but were (and are) widely referred to.

Late twentieth century empirical studies observing doctor and nurse interactions in different hospital and clinical settings in the UK have offered a different view. Devine's (1978) observations of and interviews with 11 doctors and 22 nurses on two paediatric wards revealed that relationships between the consultants and the nurses were more likely to reflect the doctor-nurse game than between the junior doctors and the nurses. A further challenge to the depiction of nurses only covertly participating in clinical decision-making came from observation of the working relations between nurses and doctors in an Accident and Emergency Department (Hughes 1988). Hughes concluded that the nurses in this working environment were overtly undertaking diagnostic activities, offering advice and information on clinical decisions to the medical staff, particularly to new and junior doctors. Senior nurses frequently intervened in the work of junior doctors pointing out shortcomings and effectively taking control. Porter's (1991)

participant observation of doctor nurse interactions in the critical care ward of an acute hospital provided further evidence of nurses overtly participating in clinical care decision making and little evidence of the doctor-nurse game. This led Porter to speculate whether Stein's observations were true of a particular time period when the gender division between the two groups was very distinct and when doctors had a greater level of control of nurse education and employment. Indeed, Stein revisited his observations later that decade and announced that nurses had unilaterally abandoned the doctor-nurse game (Stein et al 1990).

Large-scale interview studies, across multiple hospital sites, of doctors and nurses confirm that it is important to specify context and position in both occupational hierarchies when considering medical and nursing relationships. Relationships between nurses and junior doctors were reported to be very different to those with senior registrars and consultants (MacKay 1989, MacKay 1993, Walby et al 1994, Halford et al 1997). The studies by Mackay reported the almost invisibility of the junior grade nurses to all grades of doctors. All four studies revealed tensions and conflicts between the two occupational groups over work roles (perceived by both groups) and occupational behaviours (mostly perceived by nurses and junior doctors). Allen challenged these findings from an observational and interview study, at one 900 bed acute hospital, in which she examined the relationships between medicine and nursing as nurses absorbed more roles of the junior doctors over ten months (Allen 1997). She reported little inter occupational friction in face to face relationships as the negotiations took place between senior members of the occupational groups in committee meetings away from clinical care environments.

The potential for the gendered nature of the relationships between doctors and nurses to change has increased as the twentieth century progressed. There has been a significant increase in women admitted to medical schools and a slight increase in the numbers of men admitted to nurse training (described more fully in Chapter 3). In the UK, there has been little empirical work investigating the impact of these changes. Walby et al's interview study of relationships between

doctors and nurses in 5 acute hospitals concluded that "*gender appears highly relevant when looking at the internal hierarchy of each profession, in that men rise to the top more than women, but it has only a minor, in any effect on the nature of the interaction of professionals in conflict situations* (Walby et al 1994 p73). However, some of their data examples given in the body of their text can be interpreted to demonstrate that occupational gender shift does affect relationships. A Finnish survey of female doctors reported they perceived their relationship with female nurses to be different from male doctor colleagues. In junior medical positions they described making friends with the nurses to gain help in undertaking their work and having their instructions followed in patient care. They reported that only when they were in consultant positions were they able to behave to the female nurses in the same way as their male peers (Gjerberg, E. & Kjolsrod, L. 2001). Conversely, an interview study of male nurses in England reported that their relationship with male doctors was different from their female colleagues. They perceived that male doctors found their presence difficult and actively avoided working with them (Savage 1987).

4.6. The Nurse and Doctor Relationships in Institutional Settings: Counter Culture, Resistance and Challenge

Medicine has a hegemonic impact on the culture of health care provision. Nursing actively creates its own culture, some of which assimilates the dominant culture but other aspects have developed in resistance, thus creating a counter culture. Nursing accepted the dominant culture that nurses follow orders but over time have created a counter culture that assimilates that behaviour into their cultural understanding of all professional behaviour, later using it as a source of challenge to medicine. Walby et al (1994) from their empirical data described issues of conflict between doctors (particularly junior doctors) and nurses in five hospitals. They explained the conflict through an essential cultural difference in how doctors and nurses perceived and enacted "professionalism":

> *"The medical notion of profession was one where an educated person was able to respond to individual problems in undetermined, innovative yet trustworthy ways. The nursing notion was one of technicality, of pinning down exactly what was to be done and the training and staff needed to do it to agreed standards. The nurses often saw professionalism as being a rule governed process, intimately tied with checking and monitoring. Doctors saw a professional as someone who exercised independent judgement."* (Walby et al 1994 p61).

Walby and her co-researchers noted that neither group appeared to recognise the difference in the other.

Resistance and challenge to the dominant group has been present throughout the history of nursing as a paid, organised occupation. Nurse leaders in the late nineteenth and early twentieth century simultaneously acknowledged a subordinate position to doctors, while denying the influence of medicine on aspects of the occupation of nursing (Wicks 1998). Even Florence Nightingale, often portrayed as a key protagonist for the subordination of nursing to medicine, was clear that one of her objectives was for nurses to control the occupation of nursing:

> *" The whole reform in nursing both at home and aboard has consisted in this; to take all power over nursing out of the hands of the men, and put it in the hands of one female trained head and make her responsible for everything (regarding internal management and discipline) being carried out."* (Letter from Florence Nightingale to Mary Jones 1867, cited in Abel-Smith 1960:25).

In contemporary times, nursing as a profession refuses to acknowledge a subordinate position to medicine. The Nursing and Midwifery Council, unlike the licensing body for medicine, omits any statements about the relationship between medicine and nursing in the official documents. There is no mention of doctors in its key documents such as the Code of Conduct for Nurses, Midwives

and Health Visitors (Nursing and Midwifery Council 2002), the curriculum to be followed to attain registration (United Kingdom Central Council 1999) or the competencies to be obtained to be registered as a heath visitor (Nursing and Midwifery Council 2002a). The subordinate relationship is only referred to where statute exists that specifies the different medical and nursing occupational roles such as in the prescription and administration of medicines (Nursing and Midwifery Council 2002b). Health visitors went so far as to declare in their professional documents that they were '*autonomous practitioners*' (Council for the Education and Training of Health Visitors 1979), although this assertion was omitted from later documents (Council for the Education and Training of Health Visitors 1983). In complete contrast to the evidence from case law, (as described above in 4.1.3.) the nursing profession has asserted and continues to assert that the nurse alone is to be held to account for her/his actions (Nursing and Midwifery Council 2002).

Resistance and challenge to medicine is demonstrated in the pursuit of the status of profession for nursing. Witz has argued that nursing has been following an occupational strategy of "dual closure" (Witz 1994 p 23), thorough challenging medical definitions and control over what it does and clearly defining who can and cannot practice as a nurse. The history of the late twentieth century demonstrates examples of the pursuit of the professional project in the UK (Davies 1995). This can be viewed in terms of Turner's (1987) three criteria of attempting to obtain a university system of education for entry into nursing, in trying to control of access to a client group and asserting the right of autonomy in exercise occupational skills.

The pursuit of education at university level for nurses in the UK was given impetus by the problems of recruiting and retaining a nursing workforce for the NHS (Department of Health and Social Security 1972a). The sixties and seventies saw experiments in providing degree level education for nurses alongside the nursing qualification at Edinburgh, Manchester, Southampton and Surrey Universities (Owen 1977 p17). Edinburgh University piloted nursing

degrees in this period. University based education for all nurses and midwives was technically achieved in the late nineteen eighties (Davies 1995), on the back of government policy drives to widen access to higher education (Clay 1987, Rivett 1997). This shift in curriculum and educational setting was known as Project 2000. However, the reality was a lower status education compared to medicine. The registration of nurses and midwives was set at diploma rather than graduate level and mainly located in the universities created from the old polytechnics, not the universities that housed medical schools. Salter (1998) points out that not only did the nursing profession fail to achieve graduate level entry criteria but also the nurse managers lost control of the funding for nurse education to the general managers (Department of Health 1989e). Turner's (1987) two other criteria for developing occupational monopoly were: a) control of access to a client group precluding others and b) the right of autonomy at the point of using or applying the occupational knowledge and skills. The examples of nursing attempts to control access to a client group are not obvious. More explicit are the attempts of the nursing profession to a) challenge medicine's assertion that it controls access to patients and subordinates nursing in this process and b) carve out areas of autonomous practice as part of the challenge. The period of the late nineteen seventies until the early nineties is notable for well-documented examples. There experiments of in-patient units where nurses not doctors had admission rights (Pearson 1988). However, these were short-lived experiments that floundered when junior doctors refused to provide medical cover (Pembrey and Punton 1990). There were attempts at claiming a distinct body of nursing knowledge through asserting nursing theory and nursing models (Aggleton and Chalmers 1986). Porter (1995) noted that there was a complete absence of reference to medicine in the literature on nursing models. It would appear to provide another example of the nursing profession's ability to assert a counter culture i.e. a nursing world devoid of medicine. The promotion of nursing theories found physical form through: a) the introduction of problem focused recording keeping systems known as "the nursing process" (Ashworth et al. 1978, Dickinson 1982), b) the introduction of primary nursing (Pearson 1988) and c) the publicising of 'named nurses' (Department of Health and the Welsh

Office 1991) as responsible for each in-patient's nursing care. Commentators and researchers have described the failures of these attempts. They identified a range of causes including: the lack of perceived utility from some groups within nursing (De La Cuesta 1982, Clark 1985), the powerlessness of the nurses to implement change without the support of the medical profession (Keyser 1988), the difficulties of maintaining these systems in the face of resource pressure (Savage 1995) and the opposition of the medical profession (Mitchell 1984). These examples are from the hospital sector where the majority of nurses are employed. Consideration will now be given to health care settings outside the hospital.

4.7. The Nurse- Doctor Relationship in Primary Care: Accommodation, Counter Culture, Resistance and Challenge

Examination of the history of health care provision outside of the hospitals provides a structurally different relationship between medicine and nursing. There are currently three different groups of doctors who work outside the hospitals without admission rights to hospital beds. The smallest group is the public health doctors, who as medical officers of health before the 1974 NHS reforms held a direct management function in the Local Authorities for all the nurses working in primary care (Jefferies 1995). The 1991 NHS reforms removed the vestiges of this relationship when public health medicine was aligned to a commissioning function rather than a service providing function. The second group is the doctors working in the child and school health services and the family planning services. Up until the 1974, the medical officer of health led these services (Ottewill and Wall 1991). Subsequently, consultants in community paediatrics and sometimes consultants in community gynaecology lead these services. The majority of the medical posts in these services are sessional and predominantly filled by women (Elston 1993). The nurses and health visitors rarely work to the immediate direction of a doctor. Health visitors in particular have developed a counter culture in which their view of themselves is autonomous of medical influence. However, in these services, most of the

activities and most of the clinical standards of the nurses and health visitors are agreed at a service level between the consultants and the managers. The use of patient group directions as a mechanism to further enable nurses and health visitors to dispense medication and give immunisations without the explicit instruction of a doctor is one example where the instruction of the doctor is at a service level rather than the patient level (The Prescription Only Medicines (Human Use) Amendment Order 2003). The scope of the consultants in community health services changed with the introduction of the revised GP contract in 1990, in which GPs were given incentives to undertake child health and family planning services (Department of Health and Welsh Office 1989).

The largest group of doctors are the general practitioners, who have independent contractor status to the NHS. Following the introduction of the 1990 GP contract, they became direct employers of significant numbers of practice nurses; ten thousand whole time equivalents by the mid nineties i.e. over a third of the nursing workforce in primary care (Drennan et al 2004). The activities of practice nurses are undertaken at the instruction of the GP, both as a doctor and as their employer (Atkin and Lunt 1995). It is clear that the close working relationship in the practice has led some GPs to delegate areas of work that allow the nurse greater independence such as monitoring of chronic diseases (Ross et al 1994), telephone triage (Richards et al 2002), first contact for patients with minor self-limiting illness (Koperski, Rogers and Drennan 1997). The GPs regard these as delegated responsibilities not independent nursing practice (Williams 2000).

The relationship between general practitioners and nurses and health visitors employed in community health services has a chequered history, demonstrating accommodation as well as resistance and challenge. Some of the tensions could be viewed as a by-product of the historical divisions between public health medicine and general practice (Lewis 1986) rather than challenges from nursing and health visiting. The development of health visitors and nurses in public health functions, mostly led by medical officers of health in the late nineteenth and early twentieth century, gave these groups a different level of progress in the

occupational strategy of dual closure to the hospital nurses. This can be demonstrated in their direct access to a client group and in their level of education.

Health visitors obtain their client lists through the notification of births (originally established with the Notification of Births (Extension) Act 1915), through referral to each other when families move on and sometimes notification from general practice when families register. School nurses obtain their clients through the school roll. District nursing services have often allowed direct access for the public rather than on the request of a doctor, although invariably then alerting the GP to their work and requiring authorisation in any activities involving medicines and most medical devices.

As an occupation, health visiting has had a different and faster route to professionalisation than nurses and midwives. State registration was not obtained until the 1946 National Health Service Act (McEwan 1959). However, their education programmes, before and after state sanction, were located in higher education institutions not schools of nursing (Ministry of Health et al. 1956). In the nurse education reforms after the introduction of the Project 2000, health visitors retained their differential position to registered nurses by achieving degree level entry education to their register (United Kingdom Central Council 1994). At this point, other groups of nurses working in primary care shared degree level entry criteria. The culture of health visiting has been one of an occupational role autonomous of doctors, focused on illness prevention and public health rather than curative or palliative health care (Robinson 1982, Appleby and Sayer 2001). Health visitors have actively avoided conflict with GPs (Mayall and Foster 1989) and one consequence of this has been an almost invisibility to GPs (Drennan 1986), which became extremely problematic when GPs gained influence in commissioning services (Flynn et al 1996).

Resistance and accommodation from nurses and health visitors to GP direction has been evident in the oscillating history of their attachment to and separation

from general practices. Despite national policies in the seventies to increase the attachment of nurses and health visitors to GPs, there was actually a decrease (Standing Medical Advisory Committee and Standing Nursing and Midwifery Standing Committee 1981). The problems were listed in a Department of Health review of community nursing services (Department of Health and Social Security 1986a). The recommendations from this review, while acknowledging the importance of primary health care teams, promoted a comprehensive nursing service organised around a local population, managed by community health service managers and independent of general practice. It went so far as to advocate written service level agreements between nurses and each general practice (Department Of Health and Social Security 1986a Recommendation 8). There followed a period where in many areas community nurses were re-organised into geographically focused Neighbourhood Nursing Teams (Dalley and Brown 1989), in the face of opposition from GPs (General Medical Services Committee 1986). This model of organisation was swiftly dismantled as the power of the GP in fundholding and commissioning became apparent (Jackson 1994). District nurses and health visitors were attached to GP practices in every area of the UK, despite the problems it created in areas where small general practices predominated rather than group practices (Drennan and Williams 2001).

The difficulties in working relationships between GPs, the community nurses and health visitors have been recorded in numerous empirical studies on team work in primary care (McIntosh and Dingwall 1978, Bond et al 1985, West and Slater 1996, Williams 2000). GPs are reported to view themselves as leaders of the primary health care team (Hudson 2002), the decision maker who delegates work to *their* nurses without the interference of nurse managers (Flynn et al 1996). The community nurses desire a more collaborative team working relationship with GPs but rarely perceive themselves as in a position to influence that (Jefferies and Sachs 1983, Mayall and Foster 1989, Goodman 1998, Rowe 2002). However, there have been a number of changes in recent years that have the potential to substantially alter the relationship between GPs and nurses. Before

discussing these, there is one further element that needs consideration and that is the internal organisation of nursing in primary care. As has been pointed out earlier, relationships between doctors and nurses are structured and experienced hierarchically. The next section considers the internal organisation of nurses as a subordinate group before moving on to review late twentieth century shifts in the relationship between medicine and nursing.

4.8. Internal Hierarchy in a Subordinate Occupation

Nursing as an occupation has always had a stratified internal organisation. So the reality has been that doctors have passed on their instructions to senior nurses who relayed them to more junior nurses. Nursing in primary care has had flatter structures than the hospital setting. However, the growing acceptance of the economies to be made through introducing fewer specialist primary care nurses and more registered nurses and nursing assistants has created more hierarchical nursing teams in primary care (NHS Management Executive/Value for Money Unit 1992, Audit Commission 1999a).

Nurses managing nurses has been one strategy for resisting medicine. National attempts to develop nursing management have always been met with a powerful negative response from medicine as evidenced by responses to the Salmon Report (Ministry of Health 1966) documented by Clark (1995) and the Cumberledge Report (Department of Health 1986a), recorded by Ottewill and Wall (1991). More recently general practitioners have demonstrated their ability to resist nurse management: firstly, through their direct employment of practice nurses without nursing management and secondly, during the creation of the internal market. The exponential rise of the direct employment of clinical nurses by GPs was first noted in the early nineties (Atkin and Lunt 1995) and has continued to increase ever since (Drennan et al 2004). The implementation of GP fund holding created an opportunity for GPs to question the value of paying for nursing management overheads. In many areas this led to a drastic reduction in nurse management posts and the introduction of what was described as self-

managing nursing teams (Morgan 1996, Owen 1998, Goodman 2000). That the clinical nurses did not resist these changes (see for example Bull 1998) indicates the level of ambivalence felt towards nurse managers.

The strategy of nurses managing nurses is not one that all within nursing subscribes to. There is certainly evidence of suspicion, critique and resistance to nurse managers from clinical nurses (see for example, Bellaby and Oribar 1980, Hennessy 1986, Forbes 1996). These provide examples supporting the proposition that the subordinate group members treat those assimilating to the dominant culture with suspicion. Interestingly, in all of these the dominant culture being resisted is that of the bureaucrats not medicine. Rosemary White argued from her historical analysis that nurse managers assimilated to the culture of the managers and detached themselves from the culture of the two types of clinical nurses (White 1985). Traynor (1999) undertook interviews with nurse managers and community nurses in three geographical areas during this period. He provided further empirical evidence that the nurse managers assimilated to a dominant group but not that of medicine but of the managers. The clinical nurses asserted that they had a greater moral authority based on their clinical skills than the nurse managers. They actively criticised the language and values of the nurse managers, seeing them as representatives of the business managers. In this Traynor provided evidence that tension between clinical nurses and nurse managers might not be the result of oppressed group behaviours but another example of conflict between professional and bureaucrat.

The internal culture of nursing is often characterised as military like, with a command and control attitude to the lower ranks, a socialisation process that emphasises an unquestioning attitude, and a punitive response to actions outside of the commands. Like much that is written about nursing the emphasis on its homogeneity belies the heterogeneity. The experience of being a nurse can be as characterised as above (see for example Salvage 1985). It may account in part for the growth of unionisation in some sectors of nursing (see for example, Lewis 1976). Nurses in the UK, unlike medicine, have a strong history of trade

unionism. The relationship between clinical nurses and nurse managers, when viewed through this history, is of the division of interest between employee and employer rather than members of the same occupational group (see for example Hart 1994). Even the Royal College of Nursing, which never affiliated to the Trade Union Council unlike other professional organisations such as the Health Visitors Association (Health Visitors Association 1996), has clinical nurse '*stewards*' to represent their members points of view to managers and at a local level (Royal College of Nursing 2003). The level of unionisation could be seen both as a continued response to a repressive culture or as evidence of a large number of nurses who are not repressed.

Analysts have argued that the negative image of nurse managers as incompetent and punitive has been a reflection of the gendered attitudes to women as managers (Carpenter 1977, Halford 1997). The two major reviews of nursing administration structures in the nineteen sixties; the Salmon Report (Ministry of Health 1966) in the hospitals and the Mayston Report in the community (Department of Health and Social Security et al 1969), heavily critiqued the matron led nursing administration of the time and emphasised the need for modern management and a linear, hierarchical structure. The implementation of these reports created a short lived nursing hierarchy to match that of the NHS administrators. These reports and others since about nursing in the UK have argued for a greater availability of management skills education for ward sisters and nurse managers, with seeming disregard to the scale of that already available. The first specific management skills courses for ward sisters were established in the 1940's (Lathlean 1988) and initiatives since the late eighties have increased the availability of management education to nurse managers (Bryant 1990, NHS Management Executive 1992, Woolnough et al 2002). So while there is a repeated characterisation of nurse managers as punitive and lacking in management skills, the history of the management education programmes available to them would suggest this is a stereotype used for devaluation. There are many published descriptions of nurse managers who have created positive clinical environments to work in and opportunities for shared decision making

with staff (see for example Field 1984, Smith 1992, Savage 1995, Geoghegan 1995).

Roberts (1983) argued that nursing, as a subordinated group expressed horizontal violence within the group rather than to the dominant group. Feminists have proposed a "Queen Bee" syndrome in nursing; this argues that the most senior nurse becomes preoccupied with the maintenance of her own position, rather than the concerns of the worker bees, and actively minimizes any threat to her status by other bees (Halsey 1978). It is has not been possible to find UK empirical evidence that explicitly addresses the active minimisation of threat from other nurses by the "Queen Bee". However, there is certainly substantial evidence of denigration to more junior nurse members and bullying of nurses by their managers (Pearce 2001) that could support both Robert's theories of oppressed group behaviour and theories of a Queen Bee syndrome. However, nursing is not alone in this as evidenced by recent studies demonstrating that the widespread presence of bullying of doctors in training and as a pervasive management style throughout the NHS (Quine 1999, Quine 2002).

Finally, it is necessary to briefly consider any evidence of suspicion or hostility towards nurses who assimilate to medicine as the dominant group, rather than management. One group who have experienced this, were the nurses educated at degree level at the time before nursing education moved into Higher Education. At this point only medicine enjoyed a university level education. The hostility from many other nurses was well documented (Ring 2002). The shifts in work roles that will be described in the next section between doctors and nurses and the creation of nurse practitioner roles has certainly provoked debates that these nurses are becoming physicians assistants rather than nurses (Castledine 1995). However, it is not clear that there has been real hostility or suspicion in the face of an inexorable central policy driven movement (Department of Health 1999c).

Having considered the empirical evidence of nursing's response to an occupational subordinated position, this chapter will finish by considering the

potential changes in the occupational relationships at the end of the twentieth century.

4.9. Changes in the Relationship between Medicine and Nursing in Health Care

The end of the twentieth century provided new opportunities for nursing to assert its occupational powers and challenge medicine. The economic pressures, increasing patient demand and medical workforce problems facing the National Health Service prompted politicians and NHS managers to promote the use of nurses in roles previously only ascribed to medicine. In the hospital sector, the need to reduce junior doctor hours precipitated major changes in the technical activities nurses were expected to undertake (Greenhalgh and Co 1994, Department of Health 1999c). These changes have been accompanied by the national development of a new senior clinical nursing post known as the nurse consultant. The nurse consultant post has three strands of work, 50% clinical care and the rest research and teaching (Department of Health 1999d). It offers a career route for a nurse that does not involve management responsibilities for other nurses. A national evaluation has commenced but it is too soon to comment on the impact on the relationship between medicine and nursing (Guest et al 2001).

In primary health care specifically there have been some significant shifts in roles undertaken by medicine and nursing in the past fifteen years. Key differential roles between the occupations have been the medical roles of diagnosis, requests for diagnostic procedures by other occupations and the prescription of medicines (both prescription only medicines and medicines financially subsidised by the NHS). The last fifteen years have seen shifts in which nurses have started to be legitimised in undertaking these roles. The development of nurse practitioners is one example (Touche Ross 1994,) where nurses are expected to act autonomously in making clinical assessments, ordering investigations, diagnosing complaints and initiating treatment. In primary care

some GPs, faced with escalating workloads and problems in recruiting doctors, also supported the development of nurse practitioners in their practices (Koperski et al. 1997). In less than twenty years, the resistance to nurses working in general practice identified by Bowling's study (Bowling 1981) changed to an acceptance of the place of nurses (Royal College of General Practice 1996). The lone experience of Barbara Stilwell as a nurse practitioner in general practice (Stilwell 1987) has slowly developed into more widespread development of such posts (Chambers 1998). Another key medical role that has been extended to nurses is the legal right to prescribe prescription only medicines. As a policy issue it first found voice in the Cumberledge Report (Department of Health and Social Security 1986a). However, it took over ten years before the legislation and accompanying Department of Health policies allowed some nurses to prescribe treatment from a formulary that included prescription only medicines without recourse to a doctors instruction (Jones and Gough 1997).

The NHS policies of the labour government has encouraged and expanded the provision of nurse only primary care services. The development of minor injuries clinics, staffed only by nurses, began in the early nineties but accelerated with the funding of NHS Walk In Centres, which are direct access primary health care for those unable to register with GPs, and NHS Direct, a direct access telephone health help line staffed by nurses (Department of Health 1997). Personal medical services (PMS) have been experiments under the Health Act 1997 Act to provide medical services in different ways (The Personal Medical Services National Evaluation Team 2000). This has provided the opportunity for salaried GPs to be employed by Trusts to offer general medical services in under doctored areas. It has also created situations of a significant change in the relationship between nurses and doctors. There are examples where nurses have become full financial partners in general practice for the first time (Department of Health 1997c, Wright 2004). There are also a handful of the PMS pilots led by nurses who employ GPs to provide sessional clinics (Baranaik 1999). All of these changes have occurred against a backdrop of significant changes in the

demography of general practitioners. By the beginning of the twenty first century women GPs were in the majority (Department of Health 2003).

This chapter has outlined the complex power relationships between the two occupational groups that were offered a joint leadership role in the PCGs. It has tried to demonstrate that the stereotypes built on ideal types within in hospital setting belie the plurality of relationships derived from the heterogeneity of health care setting and health care function and the multiple occupational histories. The very different history of relationships in primary care from the acute institutional setting set a very different backdrop against which to examine empirically these relationships in the context of Primary Care Groups.

Chapter 5: The Study Methods

5.1. Introduction

This chapter describes the methods used in this study. The initial part of the chapter considers the research approach and the study design before reporting the data collection and analytical methods. This section concludes with a critique of the method. The chapter concludes with a description of the sample PCGs and informants.

5.2. The Research Approach

This enquiry was concerned with contemporary social interactions and relationships in the implementation of a state policy innovation. The research approach drew on ideas of critical realism (Robson 1993). Robson drew on the work of Roy Bhaskar (1986) and Rom Harre (1986) to synthesise his ideas. Critical realism integrates both subjectivist and objectivist approaches to social theory. The former emphasises that human action is meaningful and intentional, and denies the existence of an external reality beyond the individual interpretation. Objectivist approaches, emphasises the external reality of society, tending to deny the causal role of agency by the actors. Critical realism argues that social structure is at the same time the product, and also the medium, of motivated human action. Therefore social reality incorporates individual, group, institutional and societal levels. Knowledge is seen as "a social and historical product that can be specific to a particular time, culture or situation" (Robson 2002 p34). The explanations are constructed in terms of how mechanisms, in specific structural contexts, produce events or experiences. The research task is, therefore, to obtain evidence about the existence of hypothesised mechanisms.

5.2.1 The Theoretical Context

This study drew on theories from sociological and political science concerned with authority, leadership and the nature of power to inform its design and

analytical framework, as discussed in chapter 3. Weberian theory on the sources of authority for leadership suggested the potential for conflict between professionals and managers (Parsons 1949). Alford (1975) proposed a further refinement on this situation of potential conflict, through the use of political theory on interest groups in public policy decision making. He discriminated between dominant, challenging and repressed interest groups in health care decision making. He argued that the "professional monopolists" dominated the decision-making against the challenges of the "corporate rationalisers" and that the voice and interests of the community was repressed.

Critiques of both Weberian based conflict theory and political theory in the seventies and eighties argued that other factors such as social class and gender needed to be incorporated in order to more completely understand the dynamics of power in society (see, for example, Mitchell 1971). This challenge was particular relevant in the present study as it has been argued that the relationship between doctors and nurses is strongly influenced by the gendered nature of their occupations (Davies 1995). However, the British primary health care has a more female medical workforce profile and occupational boundaries unlike other parts of the health care system (see chapter 4) that have the potential to alter some of the power dynamics.

Previous studies of local NHS governing bodies have indicated variation in the role and authority of different member groups (see chapter 2). A number of studies reported that the medical membership has held a greater level of influence than other member groups, while some studies have indicated that both the medical members and the lead manager have been perceived as influential. One description of the 40 GP commissioning pilots for Primary Care Groups commented that the nurse members were viewed as less influential than medical or managerial members (Regen et al 1999).

The propositions informing the investigation are therefore derived from theories of authority and power, the structured nature of occupational relationships and the findings from empirical studies concerned with local decision-making bodies. The propositions were that:

- The doctors and nurses would not equally hold leadership roles. The dominant structural interests expressed in the Board activity would be medical and specific to the general practitioners
- There would be conflict between the professionals and the managers as to the role of professional leadership in the activity of the PCG. This conflict would be experienced differently for GPs and nurses
- The increasing numbers of women GPs would mean that gendered experiences of Board membership would be less clearly associated with occupational groups
- The nurses would have a differential experience of leadership according to a) their position in the hierarchy of the community health services or general practice, and b) their clinical relationship to general practitioners

5.3. The Study Design

Study design has been categorised into two types: fixed and flexible (Robson 2002). In fixed designs the five study components of purpose, theory, research questions, methods and sampling strategy are immutably specified before commencement, for example in a randomised control trial. Flexible designs allow for an iterative process between the five components so that the detailed framework emerges during the study (Maxwell 1996). The flexible design framework, informed by critical realism, acknowledges multiple realities, through a focus on participants' views (Cresswell 1998). It also presents data analysis at multiple levels of abstraction, moving from the individual to the group level but retaining the concept that it is theory that it is central to explaining reality (Robson 2002).

The flexible study design used in this investigation was multiple case studies. Case study design " is a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence " (Robson 1993 p 52). Case study design is appropriate when the context is important to the phenomena under investigation (Clyde Mitchell 1983). A single case study design was considered

and rejected because this is argued to be most appropriate when the phenomena have never been explored before, or a critical case can be identified for testing a well formulated theory (Stake 1994). Neither of these criteria applied to the present study. Yin (1994) argued that a multiple case study design was appropriate where the researcher sought both replication of evidence to support theoretical predictions and theoretically predicted contrasting evidence (Yin 1994). A multiple case study design was therefore appropriate, as some theoretical predictions detailed above had been generated from previous empirical studies.

Primary Care Groups are the real life context within which the roles of the general practitioner and primary care nurse board members are enacted. Miles and Huberman (1994) have pointed out that the phenomenon under study, i.e. the case, always occurs in a specified social and physical setting and cannot be separated. They argue that the term case study site would be preferable. The case or phenomena under investigation is this study was the designation of a leadership role for these clinical professionals. The case study site was chosen as the primary unit for devising the sampling frame in order to ensure contextual diversity in which to search for replication of observations and explore the theoretical predictions. The sampling frame therefore included contexts that demonstrated diversity in:

- Levels of socio-economic indicators of population deprivation, as a proxy for differing types of demand on health services
- PCG level (as defined in government policy) as an indicator of different levels of PCG Board responsibility within the local health economy
- Previous levels of GP fund holding and multi-funds, as a surrogate indicator for different levels of expert knowledge and experience in commissioning services amongst the GP community
- Method of recruiting nurse members to include a) eligibility criteria excluding nurse managers and b) voting by peers and selection by senior manager interview

A total of eight case study sites were decided upon as this number would cover the requirements of the design and be feasible within the financial resources of

the project. The sample had to be within two NHS Regions for resource reasons. These merged to form one NHS Region during the period of the study.

5.3.1 Designing the Data Collection Methods

In choosing the data collection methods, consideration was given to the elements that would contribute to the validity and reliability of the enquiry. There has been much debate about whether these are appropriate terms to use in assessing qualitative research (see for example Lincoln and Guba 1985). Robson (1993) suggested that using the term "trustworthiness "in assessing an enquiry more accurately reflected the approach of qualitative research. However Robson (2002) like others has since shifted his view, swayed by the argument that to dismiss validity and reliability completely only supports the view that such research is therefore invalid and unreliable (Morse 1999). Robson (2002) argues that these terms have been operationalised in the natural sciences in a rigid way to support the ultimate test of validity through replication of findings by an independent researcher. Investigators of social life have to operationalise these terms in appropriate ways to the phenomena under scrutiny, rather than with the expectation of being able to re-create the events for the purposes of replication.

Lincoln and Guba (1985) discuss possible threats to the validity of qualitative research under three broad headings of reactivity, respondent bias and researcher bias. Reactivity refers to the impact the actual presence of the researcher may have on the social milieu under study, in particular people's behaviour. Respondent bias refers to the spectrum of responses people may have to being research objects. At one end of this spectrum people may purposively provide inaccurate or incomplete information, at the other end people may try to provide the data they believe the researcher is seeking. Researcher bias refers to the assumptions or preconceptions a researcher may bring to the study. These may shape decisions in the study design, behaviour in data collection and interpretation in analysing the data.

Many commentators offer sets of strategies to address these threats (see for example Miles and Huberman 1994, Maxwell 1996, Silverman 2000). The most

common strategies include the maintenance of a research audit trail, prolonged involvement in the research situation, triangulation and member checking (Robson 2002). These will be discussed in turn. Contemporaneous records for each element of the study provide a research audit trail. Contemporaneous records, including a research diary, of all research activities were kept through out this study and drawn upon in the written report.

It has been argued that prolonged involvement in a research situation will reduce the level of reactivity to the researcher and reduce respondent bias as acceptance and trust is developed, although researchers may find it difficult to maintain an independent observer stance over a prolonged period (Silverman 2000). The extent to which this strategy is used depends significantly on a) the research approach, for example prolonged involvement is a defining characteristic of ethnography, and b) the resources available to the researcher. In this instance, the multiple case study design and limited resources, precluded prolonged involvement.

Triangulation is the strategy that is most widely advocated to address threats to validity from reactivity, respondent and researcher bias (Robson 2002). It suggests that validity of evidence can be enhanced if the same evidence is identified from different view points, hence the use of multiple perspectives, data collection methods or researchers. Denzin (1988) has identified four types of triangulation:

- Theory triangulation: the use of multiple theories or perspectives in a study
- Methodological triangulation: using quantitative and qualitative approaches to gather data in a study
- Data triangulation: multiple methods of data collection in a study
- Observer triangulation: the use of more than one researcher to gather and analyse data

The multiple theoretical perspectives and methodological perspective, informing the study, have been discussed above. The resources within the study limited

the use of additional researchers. Multiple methods of data collection were feasible and are integral to a case study methodology (Yin 1994). However, the nature of critical realism is that it accepts that there may be more than one perception of events and experiences. In studies concerning power relationships, the accounts and sources may provide disputed and contradictory data rather than validation. Bloor (1997) has provided an empirically based critique of the concept of triangulation as a form of demonstrating validity. He points out that logically one method will be superior to the others for answering the research question. It is therefore illogical to refute the evidence from that method if it is not corroborated by evidence from inferior methods. He has argued that data collected by different methods differ in their form and specificity so that direct comparison is problematic. He concludes that "methodological pluralism allows new light to be shed on topics and allows different facets of problems to be explored, so the mix of different methods has an interactive impact. However, this mix of methods does not allow validity tests on findings." (Bloor 1997 p 41).

Member checking is term used whereby research subjects views are sought on the veracity of the research data they provided or the research analysis. Robson (2002) warned of some of the pitfalls in these techniques such as research subjects seeking to subsequently change or suppress material. Bloor (1997) argued that member checking is a social interaction, fraught with all the problems and biases of the original data collection. It was therefore decided to check for veracity of data collection and interpretation of individual experience within each interview. This ensured that the process was contemporaneous with the data collection and not affected by subsequent changes in the context. It also placed no further time demands on informants who, by virtue of their occupation and roles, had significant competing calls on their time.

With these points in mind, the following data collection methods were initially considered and piloted in order to provide multiple sources of evidence for each study area:

- Semi-structured interviews with multiple key informants in each study area,

- Observation of primary care group board meetings,
- Collection of documents produced by the Primary Care Group Board,
- Collection of documents related to the context of each Primary Care Group,

Final decisions on the detail of the methods were deferred until the feasibility was explored in the field.

5.3.2 Identifying the Case Study Sites

A database of the 66 PCGs in two NHS Regions was constructed using a computer software package (SPSS) to assist in identifying the sample. Information was obtained regarding:

- PCG levels, (NHS Executive 1999),
- Deprivation indicators for the relevant Health Authorities (Bardsley et al 1998),
- Information on the nurse member recruitment processes (Fletcher 1999)
- Information on previous levels of GP fund holding and multi-funds.

This last category of information was more difficult to obtain systematically. Information was gathered verbally from an NHS regional officer who was asked to identify areas with exceptionally high or low proportions of GP practices working in this way.

The PCGs participating in other national evaluation studies were noted and then excluded, as it was felt they were would be unreceptive to further approaches for study. Details of these PCGs were obtained through contacting the evaluation team (Malbon 1999). A list was generated from the database for each cell of the sampling frame. Only their database identification number identified each PCG. Identification numbers were picked at random for each cell to determine the PCGs to be approached.

5.3.3 Negotiating Access

The informants within the case study sites were all members of elite groups, either as board members, senior executives in the NHS or professionals. Some of the informants would be members of more than one elite group. Research into elite groups is acknowledged to be very difficult because an elite group, by its nature, establishes barriers that set its members apart from the rest of society (Moyser & Wagstaffe 1987, Hertz and Imber 1995).

The recruitment of potential subjects in each PCG began by writing to the chairperson. The chairperson was elected from the clinical membership and was expected to be a GP. The letter explained the purpose of the study, the methods to be used (face-to-face interviews), the commitment to ensuring confidentiality and anonymity, and outlined the research experience of the investigator and supervisors. The letter was sent first to eight PCG chairpersons and then subsequently a further eight. Initial responses to this recruitment letter were very negative and attempts to follow it up were frustrating and unsuccessful. Work overload was the main reason cited for refusal to participate. No PCG chairpersons were recruited at this point.

Consequently, the approach for negotiating access was reconsidered. Social researchers reflecting on success in gaining access to people from elite groups have emphasised the value of their personal contacts and personal introductions from one elite member to another (Arthur 1987, Deem 1994, Ostrander 1995, Hunter 1995). While the researcher had working relationships with PCG members in one part of London, the sampling framework would have been undermined by this approach. Hunter (1995) notes that academic researchers may need to call on the "prestige of their academic status, their cultural capital, to achieve greater symmetry in the power relationship" between elites and researchers. The recruitment letter was redrafted in a way that called on that prestige. The letter placed the study more visibly under the auspices of the medical school, sited in a Russell group university, with the confirming signature of a Professor of General Practice (see appendix 2). It emphasised that what was sought was individual recruitment to the study, not recruitment of the Board as a

whole. The chief executive and the chairperson were now approached concurrently, in order to improve the chances of a positive response. Potential subjects were also given the option for the interviews to be conducted by telephone.

The new recruitment letter was sent out to the chief executive and chairperson of a further eight randomly selected group of PCGs and received immediate positive responses. In all of this sample either the chairperson or chief executive agreed to participate. It is impossible to determine whether this was the result of the call on the medical school prestige, the inclusion of the chief executives in the first approach or the additional time since the PCGs had been launched.

Once the chairperson or the chief executive had agreed to participate, recruitment of other participants commenced. The data collection design employed a methodology from political science and organisational development known as stakeholder analysis. This openly acknowledges that there may be varied perceptions of a phenomenon by different interest groups, who also hold diverse levels of power and influence. Groups with an interest (i.e. a stake) in the phenomenon under study were identified and from this the key informant sampling template devised for each case study site:

1. Within the Board: a nurse member, a GP member, a lay member and the chief executive member
2. Outside the Board: the health authority chief executive, the community trust chief executive, a primary care nurse linked to the Board nurse through a local nurse Forum, and a GP member of the Local Medical Committee.

PCG Board members' names and membership categories were available on the English PCG Database (NHS Executive 1999). Identification of the chief executives and lay members from the database was straight forward as there was only one person in that category. The first name listed for the nurse membership was selected unless information from the PCG administrative base indicated this person was not available at present through illness, or other reasons. GP members were approached when the Chairperson declined to participate or never

responded. Initially, GPs whose names were listed first on the national database were approached. However, it became clear that GPs selected in this way were extremely difficult to recruit and this method was reviewed. It was decided to approach those GPs who had a designated role that was identifiable on the database. This role was the lead for clinical governance. As a last resort when these GPs either declined or failed to respond in the PCG, the personal assistant to the chief executive and/or the chairperson was asked to identify a GP they thought was the most likely to agree to participate. The personal assistant's view was sought on the basis that they knew the Board members but would not have a view on their role in the Board.

Outside the Board, senior manager informants' contact details were obtained from national publications (Institute of Health Service Management 1999, 2000) and later from the NHS Regional office web pages (NHS Executive London Regional Office 2000). The clinical professionals outside the Board were more problematic to identify and recruit. The Board nurse member identified primary care nurses who were members of local nurse forums. In one area, this type of forum or network did not exist and the nurse board member tried to identify a local colleague who might be willing to be interviewed, but they all declined. A number of areas only had ad hoc forums and the membership fluctuated. In three instances, the nurse Board members passed on recruitment letters that resulted in a non-response. In five areas, they asked two or three members whether they would be willing to participate and then having gained consent passed these details on.

Recruiting Local Medical Committee (LMC) members was extremely problematic. Two approaches were taken. In one area individuals, whose membership and contact details were available in the public domain on the World Wide Web, were contacted directly. In the other areas the secretary of the LMC provided contact details of Committee members who held named positions. These were approached first by letter, and then by telephone. All of those approached declined to be involved.

5.4. Ethical Practice

The key principles in the ethical practice of social science research (Social Research Association 1999) were utilised in the study design. The first principle is linked to the integrity of the research protocol, ensuring it is worthwhile and the techniques appropriate and feasible. The second principle is concerned with entering moral relationships with the research participants. The research protocol was developed over a number of months. During this period, elements such as the value of the question and the feasibility of subject recruitment were tested with academics and NHS personnel. Each element was considered in supervisory sessions that included two supervisors. The protocol was peer reviewed (including ethical review) and approved within the North Central London Research Consortium. It fulfilled the research governance requirements in the NHS and was registered on the national NHS research database. It also received ethical review within the academic department where the M.Phil./PhD. was registered.

The invitation to participate letter (Appendix 2), developed as part of the research protocol, detailed the purpose of the research, the methods to be used, the procedures, the anticipated use of the study findings, the identity of the investigator and supervisors, and the degree of anonymity and confidentiality. Agreement to the interview was considered as consent. The aide memoire for the interview repeated the information in the letter as well as seeking explicit consent for recording of the interview. Mechanisms, such as the use of identification codes, were established for ensuring that confidentiality was maintained in the storing and analysing of the data. All data collected have been stored in locked filing cabinets.

5.5. The Data Collection

The following section describes the data collection processes undertaken in relation to the interviews, first of all, then in relation to the observation of Board meetings and finally, the PCG documents.

5.5.1 Semi-Structured Interviews

The enquiry was underpinned by an assumption that reality is not objectively separate from the experience and interpretation of people. In this, the enquiry adopts a broadly interpretative perspective, agreeing that; " reality is socially constructed and interpreted through the actors, and is based on the definitions people attach to it" (Sarantakos 1998p 36). Consequently, the interview method was chosen in order to access to those interpretations, beliefs and attitudes. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable and able to be made explicit." (Patton 1990 p 278). Commentators warn of the limitations of interviews through interviewee lack of knowledge, recall error, personal bias or reaction to the interviewer. Interviewing methodologies range from the highly structured to the very informal based on non-directive techniques. Pawson and Tilley (1977) argue that in theory driven research the questioning should be channelled in a way that allows these theories to be responded to. The interviews in this study were therefore semi-structured, allowing flexibility in pursuing issues raised during the responses but ensuring that particular enquiries were responded to.

Researchers have noted that elites, by their very nature, are used to being in control. Consequently retaining control of interviews to cover the issues of interest to the researcher can be problematic (Moyser & Wagstaffe 1987, Hirsch 1995). Ostrander (1995) offered a number of tactics to deal with this problem. These included having a visible, type-written schedule of questions to refer back to when the respondent has shifted the focus, and taking notes rather than audio-tape recording so that not taking notes visibly alerts the respondent to the fact that they are not saying anything of interest to the researcher. She also addressed the issue of asking threatening questions of elites and offered three strategies. The first is to learn the language of the elite enough to be able to proffer the question in terms that are more acceptable. The second is to acknowledge that this is a situation outside of normal social etiquette. The last is to offer the elite the opportunity "to respond directly to criticisms that others may have made about their actions" (Ostrander 1995 p147).

To support the interviewer an aide memoire was prepared for interviewing each sub-group of the key informants (see appendix 3). The aide memoire had three purposes: be a visible reminder for the interviewer and the interviewed of the process of the interview, to offer prompts to key themes and potentially threatening questions, and to ensure specific information for the study area database was collected. The potentially threatening questions on power relationships between the different interest groups were couched in terms of asking for responses to the headlines from the nursing and medical press, as well as responses to the descriptive phrase in the policy documents of "doctors and nurses in the driving seat". Three pilot face-to-face interviews were undertaken with a GP Board member, a Nurse Board member and a Director of a Community Trust from outside the sample PCGs. The question areas were tested and the wording subsequently refined. The pilot interview with the GP Board member was the shortest. The GP had clearly allocated less time than originally agreed, as he was called to another meeting in the practice.

Researchers have emphasised the importance of being knowledgeable about the issues or milieu that the elite group is operating in (Heclo and Wildavsky 1984, Moyser and Wagstaffe 1987, Strong and Robinson 1988, Ball 1994, Hirsch 1995). Hunter describes the balancing act this requires,

> " *To show that one lacks knowledge is of course, the raison d'etre for doing the research in the first place and is often the basis for convincing informants that they should take the time to inform you of what they know. However to be too ignorant of the setting and current affairs may convince elites that you are too unconcerned or uninterested to have done your homework for them to waste their time with you*" (Hunter 1995 p164).

It is also clear that some researchers have gained access to elite groups by virtue of their expert knowledge of the policy issues (Klein 1983, Kogan 1994).

Preparation for undertaking the interviews therefore included intensive and continued reading of the current Department of Health publications, the medical, nursing and management press as well as daily newspapers and relevant parts of

Hansard. It also included informal discussions with GPs and nurses participating in the establishment of PCGs, local to the researcher's academic base. In addition, the researcher attended conferences and seminars organized at a national and regional level on developing PCGs. These included:

- A series of five seminars on primary care group management and public health issues hosted by the Kings Fund, London 1999/2000,
- Four seminars given by GP PCG Board members and policy analysts in the Department of General Practice in the Royal Free and University College London Medical School and the Public Policy Unit of University College London 2000
- North London NHSE Regional Office sponsored conference for nurse Board members in April 2000
- A Community Practitioner and Health Visitor Association (CPHVA) networking event for nurse Board members held in London, in May 2000 and a seminar held by nurse board members at a national CPHAVA conference in Bournemouth in October 2000.

At a local level the researcher attended PCG networking events that were open to all primary care practitioners in the area of her academic base. These were held five times between Summer 2000 and Spring 2002.

5.5.2 Interviewing by Telephone

The original intention was to have all interviews as face-to-face encounters. The pilot interviews were face to face although the GP Board member initially suggested a telephone interview. Following the initial negative responses to the requests to join the study, an interview over the telephone was offered.

The use of the telephone in conducting interviews has gained increasing support from the research community as well as health and social care providers in the last decade. Market research surveys by telephone are well established, particularly in countries where there is widespread access to low cost telephone. There are many examples of the telephone interview being used successfully in

different types of academic research studies. These include: epidemiological studies (Siemaitycki 1979), patient surveys on use and attitudes to health care services (Thompson and Nussbaum 2000, Cockburn J et al 1992), qualitative studies of health professionals views (Ziebland et al 1998), and qualitative studies of peoples' experiences of ill-health (Bedell 2000).

The advantages of this method have mostly been described in terms of the cost effectiveness in comparison to face to face interviewing and the efficiency it provides in improving response rates. Frey (1989) suggests that telephone interviewing also eliminates the non-verbal effects of the interviewer that may encourage particular types of responses. Conversely, one particularly disadvantage has been identified in that all the non-verbal cues that happen in face to face encounters are missed. From their work replicating telephone interviews with older adults by face-to-face interviews Herzog and Rodgers (1988) suggest that, while there may be less extensive responses to open ended questions via a telephone interview, as interviewers become more experienced in using the method such effects are lessened. The increased use of telephone technology in clinical interactions has produced a number of studies that have compared favourably the reliability of information given by patients over the telephone with that obtained face to face on sensitive issues (Rohde et al 1997).

5.5.3 Timing of Interview Requests

It became apparent that the timing of the request was an important factor in gaining agreement for interviews. This timing was not just in terms of the intensity of potential informant's work life and the cyclical nature of the work surges of the PCG (see Table 1) but also in terms of individuals' readiness to share their perceptions with others. It appeared that people became more responsive to the interview request, the longer the PCGs existed. In addition, some individuals who were leaving their roles associated with the PCG were more willing to share their views than when they were still in those roles. These could be described as "exit " interviews. Other researchers have noted the value of elite informants who have recently left office (Ham 1981, Heclo and Widalsky 1984). Kogan (1971) and Raab (1984) set out to only interview senior civil

servants who had retired or moved on in their careers in recognition of the difficulty of gaining access to elite policy makers.

Table 1: Time line of key policy events concerned with PCGs

Date	Event and Policy Document	Details
1997		
April	The NHS (Primary Care Act) 1997	Introduction of flexibility in primary medical services (PMS) and salaried GPs
May	Labour government voted into power	
May	Changing the Internal Market (Department of Health 1997b)	GP fund holding suspended
June	GP commissioning group NHS executive (Department of Health 1997a)	GPs commissioning group pilots initiative launched
December	The New NHS, Modern and Dependable: Cm 3807 (Department of Health 1997)	White Paper Proposal for Primary Care Groups and Trusts
1998		
February	Better Health and Better Health Care (Department of Health 1998f)	Health Authorities instructed to develop partnerships to agree the local configurations of Primary Care Groups by July 1998
February	Our Healthier Nation (Department of Health 1998g)	Public health white paper
March	NHS Direct Launched	Three pilot 24 hour advice lines were staffed by nurse
March	Guidance Notes for GP Commissioning Groups (Department of Health 1998h)	Pilot GP commissioning groups due to go live on April 1998 instructed to take account of guidance for PCGs
April	Establishing Primary Care Groups (Department of Health 1998b)	Guidance on the arrangements necessary for PCGs to become operational from April 1999
April	A First Class Service: Quality in the New NHS Department of Health. (1998e)	Detailed framework for clinical governance activities across the NHS
May	BMA publicly demands majority control over PCG Boards	Anon. Health Service Journal 14th May 1998 page 7
August	The New NHS Modern and Dependable: Developing Primary Care Groups (Department of Health 1998c)	This detailed the membership of the PCG Board and the timetable for establishing the primary care boards by 31st October 1998.
September	The new NHS Modern and Dependable Primary Care Group Remuneration (Department of Health 1998d)	Initial guidance on Primary Care Group's governing arrangements and remuneration for non-executive Board members
October		Shadow PCGs commenced (population ranged from 43,000 to 277,000)
September	Modernising Health and Social Services; National Priorities Guidance 1999 00 & 2001 02 (Department of Health 1998i)	The first joint national priorities guidance for health and social services. It specifies that the first health improvement plans and draft service and financial frameworks must be in place by April 1999.
	Personal Medical Service Pilots Second Wave. (Department of Health 1998j),	Applications invited for second wave PMS pilots

Date	Event and Policy Document	Details
October	Health Improvement programme: Planning for better health and better health care (Department of Health 1998k)	Detailed guidance for developing health improvement programmes to be agreed by April 1999, also states that first draft of service and financial frameworks for the NHS between NHS trust, and primary care groups should be drafted by mid-January 1999.
December	The New NHS Modern and Dependable, Primary Care Groups Delivering the agenda (Department of Health 1998)	Detailed Guidance on how PCGs should manage their financial and operational responsibilities, particular related to financial risk management, prescribing management issues, financial incentive schemes and financial monitoring. The primary care group boards should have identified primary care group chairpersons and begun to recruit staff. Services departments before going live in April 1999.
December	Governing Arrangements for Primary Care Groups (Department of Health 1998a)	Specified the governing arrangements and authority of the PCG Boards
1999		
January	The Health Bill published	
February	Second Wave PMS Pilots announced	
February	Corporate Governance (Department of Health. 1999e).	Governing principles of Primary Care Groups announced
	Primary Care Trusts: Application Process. (Department of Health. 1999f)	Detailed discrete phases leading to PCT s becoming operational 1 4 2000.
February	House of Commons Select Committee on Health Second Report: Primary Care Groups (House of Commons Select Committee on Health 1999)	This reviewed the early stages of the establishment of PCGs and highlighted potential obstacles to their long-term success.
April		481 PCGs go "live "
September	Primary Care Trusts (Department of Health. 1999,1999i)	These HSCs set out guidance on the consultation Health Authorities had to undertake on proposals to establish Primary Care Trust then detailed information on the constitutions.
December	Modernising Health and Social Services: National Priorities Guidance 2000 01, 2002 03 (Department of Health 1999g)	Targets for NHS and social care agencies to address on public health, improving acute sector waiting times, modernising primary care, implementing mental health services framework, improving services to older people, improving services to children, addressing quality issues, staff employment and the introduction of information technology strategy.
December	Primary Care Groups: taking the next steps (Department of Health. 1999h)	Guidance for PCGs on moving to PCTs status

Date	Event and Policy Document	Details
2000		
April	Press announcement (Department of Health 2000)	17 (out of 481 PCGs) first wave PCTs go live (average population 135,000)
	The NHS Plan: a Plan for Investment a Plan for Reform. (Department of Health. 2000 a)	White Paper on Health Service Reform
October		23 second wave of PCTs launched (Peckham and Exworthy 2003)
2001		
April	Shifting the Balance of Power: Securing Delivery (Department of Health 2001)	124 further PCTs formed (leaving 237 PCGs)
September	Shifting the Balance of Power: Creating Strategic Health Authorities (Department of Health 2001c)	Planned reconfiguration of 95 Health Authorities into 28 Strategic Health Authorities from April 2004
	Care Trusts (Department of Health 2001d)	Guidance on the establishment of Health and Social Care Trusts
2002		
April		All but one PCG became a PCT (Peckham and Exworthy 2003)
	Delivering the NHS Plan (Department of Health. 2002a).	Third White Paper on NHS Reforms. Abolition of Regional Offices of NHS Executive and creation of Health and Social Care Directorates
2003		
April	All PCGs now PCTs	
	Abolition of Health and Social Care Directorates	

The first attempts at recruiting informants were made between October 1999 and January 2000: all those approached during this period refused. The first acceptance was received in March 2000. Interviews were conducted from then until the last one in February 2002. The last two interviews were with chief executives of PCGs who had just moved to new posts. In total, forty-one interviews were undertaken. Fifteen were conducted by telephone and twenty-six were face to face.

During each interview, the veracity in data and interpretation was checked at a number of points:

> *Interviewer: The issues that you picked out that were problematic were; first of all the unreal timescales for implementation and secondly, the lack of understanding on the part of general practitioners about human resource management such as equal opportunities. Is that right?*

Informant: Yes, Yes. (Informant 31 text unit 90 –91)

All interviews were recorded and transcribed in order to minimise inaccuracies from interviewer recall. The tapes were subsequently deleted. Each transcript had an identification number only. In the two interviews where the recording equipment failed the interviewer made bullet point notes in the interview but immediately after leaving the interviewer used a dictaphone to recount the interview in as much detail as possible and then transcribed this tape.

5.5.4.Observation of Primary Care Group Board Meetings

Observation of Board meetings was initially considered as a data collection method to support triangulation of data collected through the interviews. Observation is a direct technique for gathering data with the potential to offer behavioural and linguistic evidence in answering research questions. Methods of observation that can be used range from total immersion in the field as a participant observer through to structured detached observation using coding schemes to quantify behaviours (Silverman 2000). Commentators tend to point to two main limitations of the method in general. The first being the "Hawthorne Effect" that is people changing their behaviours in response to being chosen and observed (Nason and Golding 1998). The second limitation is that the methods are time consuming and resource intensive. With this in mind, a decision was made to pilot non-participant observation of the Board meetings of the Primary Care Groups. All the Primary Care Group Boards had at least bi-monthly public meetings. They usually also had a meeting in the intervening period which was not open to the public. Initial approaches to chairpersons and chief executives to discuss the feasibility of observing the non-public meetings were met with negative responses. They considered these meetings as important "private" spaces for the members to initially learn to work together and deal with sensitive issues.

Four public meetings of different Boards were observed to consider what data could be collected through observation and what value it might add to the study.

In all four, the Board members were clearly very aware of the public as an audience. They were arranged at horseshoe shaped tables, at one end of a room, so that they could face the public who were sitting in rows of chairs at the open end of the horseshoe. Proceedings were conducted along formal lines with very little discussion. The main speaker was the chairperson, who announced items and then the chief executive followed by reporting progress in that item or announcing a decision or recommendation made by a sub-group of the Board. Members of the Board would also report to the Board on sub-group activity such as on clinical governance. Occasionally, other members would ask for clarity on a particular item, but clearly most of the debate or discussion between members had already happened elsewhere. Reflecting on this experience, it appeared that these meetings were a "performance", almost a ceremonial occasion, with prescribed roles and behaviours by members in front of an audience. It appeared that observation of public Board meetings would add little to the information that was recorded in the minutes of the Board. It was considered that the investment of significant amounts of time in observing these public meetings would not yield commensurate levels of data. It was therefore decided not to pursue this line of data collection. The interviews with Board members later in the study revealed that most of the Boards had mechanisms for discussing potentially difficult issues prior to the public meeting. This supported the decision not to pursue this method of data collection.

5.5.5 Collection of Data in Documents

"*For case studies the most important use of documents is to corroborate and augment evidence from other sources*" (Yin, 1994 p 81). Yin (1994) appears to advocate a trawling approach to the collection of documents, although May (1997) has pointed out that the use of documents in social research is one of the least explained techniques in the literature on social science methodology. Internal documents produced by a public body such as a PCG may or may not be available to the public in the UK. The minutes of the Boards were to be publicly available documents (Department of Health 1998c). The PCG Board minutes were viewed as an important source of evidence. The minutes of the different Boards in the study took slightly different formats, however, they were all

subject to the Board members contemporaneously agreeing them as an accurate record of the proceedings. Ham (1981) noted that in his study of the Leeds Regional Health Board one member refused to participate in interviews, arguing that the minutes reported all that could be said about the Board activity and relationships. Ham reported that no major issues or different relationships were revealed through the interviews that were not recorded in the Board minutes. For each PCG, the public minutes of Board meetings over twelve calendar months were collected. Although these were public documents, the administrators in two of the PCGs were very unwilling to share these documents but eventually did. They had clearly never been required to circulate Board minutes beyond the Board members and the Health Authority. Six PCGs supplied electronic versions of the minutes: one of these had posted all minutes on their web site. Two of the PCGs supplied minutes in paper format only.

Documentary evidence to assist in contextual description for each study area was collected as available on field visits, both from individuals and from sources such as public libraries and Health Authorities. Types of documents collected in this way included: annual reports for Health Authorities, Trusts, Public Health, health improvement plans, Local Authority strategic plan and Trust and PCG newsletters. These documents were indexed on the word processing function of the computer. The variety in availability, format, and content between the different Health Authority Areas and PCGs made these very difficult to utilise in a systematic way. The Health Authority Reports provided the most consistent information on population and finance between the PCGs. Some PCG newsletters provided detailed information about the activities of the PCGs, others provided very brief information of Board activities together with profiles of services or individuals in the PCG area. Two PCGs did not produce newsletters. However, the material had value in developing the researcher's local knowledge to assist in the interviews and as it helped identify key characteristics of the population and local health economy.

5.6. Data Analysis Methods

A template approach was taken to the analysis of interview and document data (Crabtree and Miller 1992). The initial key codes were derived from the theoretical propositions and used to provide the template for the first level analysis (Ritchie and Spencer 1994). This did not preclude the addition of new coding if the data suggested issues or themes other than the a priori template, but served to help focus the coding effort. Robson (2002) warns that researchers tend to ignore information that conflicts with hypotheses already held and emphasise information that confirms them. The search for the negative case is one strategy for supporting the validity in analysis (Lincoln and Guba 1985). The coding template (Appendix 4) therefore specifically included the converse of the theoretical propositions. The computer software package N5 was used to assist in the coding and retrieval of material from the semi-structured interviews. The use of the software meant that the data could be interrogated repeatedly and systematically through the multiple theoretical propositions.

The Board minutes were analysed for both the process and the content. It should be noted that the different styles of reporting minutes in the PCGs made some aspects of the analysis problematic, for example, some PCG minutes did not always report individual contributions whereas others reported individual contributions in great detail. Sections of the coding template used for the semi structured interviews, together with additional descriptive process categories, formed a second coding template (Table 2). The minutes of the PCG Boards were analysed against the template and additional categories were added when new themes emerged. This analysis was conducted on paper as not all the minutes had been received in electronic format. An example of a summary analysis through the template is given for one PCG in Appendix 5.

Table 2: The coding template for the documentary analysis

Element	Key aspects
Presentation and detail of the minutes	Whether speakers were identified Whether reports on particular items were summarised or appended
Attendance patterns	Categorisation by membership group and presence of representatives from other organisations. Frequency of individual attendance
Agenda	Set pattern or changing pattern. Frequency and pattern of item appearance Frequency of public exclusion for confidential business
Decision making	Frequency of reported decision making, Method of decision making e.g. formal voting
Non public decision making meetings	Reference to, frequency of, purpose of other types of meetings of Board members
Conflict of interests	Reference to and resolution of conflicts of interest
Sub Committees	Number and purpose Frequency of reporting at the Board
Finance and Commissioning	Type and frequency of issues
PCG specific new service developments or initiatives	Type and frequency of issues raised
Table 2 continued.	
Element	Key aspects
Clinical governance	Types of activity reported, reporting of success, problems and issues to be addressed
Health Improvement Plan	Type of activity and reporting of success , problems and issues to be addressed
Relationships with other health and social care organisations	Type of organisations, frequency of discussion of interaction, positive or negative relationship reported
Clinical Board member involvement	Involvement of clinical members in agenda items by professional group, by agenda item and frequency of reporting
Community and lay member involvement	Reported involvement of lay members and other representatives of the community

5.7. Critique of methods

The methods used in this study had a number of weaknesses. These included: the limited recruitment of informants outside the Board particularly GPs, the limited recruitment of nurse members at different levels in their organisation, the differential level of the data obtained through the use of interviews by telephone, and the multiple case study design within limited research resources.

Recruitment of intended informants from the different groupings in all case study sites was not fully achieved. Two chief executives, a GP, three nurses outside the Board and all 8 GPs outside the Board were not recruited as intended. However, analysis of the interviews from Board member informants revealed that the last interviews, across the groupings, were not adding new issues although they were adding some new illustrations. The last interviews with chief executives were undertaken at a point where either the PCG was about to change to a PCT or the person had just left the PCG. These interviews provided in depth, detailed data, which would probably not have been the case if these individuals had been interviewed earlier. The depth of these interviews ensured that 'saturation' (Robson 2002) was reached in fewer interviews than if a larger number had been conducted at an earlier time point. The study demonstrated the problems of timing data collection in an environment where public policy is in constant evolution.

The limited recruitment of professional informants outside of the Board, especially GPs, was a weakness. On reflection, the proposed mechanisms to identify individual clinical informants were based on several optimistic assumptions. These assumptions were : that there was a pool of clinicians in the PCG, who were interested and knowledge about the Board and board member activities, that these clinicians would be easily identifiable through their participation in other organised activities, and that it would be possible to locate individuals who would see enough value in the research to offer their time to participate. All of these assumptions were flawed and needed to be tested more fully before the informant template was finalised. In retrospect, different approaches should also have been tried. One approach could have been through attendance at local PCG sector meetings for professional members in order to identify clinicians interested and knowledge about the Board activities. Another might have been to describe the research in terms of interest in a specific Board activity, such clinical governance, through which clinical leadership would be explored. This might have made the research appear more relevant to clinicians and increased recruitment.

The limited recruitment of nurse members at different levels in their employing organisation was a problem in then trying to address the proposition which suggested those in managerial positions would have a different experience of leadership on the Board. In retrospect, the sample size of the nurse members was too small to gain enough informants with characteristics that covered all the dimensions of interest. However, even if the sample had been increased and managerial nurse members sought this might have proved problematic because nationally only 7% of nurse members were also managers (Cook 2000).

Some interviews by telephone were very difficult to conduct and may not have produced the same level of detailed response as a face-to-face interview. Robson (2002) has suggested that the absence of non-verbal clues in telephone interviews curtails the ability of the interviewer to interpret the responses. Non-verbal information was not collected as part of the data of interviews, however, the researcher was conscious of having to listen extremely carefully to the tone of the voice in order to identify nuances such as irony that would have been accompanied by physical clues. The telephone explicitly places distance between people in communication. The inability to receive non-verbal information as signals to the areas that animated the interviewee meant it was often difficult to identify the issues that needed to be explored. For some telephone interviewees who offered detailed, reflective answers without prompting, this was not an issue. However, some interviewees responded briefly and without embellishment. It was difficult to develop a greater rapport with these interviewees so that they would become more discursive, in the absence of eye contact and non-verbal communication. This was a weakness in some data collection episodes. In retrospect, a more detailed prompt sheet, with supplementary questions to explicitly deal with short, factual answers may have assisted with this problem.

The use of a multiple case study design by a single researcher meant that resource limitations were significant considerations in the decisions about data collection methods. The method provided data from individuals, from stakeholder groups and from the publicly agreed decision making and activity, but there was no data collection from the many and varied informal events and

interactions in which Board members participated in decision-making. In order to have captured more of this type of data, a different design would have been required in which the researcher became immersed in PCG Board activity over a period of months or years, as a non-participant or participant observer. This type of design has significant resource implications. Within the resource limits of this study it would have meant studying only one PCG, however, to have used data from only one PCG would have weakened the evidence to support generalisability at a theoretical level. In retrospect, a design that included a period of immersion in more than one PCG could have strengthened the study. Additional funding might have been sought more vigorously, although at the time it was difficult to see where to apply as both the Department of Health and the Kings Fund had committed funds to a national evaluation.

5.8. The Sample PCG Boards

This section describes the PCGs and their Boards involved in this study. An individual description of each of the eight Boards and their membership is not given as to do so would make the individuals identifiable. For the purposes of this study, the PCGs are grouped in order to demonstrate the spectrum of populations served and the PCGs internal characteristics. Each Board had to address the same central policy directives outlined in Table 1 (section 5.5.3).

5.8.1 The PCG Populations

Members participated in the research from eight Boards, which were purposively chosen to ensure diversity across a range of geographical, demographic and organisational characteristics.

The eight PCGs were spread across Greater London, both north and south of the Thames (Table 3). They were in four of the fourteen Health Authorities present in London in 1999, although this changed in 2001 with some mergers of organisations. All the Health Authorities were dissolved in March 2002. Two PCGs were coterminous with Community Health Service Trusts. Six were one of a number of PCGs within the geographical provision of Community Health

Service Trusts. Two PCGs were coterminous with the boundaries of Local Authority: the others were one of several within a Local Authority.

Geographical Location	North of the Thames	South of the Thames
	4 PCGs	4 PCGs
Geographical relationship with Community Health Service Trust	Coterminus boundaries with a single Community Health Services Trust	One of several PCGs in the boundaries of a Community Health Services Trust
	2 PCGs	6 PCGs
Geographical relationship with Local Authorities	Coterminus boundaries with a single Local Authority	One of several PCGs in the boundaries of a Local Authority
	2 PCGs	6 PCGs

Table 3: The geographical range of the PCGs in the study

The Eight PCGs served varying sized populations. They were chosen to ensure diversity in socio-economic factors. Four served populations of under 100,000, two between 100,000 and 149,000 and two over 150, 000 (Table 4). This range reflected the national picture (Bojke et al 2001). Three PCGs were within inner London. Two of these had populations characterised by very high levels of deprivation with Under Privileged Area Scores (Bardsley & Flately 1998) of over 50. The Under Privileged Area (UPA) score is a composite of census variables selected to indicate need for primary care (Jarman 1983). The England and Wales value is zero, the higher the value the greater the deprivation and the need. These PCGs had standardised mortality rates and morbidity rates well above the national averages.

Three PCGs were in outer London and had UPA scores of between 15 and 30. Two of these had populations characterised by significant ethnic diversity. The remaining two PCGs were on the outskirts of London, bordering on farmland. These PCGs had populations characterised by affluence and were commuter suburbs for Central London and the City. The UPA scores for these areas were less than minus 5. These PCGs had correspondingly very low rates of mortality and morbidity compared to national averages.

Characteristic	Range		
Population range	<100,000	100,001-149,00	150,000
	4 PCGs	2 PCGs	2 PCGs
Type of urban setting	Outer London suburbs bordering on farmland	Outer London,	Inner London
	2 PCGs	4 PCGs	2 PCGs
UPA Score (England value =0)	< -5	15-30	>50
	2 PCGs	*4 PCGs*	*2 PCGs*

Table 4: The range of urban and population characteristics of the PCGs in the study

5.8.2 PCGs and Commissioning

The eight PCGs were in areas where there were different levels of previous involvement of GPs in commissioning and fundholding (Table 5). Six PCGs had between 40 and 60 GPs working in their area. The remaining two PCGs had between 60 and 80 GPs in their area. Four were in areas where over 75% of the GP practices had been fundholding or were part of larger multi-funds (i.e. where groups of small practices commissioned services together) prior to the establishment of the PCGs. Two of the PCGs were in areas where 50% per cent of the GP practices had been fundholding. The remaining two PCGs were in areas where 15% per cent or less of the GP practices were fundholders. This range reflects the diversity of GP involvement in commissioning prior to the introduction of the PCGs (Mays and Dixon 1996).

Characteristic	Range		
Number of General practitioners within the PCG	40-60	60-80	
	6 PCGs	2 PCGs	
Percentage of practices that were previously fund holding or multi-funds	>75%	About 50%	< 15 %
	4 PCGs	2 PCGs	2 PCGs

Table 5: GP presence and prior involvement in fund holding or multi-funds.

All eight of the PCGs were established at level two, i.e. to have responsibilities for some aspects of commissioning health, on 1st April 1999. Levels of PCGs are described in detail in chapter 2 section 5 Half of them had dissolved by April

2001 to become part of a new PCT. The remainder dissolved in April 2002 to form new PCTs.

5.8.3 Establishing the PCGs and their Boards

Two PCG Boards had been operating in a shadow form earlier than the date set in the national guidance as a direct result of prior GP commissioning groups. Two PCG Boards were established in shadow form slightly later than the central government required date. Four PCG Boards did not have chief executives appointed and in post by April 1999. Three chief executives took up post between two and eight months after the April 1999 start date. Four PCG Boards had established, identifiable office premises for their administrative staff by April 1999. The other four took anything up to six months to establish premises. The number of administrative staff to the PCGs changed over their life span. In the first twelve months, the sample PCGs had administrative support that ranged two to twenty staff member.

Two PCG Boards did not recruit their full complement of non–executive members until after the official date of going "live" in April 1999. In all of the Boards the professional non-executive members were appointed before the lay member and the social service representative. The GP members in all Boards were elected through Local Medical Committee conducted elections. Six of the PCGs experienced changes in the GP Board membership in the first two years.

In each Health Authority and for some individual PCGs, there were prior agreed eligibility criteria for nurse membership places. All stated that the nurse member had to be involved in clinical practice but the interpretation of that phrase varied in different areas. In two PCGs, nurse managers were specifically excluded from seeking Board places. In two other PCGs, one nurse place was specifically reserved for nurse managers. In two PCGs, one place was reserved for practice nurses and the other for nurses employed by the Community Trust. In four PCGs, the nurse members nominated themselves and were directly elected by their peers. In the other four, a panel of Health Authority and Community Trust managers interviewed applicants to determine which nurses were suitable

candidates. The selected nurses then went forward to election by their peers. There is no available information to indicate whether this reflects the national diversity in processes. Two of the PCGs saw changes in the nurse membership in the first two years. .

Each of the sample PCGs had a non-executive membership composed of seven GP members, two nurse members (in one PCG a job share resulted in an additional nurse), a lay member, a social services representative and a Health Authority non-executive. All the chairpersons were GPs, as was the case in the majority of PCGs across the country (Peckham and Exworthy 2003). Seven of these were male and one female. Five of the eight PCGs had female chief executives. A count of chair persons and chief executives in the 60 London PCGs in 2000, named on a Department of Health website (NHS Executive 1999) revealed that 74% of chair persons were male while 52% of chief executives were female.

5.8.4 The PCG Agenda

The activities of all the PCGs in the first two years were characterised by attention to a very detailed agenda set by central Government (Table 1, section 5.5.3). This focused on strategic and operational planning for financial governance, clinical governance, health improvement and the devolution of responsibility for commissioning community and acute sector health services. The guidance gave prescriptive annual tasks, for example, developing a Primary Care Investment Plan (PCIP) that included establishing requirements for GMS infrastructure support, financial incentive schemes for general practices for meeting targets, setting and managing indicative practice prescribing budgets, and establishing a prescribing incentive scheme for all general practices, (Department of Health HSC 1998). Family health service expenditure accounts for 24% of the annual NHS expenditure (£36,500 million): within that 50% is spent on pharmaceutical services and 32% on general medical services (Department of Health 1998l). By 2000 detailed guidance was produced by central government on establishing PCTs (Table 1 section 5.5.3). In 2001, the minutes of the PCGs in the study demonstrated the attendance of the PCGs to the

central government directives. The most frequently minuted items were, in descending order:

- Finance
- The under spending of the General Medical Services budget
- The over spending of the prescribing budget
- The projected or actual overspending in the acute sector commissioning
- The development of the PCTs
- The establishment or changes in other local organisations e.g. Health Authority mergers, establishment of Health and Local Authority Partnership Boards

Clinical governance was not a regular minuted item for all the Boards. While some Boards had a regular agenda item on clinical governance, others did not. References to the Health Improvement Plans were rarely minuted. It was noticeable that the inner city PCGs frequently discussed the problems of closed GP lists and the associated difficulties in recruitment and retention of GPs and nurses.

5.9. The Sample of Informants

The study design sought eight types of informant for each PCG (section 5.3.3). The Health Authority and Community Trust manager interviewees could provide information linked to two PCGs. Consequently for the eight PCGs studied 56 informants were sought. In the event 41 informants were recruited and interviewed (Table 6). The difficulty and consequences of recruiting the anticipated sample iare discussed in section 5.3.3 and in the critique of the methodology section 5.7. Informants were recruited for all eight PCGs. Six types of informant were recruited for seven PCGs and seven types for one PCG (table 7).

The breakdown between informant groups shows that 73% of informants were female (Table 6), although the greater number of male GP and Health Authority senior manager informants reflects the higher numbers in these occupational

groups in the NHS (Department of Health, 2003). A similar number of interviews were conducted face to face as over the telephone (Table 6). The PCG nurse members were the groups most likely to agree to face-to-face interviews.

	Number interviewed	Sex		Interview Method	
Type of Informant		Male	Female	Telephone	Face to face
PCG chief executives	6	2	4	5	1
PCG GP members	7	5	2	5	2
PCG nurse members	8	0	8	1	7
PCG lay members	7	2	5	3	4
Health Authority Chief Executives or Directors	4	3	1	3	1
Community Trust Chief Executives or Directors	4	1	3	4	0
Clinical nurses involved in a reference group to the nurse members	5	1	4	1	4
Local Medical Committee members	0	0	0	0	0
Total	41	15	26	22	19

Table 6: The sample of informants by type, gender and interview method

	PCG							
	1	2	3	4	5	6	7	8
Board members interviewed	4	3	4	4	3	3	4	4
Others interviewed	3	3	2	2	3	3	2	2
Total informants recruited per PCG out of a possible 8 types of informant	7	6	6	6	6	6	6	6

Table 7: Number of Informants for each PCG.

There was a marked contrast between the lengths of time that GP and lay informants had spent working or living in a PCG area compared to that of the managers (Table 8). General practitioners financially invest in their practice or

practice partnership, including premises (Peckham and Exworthy 2003) and consequently demonstrate significant occupational stability.

	Number interviewed	Number of years in the area		
Type of Informant		Under 5	6-10	Over 10
PCG Chief Executives	6	6		
Health Authority Chief Executives or Directors	4	3	1	
Community Trust Chief Executives or Directors	4	1	3	
Clinical nurses involved in a reference group to the nurse members	5		3	2
PCG nurse members	8	2		6
PCG lay members	7			7
PCG GP members	7			7

Table 8: Length of time informants had worked or lived in the area

Three of the seven lay members had occupational backgrounds in public sector management. Two of these in addition had experience of Board membership of local health organisations of over 15 years. The division in occupational background between the different groups of managers was also marked (Table 9). Most of the PCG chief executives had only worked in health service management concerned with general practice. The other managers had only worked in the hospital and community health services element of the NHS. None of the PCG chief executives had health professional backgrounds, while a number of the managers in the Health Authority and Trusts had nursing or medical backgrounds. Data on this issue were not found in any other studies or nationally.

Occupational Background of Managers			
	NHS HCHS* Management (with and without experience outside the health service)	Health professional then NHS HSCS management	NHS GMS** management (with and without experience outside the health service)
PCG Chief Executives	1		6
Health Authority Chief Executives or Directors	2	2	
Community Trust Chief Executives or Directors	1	3	

Table 9: Occupational backgrounds of the manager informants

*Hospital and Community Health Services ** General Medical Services

The nurses also had varied occupational backgrounds. Four were health visitors; one of these was also a part-time lecturer. One was a district nurse who was also a nurse practitioner and had been a school nurse in the past. One was a practice nurse. Two were specialist nurses and nurse practitioners, both currently managing the establishment of new nurse-led services in primary care. Their occupational variety reflected the unpublished information supplied by Health Authorities to the Department of Health (Cook 2000). At the time they put themselves forward to be Board nurses none of them had been involved in commissioning services. One was a professional organisation local steward representing members in local negotiations with managers.

All the GPs in the sample had previously been directly involved in commissioning services either as lead fundholding partners in their practices, leading members of multi-funds or part of GP commissioning groups in Health Authorities. Only one had no previous involvement in the Local Medical Committee.

Having established both the methodology and the detailed information on the sample, the next chapters will discuss the findings of research.

Chapter 6: Clinical Board Members Roles in the Early Phase of the PCGs

6.1. Introduction

This chapter considers the roles of the GP and nurse members in the early stages of the PCG. It explores first of all their motivation before reflecting on their perception of the key influences on their activities in this period. It concludes with an exploration of how the context of the PCG affected the types of roles within the Board.

6.2. Motivation and Expectations: the GPs

All the GP members, without exception, stated that their prime motivation was to continue their involvement in commissioning health services. They had all previously been involved either in fundholding, multi-funds or GP commissioning groups:

> *"I think it was probably because of my experience in fund holding and being involved in setting up ** Fund-holding Forum, a group of fund holders who worked together. In* [name of area] *we've got quite a lot of small practices who were fund holders with relatively little clout and we learnt to work together. Then we could change things. When PCGs came along, that group led locally to then set up the PCG".* PCG GP member 19, text units 4-19

None of them expressed any self-doubts about putting themselves forward to undertake this role. Some cited their previous experiences as part of the rationale:

> "*And the next question is "why did I think I could do that?* [be a board member]*", because I was lead partner for fund holding and I'd had experience on the LMC.*" PCG GP member 21, text units 19 –22.

Four of the GP members had been very instrumental in the actual formation of the PCG and its Board:

> *"When the fund holding finished I had some time left, which I used to spare for fund holding. And I as an ordinary ground level GP, I wrote a letter to all the* [area] *GPs that I would be interested to know how many would like to share with me the views of the new PCG. And it started from there. I organised one meeting. I had about 4 or 5 doctors came out of 60 and then everybody wanted the following meeting, following meeting and by the time I reached my 5th and final meeting about 80 people".* PCG GP member 26, text unit 6

The GP members were clear not only that they wanted to continue their involvement in commissioning but also that they wanted to pursue the same commissioning objectives. They wanted to assert the interests of primary care and general practice against secondary care services in the commissioning process. They often described this in terms of improved health services for their patients. They emphasised that their motivation was to improve financial flows into primary care services:

> *" So I was concerned about protecting primary care, getting appropriate resources, educating managers about primary care and resisting secondary care eating all the budget."* PCG GP member 2, text units 12-14

This was confirmed by more than one PCG chief executive, who reported that the GP motivation was to act in overtly political ways to ensure a greater proportion of health service funds were directed into general practice.

All the GP members provided additional motivating factors. Mostly these were in terms of ensuring their own interests, either as general practitioners or their practice, were represented on the Board. Sometimes this was reported as a distrust of the other GPs in the area:

> *" There are several answers to that. The most important answer being because I believed that it would give me an opportunity to benefit the health care for my patients. Subsidiary answers are because I didn't like*

the quality of the other people who volunteered - that's it". PCG GP member 21, text unit 7-17

In addition, some GP members reported very personal motivation:

"I was interested in becoming a PCG member, I suppose, partly to give a bit of variety, something different to do apart from visiting patients." PCG GP member 29, text unit 4-7

The GP members therefore came to the Board with a range of motivations but mainly with a clear expectation of continuing previous commissioning activity focused on increasing finance towards primary care in general and improving the responsiveness of the secondary care sector to the needs identified in primary care.

6.3. Motivation and Expectations: the Nurses

The nurses reported a different set of motivating factors to become a PCG Board member. The primary motivation reported was to seize a rare opportunity for clinical nurses to be involved in decision-making:

" I got carried along as being one of the primary people who was saying, 'this is an opportunity, let's get in there and grasp it' ". PCG nurse member 40, text unit 32-35

The nurse members believed they could offer two things to the Board decision-making: firstly, their own clinical experience and secondly, the views of the large body of nurses that was derived from their clinical experience. They reported that their clinical experience gave them important knowledge of the health problems and patient experiences of the local population. Some of them described themselves as almost acting as proxies on behalf of the users and patients:

"And I have always felt strongly that nurses know so much about what is happening to patients in the community, but they never really ever voice what is going on. And so I stood for election and got in." PCG nurse member 4, text unit 49-51

Some of the nurse members reported that they expected to represent the interests as well as the views of sub-groups within primary care nursing:

> *" I had this naive idea that, 'isn't it great. I'll be there representing nursing views on the board'. And if there's something important for health visiting I'll be there, fighting, flying the flag, and if there's something important for district nursing, I'll go out and speak to them about it and make sure I 'm representing their views."* PCG nurse member 8, text units 77-81

Only one reported that she put herself forward with the encouragement of a more senior nurse. Two nurses reported that they had volunteered to be part of "pilot" primary care commissioning groups established in 1998 and were encouraged by that experience to continue their involvement. Four of the nurse members reported instrumental roles in organising local primary care nurses to address the implications of the national guidance of establishing PCGs.

Nearly all the nurses Board members described their decision to put themselves forward in terms of the absence of others willing to do so. Three nurses explicitly stated that they did not think they had the right qualities or abilities to undertake the role but volunteered, as there appeared to be no one else willing:

> *" No, I suppose I was fairly clear that I didn't really think that I had the right qualities, but I'm the kind of person that does their best and in the absence of any others then I was up for it."* PCG nurse member 40, text unit 38-39

In contrast to the GPs, some of the nurse members expressed a high degree of self-doubt about their capabilities. They also went through a significantly different experience in order to be appointed a Board member.

6.4. Selection processes for Board Membership

All the GP members were elected by their peer GPs through LMC conducted elections. The GP members indicated that the process of elections was a familiar part of the culture of general practice as each LMC was formed in this way.

The nurses had no single local representative body equivalent to the LMC. The situation was therefore completely novel for them. They reported a different selection process in each of the PCG areas. In some areas, the senior nurse managers in the Community Trusts and Health Authorities were reported to be very proactive in engaging clinical nurses to develop that selection process:

> "*Our Director of Nursing, she was very far sighted and she got an interest group going, because she realised that it was going to be a big culture change for nurses. So she held a meeting every couple of weeks. Very much to bring us up to speed with all the latest documents of what was going on, how are we going to implement this? What were we going to do about nurse representation? What were the implications for nursing?* " PCG nurse member 4 text unit 10- 14

This senior manager encouragement was not present in all areas. In two PCGs the nurse members reported that the managers in the Trust and Health Authority did not provide any active encouragement in organising processes for nurse membership of the Boards. In these areas, it was left to the front line clinical nurses to take the initiative and create the selection process:

> "*The difficult part at that particular time was that it was almost left to me, to organise the whole thing, left to me by the Trust. I had to go and get all the names and I had to talk to the LMC about managing the ballot and it was really quite difficult..... I think because at that point the particular Chief Executive* [of the Community Trust] *did not agree with the idea of PCGs and therefore, there wasn't really very much interest".* PCG nurse member 32, Text units 44 –52

As a result each area (variously Health Authority Areas or the PCG areas within that) developed different eligibility criteria for candidates. In the two PCGs

where the clinical nurses were left to develop the selection process only clinical nurses were eligible to stand and there was a straightforward election process. In the other areas, places were reserved for nurse manager candidates or candidates working in specific occupations such as practice nursing. In these areas, there were written statements about Board membership accompanied by core competency person specifications that the nurse had to demonstrate. The selection process included an interview held by senior managers from the Community Trust and Health Authority. In three areas the processes included an interview to assess suitability to stand for election, followed by the election by peers:

> *" It was the process of selection and election. So there were certain criteria that we had to fulfil initially and an interview. If there were more than one person for each area then you'd be elected on. And we had two for each PCG. We decided to have one from Community and one from somewhere else."* PCG nurse member 33, Text unit 28-30

The processes of the elections were varied. The LMC, the Health Authority or the Electoral Reform Society conducted the nurse member election.

The experience of selection for many of the nurses was markedly different from the GP Board members' experience. The GPs engaged in a familiar peer determined and conducted process. The majority of the nurses Board members had experienced a more bureaucratically controlled process in which health service managers played significant roles.

6.5. The Early Experience of Board Participation: the GPs

All the GPs Board members reported that the establishment and development of the PCGs was much slower than they had anticipated. Most of them described a sense of frustration at the slow pace the bureaucratic procedures created. The senior managers in the Community Trusts working with PCGs also noted the slowness in the development of the PCGs:

> *"I suppose how much of what I'm going to say* [about working with the PCGs] *is to do with my individual disposition and the way I drive things*

and how much it is to do with the under-resourcing of the PCG, I don't know. The one reflection I would make is that things grind very slowly."
Community Trust Director of Operations 5, text unit 20-25

The PCGs certainly varied in the time it took to recruit chief executives. A minority of PCGs appointed chief executives while in their shadow form, but most took up to six months to make this appointment and two nearer eighteen months. GP and lay informants in three Boards reported GP members resigning from the Board because of their frustration at the slowness of decision making and the lack of visible change.

" *One member has already resigned as a result of it. A fund holder who felt that you could do something with fund holding, then you could do it tomorrow or the day afterwards. And this* [the PCG] *is months later of unfilled promise*". PCG GP member 9, text units 105- 108

A PCG Chief Executive also described GP expectations across the PCG area of relatively quick, visible changes in finance to primary care and secondary care commissioning that he felt were unrealistic of a new organisation. Two of the Directors within Community Trusts talked about the unrealistic, as they saw it, expectations of the Board GPs that the PCG would swiftly tackle ongoing and intractable problems in primary care such as the difficulties of recruiting and retaining nurses.

The GP members had clear expectations of repeating experiences from previous commissioning activities. For some, this was tempered with scepticism about the ability of NHS bodies to be effective:

"I have to say I am cynical by nature, but it [the PCG activity] *has been no worse than I expected it..... It has been much more bureaucratic* [than fundholding], *everything has been involved in procedure. We have very little involvement in discussion of clinical issues. There has been endless waiting for authorisation from above."* PCG GP member 2, text units 17-23

Some of the GP members were more positive about the experience and reported progress in some primary care developments. However, all of them reported that their involvement in the commissioning of services, particularly acute services, was less than they had hoped for:

> *"Oh, I think it's probably been more enjoyable than I thought it would be, and I think the developments in primary care have been better than I thought they'd be. But at commissioning level I would say there has been very little development".* PCG GP member 29, text units 20-22

All the GP members agreed that the time commitment required to actively participate in Board business was much greater than they had expected. Some of them pointed out they worked much longer hours for the Board than they were financially reimbursed for. Informants from two Boards reported more GP resignations specifically because the level of time commitment required was greater than anticipated. In some Boards, particularly those with few PCG staff, the Board members appeared to take on a very operational role in comparison to those in PCGs that employed more staff. Some of the GP members, who held lead responsibilities for core activities such as clinical governance, described investing significant amounts of additional time in making these Board work streams successful.

> *"At the height of it, I've been doing 10-15 hours a week making the clinical governance work, which as you know is well beyond the remuneration".* PCG GP member 21, text units 117-8

The lay members also observed the significant time commitment the active GPs made to the PCG work, and speculated how long they could sustain that and their practice commitments:

> *"I'm worried about our GPs who are killing themselves doing a full time clinical job in their practices and are spending a horrendous amount of time, especially on clinical governance and education as it happens".* Lay PCG member 25, text units 434-436

The GP members described how they had to create time to not only attend meetings but also to undertake the other PCG supplementary activities. A lay

member observed that she often received copies of emails from GP members sent at one o'clock in the morning. All the GPs commented that the time requirement placed an added strain on their clinical practice. This was a particular issue in GP partnerships:

> *"I probably spend on average easily a day a week on PCG work and I'm not a Chair on the PCG. So if you do it properly there's an awful lot of work we need to do - meetings, daytime and evening meetings, just reading up all the stuff. It gets incredibly tiring. It's a real time pressure - I dropped one session a week from my surgery to do it, but I'm still effectively full time, I'm still doing 9 sessions, plus all that".* PCG GP member 29, text units 219-223

6.6. The Early Experience of Board Participation: the Nurses

The nurses came to the Board with expectations of the nature of their participation and the work of the Board that were vaguer than the GPs. All the nurse members described having to learn a great deal at speed in the first year, to a degree that they had not anticipated. For all of them, the level of financial and business management was new:

> *"There was a huge learning curve to begin with. I'm very au fait like with services and disciplines and practices and all the rest. But what I didn't realise until I started on the Board was how little I knew about the financing. And so there was a huge learning curve".* PCG Nurse member 17, text units 80-87

In addition, the focus of the PCG Board activity on general practice meant those nurses who had not worked in general practice had to learn about aspects of the NHS that they had not been previously aware of:

> *" To begin with it was a lot of me struggling with an area of knowledge that wasn't mine at all, very strategic, looking at issues around business plans, and budgeting. And then the focus being on the GPs, premises and, you know, their prescribing and their red book, and stuff I really didn't know anything about. So it's taken me a long time to actually feel*

that I can understand what the meetings are about and what we are discussing". PCG nurse member 8, text units 20-26

Some of the lay members, who had not previously been involved in any aspect of the health service, echoed the nurses in describing the scale of new knowledge they had to assimilate in the first year of the Board. Both they and the nurse members talked about a new language of abbreviations and acronyms they had to learn. The only nurse member who did not describe having to learn significant amounts of new knowledge had been managing a service for GPs and was currently undertaking a management role in establishing another new major out of hours service.

The nurse members, like the GPs, had not expected the time commitment required to be an active PCG member to be as much as it became:

"The hours were much more than anticipated. I have now started logging what I do and I think its at least a day and a half a week - consistently and that's not enough because I haven't been doing all the reading". PCG nurse member 15, text units 528- 535.

None of the nurse members reported that the work of the Board had been slow or frustrating in this period, unlike the doctors and some of the lay members. In contrast, most of the nurse members described the first twelve months as difficult for them. The difficulties the nurses described were not only their lack of knowledge about the issues under discussion but also actually working on the Board with GPs. The nurses in half the PCGs described how the GP members had previously been working together: either in some form of multi-fund, or GP commissioning group or an earlier version of the PCG. This meant they had established relationships with each other and did not particularly welcome additional people into that process:

"It was really hard. They [the GPs] *met more frequently and they had been for a long time. And of course, when we came into the PCG, there had already been a PCG development group with mostly doctors and so you came in at the beginning feeling that there was a whole lot of stuff*

that you had totally missed out on, that they had worked it all out between them". PCG nurse member 40, text units 195-200

The relationships between the doctor and nurse members will be explored in more detail in chapter nine. Suffice to say at this point that the nurse members recognised that they did not have the knowledge or networks that the prior commissioning groups and the LMC gave the GP members. This was not an aspect of the Board that they had anticipated.

6.7. The Early Experience of Board Participation: the Roles of Non-Executive and Executive Members

The work of most of the PCGs, following their launch, was concerned with the establishment of organisational structures and processes. The differing lengths of time this took in the PCGs was outlined in section 5.8.3. This is of note at this point because the individual PCG context directly influenced perceptions of Board membership and non-executive Board roles. The presence of a PCG chief executive early on and early agreement on devolving Health Authority resources to PCGs meant there were executive and operational personnel. Board members in these circumstances could develop strategic decision-making roles. This was not the case in all the PCGs. Two Health Authorities were reported to view the PCGs very negatively and obstruct their development:

" *This Health Authority has been especially bad in both the sense of the management allowance* [to the PCG], *which is one of the lowest in the country, and equally in terms of releasing people from the Health Authority to work out into the PCGs. That's started to change. But they were hanging on to everything they possibly could and they're still tending to do that".* PCG lay member 14, text units 391- 396

This contrasted with the relationships for PCGs in the other Health Authorities and the consequent effect on resources and infrastructure available to the Board:

"I put into operation a structure, thankfully with the support of the Director of Business and Finance in the Health Authority and therefore got the resources, very much similar to what PCTs are expected to have

now. So HR [human resources], *Finance, IT, all the usual things you have in an organisation were there from day one, at least in theory."* PCG Chief Executive 39, text units 120-122

In the Boards with little or no resources either the clinical Board members undertook executive roles, as described by some of the GP members in section 6.5, and active decision making roles or the PCG work did not progress:

"*Well, other Boards that I have been on, you felt that the Executive have really laid down the agenda and we have all listened and perhaps commented and questioned. But in fact this* [the PCG Board] *has been quite upside down, because we haven't had an Executive. It was nearly a year that we did not have anybody. But almost nothing happened till April this year in our group. It just did not get off the ground at all. It was dreadful really, just a secretary to take the minutes.* " PCG lay member 23, text units 100-102

Where the PCG Board members had taken more active roles in decision making early on, some reported a shift to a much more passive role in decision making as the chief executive role developed:

" *We, like many Boards, had a period at the beginning when we had no Chief Executive and virtually no staff. And although that was difficult, it meant that the Board had to do a lot of this itself. And I think that was very empowering. What has gone on since is, as the Chief Executive appointed all his staff, so more and more business has been pulled away from the Board. There have been several occasions when we have had the sense that they are running ahead of any decisions made by the Board.* " PCG lay member 14, text units 441 –452

The degree to which individual Board members embraced executive or non-executive roles was to some extent influenced by their expectations and prior experiences of Board level work. For some non-executives, prior experience as a member of some sort of governance committee ensured a greater understanding of the difference between executive and non-executive roles. However, it was repeatedly commented upon by the lay members, the chief

executives in the PCGs and the Health Authorities how little prior experience most of the GPs and nurses had in Boards or Committees:

> *"Most of them* [the GPs] *had no experience of corporate work at all. No experience of sitting on governance, Health Governance bodies, I suppose that's what you'd call a PCG to some extent, ... So a lot fell to me to help setting up the constitution and setting up the rules of conflict of interest and all that kind of stuff."* PCG lay member 25 text units 22-23

A few informants pointed out that some of the GP members were very experienced committee members of LMCs, institutions related to medical education, and the medical Royal Colleges. However, this did not seem to impact on the overall perception of the GP as inexperienced Board members. The GP members did not perceive themselves as inexperienced or in need of help in developing their understanding of their role. The nurse members on the other hand were not reported to be members of other types of committees. They frequently referred to educational opportunities offered to them to develop their understanding of the Board role. The Regional Health Authority or sometimes the Health Authority commissioned these development opportunities for nurses from management consultants or Universities:

> *"We* [the two Board nurses] *are also doing, the London Region, it think it was, put on a PCG Nurse development course which includes some learning sets. And we are both taking part in that and it has been very interesting, facilitated by some very high powered influential people".* PCG nurse member 3 Text units 219-222

The PCG chief executives all referred to investment in organisational development activities within the PCG aimed at the non-executive members. The activities were described in terms of both improving their knowledge about the role of a non-executive board member and also improving relationships between members of the Board. Most of the nurse and lay members referred to these activities as a positive development opportunity. In complete contrast none of the GP members refer to any of these activities at all. Others noted that

the GP members were very negative about activities for organisational development:

> "*A lot of early meetings were for bonding and something GPs are not very fond of is meetings for bonding. They will look at their watches and think my time might be better spent elsewhere.*" PCG lay member 23, text units 141-143

6.8. Differences between GPs and Nurses as Clinical Leaders in the Early Phase

Even at the early stage of the PCG there were notable differences between the GP and nurse members. GPs and nurses were given authority to hold their positions by the NHS bureaucracy but the types of authority they commanded at the local level were very different. The GPs came to the Boards not just with the authority to be in a leadership role through a democratic peer election i.e. "rational–legal" process in Weber's terms but with personal belief in their own authority to undertake the role. The nurse members ostensibly came to the leadership role with the authority of a democratic peer election, however most of them experienced a process that was controlled by more senior members of the local office of the NHS bureaucracy. Potentially this gave those who had been through 'selection' and 'election' processes, two types of rational-legal authority. Those nurses, who had only been elected, acquired only one source of authority. However, few of the nurse members had much belief in their own authority to undertake a leadership role.

The GP members came to the Boards with the strategic intentions of improving the share of finance to primary health care and improving the quality of acute services: in this they were challenging the dominant interests of the hospital sector. Alford (1975), writing in an American context, grouped all doctors within one dominant interest group, the professional monopolists. However, these primary care doctors, who were operating within a state funded health care system, presented a picture of a divided medical profession. They presented themselves as challenging the dominant group, which was formed of the hospital consultants supported by the NHS managers. The nurse members, however,

became Board members with the primary intention of having a place on the Board. They had no strategic intention beyond having their voice heard. A finding echoed in the few published personal accounts of PCG membership in other parts of England (see for example Smith 2000) and in a survey of nurse members in the first year by the national tracker study (Dowswell et al 2002). The nurse members did not articulate any goal beyond this or any aim that was shared across their occupational group. Alford (1975) ignored nurses and other groups of health care staff in his analysis of interest groups in health policy, a perspective repeated by those who have used his framework in empirical studies of Boards in the UK. The presence of the nurse Board members in itself had the potential to create a challenging interest group. However, it appeared that they were behaving much more like a repressed interest group as described by Alford (1975), anxious to take advantage of the local opportunity to influence local decision making.

The GP and nurse members joined the Boards motivated by a range of factors. This belies Ranadé's (1986) typology, which attributes only one motivating factor to each Board member. The evidence of early and frequent resignations, particularly amongst the GP members would suggest that the multiplicity of motivating factors were subject to an individual and practice cost benefit analysis in a way that Ranadé does not identify through her typology. Undoubtedly the GP members shared a strategic motivation that the nurse members did not demonstrate. Ranadé's typology predicts that members, who are identifiable by their strategic motivation, are likely to be amongst the most influential members. Using this typology it would indicate that GP members were likely to be more influential than the nurse members. However, there are structural elements that were significant in the early days and suggest that types of motivation alone is too limited a predictor. The GPs came with three structural elements of support that the nurse members did not have:

- Knowledge of the financial mechanisms in the NHS,
- Experience of local level commissioning,
- The existence of a peer network.

This chapter has examined evidence from the establishment phase of the PCGs that supports the thesis proposition (section 5.2.1) that the nurse members had a different experience of the leadership role and were less influential than the GP members. The next chapter considers the roles that the GP and nurse members undertook in more detail.

Chapter 7: GP and Nurse Members in Leadership Roles

7.1. Introduction

The policy guidance gave two specific leadership roles to clinical members of the Board. The first was that the chair should be elected from the GPs and the second, that the clinical governance agenda should have a named clinician lead. All the PCGs in this study had GP chairpersons. Nurse members shared the clinical governance lead with a GP member in six PCGs, as they did in the majority of PCGs across the country. In addition, the term 'lead role' was used with the Boards to denote leadership responsibilities for a discrete area of PCG activity. PCG Board members volunteered or were nominated to act as 'leads' for particular PCG activities or work streams, to which the Board as a group then agreed. This chapter examines the leadership roles of the GP and nurse members, concluding with an examination of the sources of authority for those roles.

7.2. The GP Members' Roles

All of the GP members reported that their roles were named positions of leadership. These were named positions on the Board e.g. chairman or vice chairman, and/or leadership roles on sub committees e.g. chair of the finance committee. Some of this was a function of the study recruitment strategy, revised after having difficulties in finding GP members willing to participate. However, the GP members described multiple lead responsibilities. All of their areas of lead responsibilities had financial implications for the PCG or a specific budget e.g. information technology development in general practices:

> *" I have got several roles on the PCG Board. I'm Vice Chair, I'm IT lead, I'm finance lead and for the moment I'm setting up a project to looking at how we set up an Ethics Committee. I also oversee the out of area treatment panel."* PCG GP member 19, text units 30- 33

The PCG Board Minutes provided additional evidence that it was only the GP members who held lead roles with responsibilities for financial issues. GP members were recorded as leading or chairing sub-groups with financial implications in all the PCGs. These sub-groups, which were responsible for issues with financial implications for the PCG, were discussed and recorded at every Board meeting of the PCGs. Those Minutes that recorded action points from agenda items always reported that it was the chief executive, a PCG manager or a GP member who would act on that item. The smaller executive groups that developed in some PCGs were reported to comprise of the chief executive and GP members only. The GP members were therefore visibly in leadership roles at every meeting.

The PCG Board Minutes recorded that GP members were participating in varied ways including raising questions, providing information, proposing ideas and actions and stating their opinions on agenda items. The GP members described their own roles in ways that indicated they were influential not just through named lead roles but through leading the direction of ideas in the Board:

> "*My role? I'll have a bash at it: as an instigator of ideas, a workhorse because of the lack of infrastructure of the PCG, an innovator. That's probably about the best of it. And I've tried to be supportive to both the Chief Executive and the Chair* ". PCG GP member 21, text units 26-29

The GPs members described success in the PCG both in terms of specific financed developments in general practice but also in terms of the influence they, as individuals, had had on particular projects or commissioning activities.

7.2.1. Non-active GP Members

Informants in each PCG supported the observation that GP members held multiple lead roles but were clear it was only a portion of them that were working like that that:

> " *We have a policy and finance group, and I'm on that one, and one of the nurses, 3 doctors and the Chief Executive. And that works really well,*

because again we've got the enthusiastic doctors who are on that group, who really do a lot of work - one of the them is a clinical governance lead, one's a professional development education training lead and so on." Lay member 25, text units 157-163

Managers, lay members and nurses described a group of GPs on each PCG Board who did not actively participate. They reported that some GP members rarely spoke at meetings, rarely participated in sub–groups and often did not attend meetings:

"Some of the GPs are so quiet and they don't always turn up. So there's possibly only really 3 or 4 very vocal, you know, dominant, that's possibly the wrong word, fairly forward GPs. The others don't get involved in a lot of stuff. They don't really speak around the table". PCG nurse member 15, text units 197 –201

Some managers, external to the PCG, reported that they worked with PCGs in which only the GP chairperson appeared to be active. The level of GP non–attendance was corroborated by the analysis of the Board minutes (Table 10). In one PCG, there were three examples of meetings that did not have a quorum through lack of GP members' attendance. The consequence was that no decisions could be taken at these Board meetings.

PCG	Maximum number of GPs recorded at a meeting	Minimum number of GPs recorded at a Board
1	5	3
2	4	3
3	4	2
4	5	2
5	4	1
6	4	0
7	5	2
8	5	3

Table 10: Attendance at Board meetings by GPs (out of 7-9 GP members) reported in PCG Board Minutes

7.3. The Nurse Members' Roles

In contrast to the GP members, none of the nurse members held the named leadership positions on the Board itself, although some were named as sole or joint lead for a particular PCG responsibility. One nurse member was the sole named lead for clinical governance, which was unusual nationally. Another was a joint lead for clinical governance. A third nurse member reported a joint lead role for the Health Improvement Programme. The other nurse members reported that they had lead responsibilities for areas that were not core PCG functions. These areas did not have significant financial implications for the PCG or budgets e.g. Caldicott guardianship. Some were participants in sub-committees that had significant financial responsibilities such as prescribing. However, the nurse members reported that they were mostly in sub groups linked to clinical governance, user involvement and education. Nurses were not reported to be part of the inner executive groups that developed in some PCGs. The sub-groups that the nurse members were involved in were infrequently recorded in the Board Minutes. Even clinical governance activities were not recorded in all Board meetings.

Most of the nurse members reported themselves confused as to what their role was as a board member, particularly in the initial period. Some of the nurse members became clearer with time and articulated a corporate role in the Board business that was of equal standing to other members:

> "*I have a special interest in nursing obviously but I am there as a full Board member without any question. With equal voting rights, with equal rights to decision making as every other Board member. And I take my full responsibility for the clinical lead, which I have got, which is the cancer lead. I take full responsibility for my input into the other sub groups and things like clinical governance and the issues around that, that are frequently not nursing related at all.*" PCG nurse member 17, text units 207-212

Even with the passage of time, other nurse members reported their role was not one of direct leadership or influence. In general, they seemed to be saying that

their role was as a conduit for other peoples' views and facilitating a wider perspective into PCG work. However, there were some nurse members who could not articulate their role or their contribution on the Board. They obviously did not view the role as one of leadership:

> *"The more I'm talking to you the more I feel as though I don't really know what the role is. I think that's quite common, it's a new job, isn't it?"* PCG nurse member 18, text units 170-171

The variety of perceptions of role was reflected in the nurse members' views of success in the PCG. Most of them described success in terms of their involvement in increasing communication between the Board and the wider PCG. Only two discussed their influence in gaining financial resources for nursing posts and practice nurse education. In two instances, informants in the same PCG attributed successful leadership activities chaired by nurse members to other people. In the first instance, a lay member attributed the success of a clinical governance programme to the driving force of two GPs, despite the fact that the nurse member was sole lead. In the second, the PCG chief executive accredited all the achievements in the developing Health Improvement Programme to her PCG project manager, despite the nurse member having described in great detail her successful strategies as co-lead member for this programme.

The Minutes provided further evidence of both the variation in roles and dissonance in accounts from different sources. The Minutes recorded that there was always at least one nurse member present at every meeting. However, the Minutes for three Boards, for the entire year, did not record any contribution from nurses. Only in one Board was one of the nurse members reported speaking at every Board meeting. Even the nurses who held named lead responsibilities for clinical governance were not reported in their Board minutes. One of the nurse provided some additional evidence of the silence of some nurse members:

> " *We have got a brilliant lay member, absolutely fantastic who's got a lot of management skills and who really knows how to speak and is*

wonderful. And I take great heart in that. She is worth four of us , who sit there and say nothing". PCG nurse member 17, text units 178 -180

The Board Minutes reported that the nurse members mainly asked questions. Unlike the GP members, they were not recorded as suggesting ideas or stating their opinion. Although the Minutes were presented in a variety of ways, all of them recorded the views or activities of named GP members at each meeting. It is not possible to judge whether the Minute writer was responding to an underlying assumption of the cultural authority of the GPs or whether this was the reality in each meeting. The impression, however ,was made that nurse members were not visibly leading or influencing anything. Even when the nurse members considered their role was to put forward the views of others, there was no recorded evidence of that activity.

7.4. Perceptions of the Leadership Roles held by Clinical Members

All informants were asked to comment on the statement in the PCG guidance that; "Doctors and nurses are in the driving seat of the PCGs". The managers and lay members were unanimous in their views that the GP members held influential leadership roles in the work of the PCG but that the nurse members did not. Table Eleven summarises these views overall but each informant group added some qualifications. These are discussed below, first, in relation to the GP members and then the nurse members.

		Summarised Views on Whether "Doctors and Nurses were in the driving seat"					
H A	PCG s	PCG Chief executives	Board GPs	Board Nurses	Lay members	HA Managers	Trust Managers
1	1 & 2	Doctors - yes but qualified as a shared role with managers	Doctors- yes but qualified in that the central government agenda is driving PCGs	Doctors –yes	Doctors -No, because the financial issues drive the PCG	Doctors –Yes	Doctors-Yes but qualified that it was on clinical improvements
		Nurses No	Nurses Not mentioned	Nurses - Yes	Nurses - No	Nurses No	Nurses No
2	3 & 4	Doctors yes but qualified as a shared role with managers	Doctors- yes but qualified by the lack of resource to implement the decisions	Doctors Yes	Doctors- Yes	Doctors-Yes	Doctors-Yes
		Nurses No	Nurses Not mentioned	Nurses - Yes	Nurses - No	Nurses No	Nurses No
3	5 & 6	No data	Doctors- yes but qualified by the lack of resource to implement the decisions	Doctors- Yes but qualified by the lack of resources	Doctors – Yes but qualified by the lack of time	Doctors-Yes	Doctors-Yes
			Nurses Not mentioned	Nurses –Yes but qualified as above	Nurses – No	Nurses No	Nurses No
4	7 & 8	Doctors - yes but qualified as a shared role with managers	Doctors- yes but qualified by central government agenda is driving PCGs	Doctors-Yes but qualified by central government agenda is driving PCGs	Doctors – Yes but qualified that it was on c linical issues only	Doctors-Yes	Doctors-Yes but qualified that it was only some doctors
		Nurses No	Nurses Not mentioned	Nurses-Yes but qualified as above	Nurses - No	Nurses No	Nurses No

Table 11: Summary of responses to the question "the Government documents state that 'doctors and nurses are in the driving seat in PCGs', does this reflect your experience?

7.4.1 The GP Members as Leaders

The managers within the Health Authorities viewed the GP members as the most influential in leading the work of the PCG. Community Trust managers agreed with this view but qualified it by observing that in their experience of working with a number of PCGs some but not all GPs were influential. The PCG chief executives agreed that the GPs held leadership roles in the PCGs but qualified this in two ways. Firstly, they noted that there was a national agenda handed down that limited the opportunity for local leadership. Secondly, they argued that they, the managers, jointly held a leadership role with the doctors:

> *"The managers and the doctors drive things. The nurses don't contribute."* PCG Chief Executive 36, text units 122.

Some of the PCG chief executives argued that they were instrumental in ensuring that the GP members undertook leadership roles. They argued that their skill as chief executive was to ensure that the GPs were actively engaged in the work of the Board. Some of them seemed to imply that they worked to ensure the impression was held by the GPs that they were very influential. One chief executive described some very different methods of working in other local PCGs that illustrated the difference between the active and inactive GP members:

> *"When I talk to some of my colleagues, as Chief Executives, they see themselves as driving things. There are other PCGs even within this borough, where the GPs have very, very little input into decisions and are presented with papers that are written by the Chief Executive, or Chief executives and chairs, and basically just sort of seen through."* PCG Chief Executive 6, text units 86-100

Despite this view, the PCG managers corroborated that some GP members demonstrated leadership through ideas as well as holding named positions:

> *" I've got quite a lot of experience and have a very experienced commissioning manager but the GPs have come up with new ideas, which I don't think we would have come up with".* PCG Chief Executive 13, text units 72-75

The GP members reflected these views to some extent. Those, who were chairpersons or vice chairpersons, were unequivocal about the leadership role the GPs performed in the PCG. They particularly pointed to their role in leading the infrastructure developments to support general practice clinical activities, in clinical governance activities and commissioning services responsive to general practice clinical concerns. The other GP members however qualified the extent of their leadership role. They argued that the work of the PCG was directed by a central government agenda, pushed forward by the local managers. They contended that there was little opportunity for any local leadership role:

> *"No, we've not been in the driving seat. It's this way. Those that can read the papers pull the shots. A huge effort goes into making managers do what the central government want them to do. They can't focus on local innovation because they are running around in circles doing things that are being directed from above."* PCG GP member 2, text units 33-39

Some of the GP members observed that while they might be influential in the decision-making about the PCG activities, the reality was that their PCGs had few resources to act on those decisions, thus negating a leadership role. Most of the GP members felt there was an therefore an illusion of leadership:

> *"Yes, I suppose it is* [an experience of doctors being in the driving seat] *except the driving seat has no wheel and no pedals."* PCG GP member 9, text units 112-113

The GP members tended to respond to this area of questioning from the perspective of the GPs only, although the question was about doctors and nurses.

7.4.2. The Nurse Members as Leaders

In contrast to their views that the GP members were influential, the PCG chief executives, the managers and the lay members observed that the nurses were not influential in driving the work of the PCGs:

"I would have said that it's not very evident that nurses are in the driving seat, I think that they play generally a much lower key role, "Health Authority Chief Executive 20, text units 85-87

Informants from different backgrounds, including some GP members, observed that the nurse members tended to only be interested in PCG business concerned with their own clinical work area and professional activities. Some of the managers noted that the nurse members took little active interest in PCG issues that were outside of that.

Managers from the Community Trusts were quite critical of what they saw as a lack of any behaviour in nurse members that demonstrated leadership. A community trust manager declared that even those with joint clinical governance leads were not leading anything. Rather they were acting more like "*administrative assistants*" in data collection for the PCG chief executive or the lead GP. A different Community Trust manager provided additional evidence for the lack of contribution by the nurse members at Board meetings:

"I talk to them [the Board nurses], *and I say, ' if you're not going to speak at the meeting, why are you there? I mean, yes, they can get it from your facial expression. But you have a unique contribution to make and unless you open your mouth and the words come out, nobody's going to have the benefit of your wisdom'. And they say, 'yes, we know what you're saying, and we are trying'."* Community Trust Director 5, text units 390-397

Some of the informants reported that there was an underlying confusion about the role of the nurse Board members. They observed that the confusion resulted in nurse Board members themselves taking up very different types of roles within the Board. They also noted that GP Board members and some PCG managers believed the Community Trust employed nurses to be representatives of the Community Trust. This was thought by some managers to further aggravate the difficulties of the nurse members in finding a role within the Board:

"I think what has been a problem is that nurse representative are employed within the Community Trust. And there are occasions when

criticism about Trust services is directed at them. And that's quite inappropriate really. I think the GPs forget that the nurses are there as nurses, not the Community Trust. You just have to stop them and say "I don't think this is actually for either of our nurse members to be answering, its for the Trust". PCG Chief Executive 13, text units 176-188

Some of the managers implied the nurse members were reactive to what was presented to them, rather than proactive with a longer-term view of how primary care could be improved. However, as one Trust manager pointed out the nurse members were expected to be clinical nurses and then viewed negatively when that was the perspective they brought to the Board:

"*I think the community nurses struggle because it's not a role they've historically been used to. From operational to strategic suddenly overnight hasn't been easy for some. Some have actually lapped it up. And what some have brought* [is] *a fresh breath of inspiration by talking about, 'Well, I don't know what strategy means, but I'll tell you what my patients need'. It's a real Godsend, really, so I suppose you can't have it both ways*". Community Trust Chief Executive 12, text units 140-146

The GP members did not place themselves in juxtaposition to the nurses in answering these questions. Like the Board Minutes, they tended to not mention the nurse members. The GP members only discussed the role of the nurse members when asked directly, not when asked about the role of doctors and nurses. When the GP Board did comment on the nurse members' contribution, they were positive:

"We have two nurse members, one of whom is the lead in education and training the other's a joint clinical governance lead. They make a valuable input." PCG GP member 19, text units 144-146

When the nurse members were directly asked, "Were the doctors and nurses in the driving seat of the PCG?" they invariably responded yes. This was despite the fact that some of the nurse members had reported themselves quite confused about their role. The nurses tended to not place qualifications on these answers,

although those that did reflected the views of the GPs in that PCG i.e. that the resources were too small to act on the decisions, and that the agenda from central government was the real driver (Table 11). Most of the nurse members argued that there was no difference between their roles and that of the GPs on the Boards. However, some qualified that by noting that there were aspects of the Board business of more interest to each group with consequent different levels of activity:

> *" No, there's no difference in our* [doctors and nurses] *roles. Only in that they can argue stronger for issues that they feel are for them. Anyway, then we can argue stronger for our issues."* PCG nurse member 8, text units 233-234

The nurse members' presentation of themselves provides another example of dissonance in accounts between groups of informants about the nurses' role.

7.5. Sources of Authority for GP and Nurse Leadership Roles

The authority for the leadership role of doctors and nurses Board members came ostensibly from national policy statements. However, as has been demonstrated above, the policy statement did not translate into local reality. In order to understand the different experiences, the different sources for authority at the local level will now be examined.

7.5.1 Representation of Other Clinicians as a Source of Authority

One potential source of authority for the clinical Board members was that bestowed by their peers through a democratic election to the position as detailed in section 6.4. The non-clinical members viewed the GPs, in particular, as representatives of their peers. The GP members did not volunteer that view of themselves and in fact two categorically refuted it, arguing that was the role of the LMC:

> *" I told the Chairman* [of the LMC] *at the time, he's finished his term now, I told him 'your view is different than mine'. I told him, ' if I have any problems in the surgery or as a GP then I will give you a ring and*

ask for your help. But my PCG role is different; I have the responsibility for the community as a whole'. But it was not very well received," PCG GP member 26, text unit 68-69

None of the GP members described themselves as having a constituency of other GPs to refer to. Instead, some of them argued that it was important to have GPs on the Board with different types of experience such as a single-handed practitioner, or belonging to a minority ethnic group or practising in a particular location. The GP members' view seemed to be that the election process gave them the authority from their peers to take their place on the Board, it was not however the source of their authority while participating in Board activities.

In contrast, the nurse members discussed representation of other nurses much more frequently as a source of authority, although in contradictory terms. They all argued that they were not representing nurses on the Board but that they were providing a nursing view on issues:

> *" As far as I was concerned I was representing a nursing view relating to patient care and not representing nurses and I had to get that very clear in my mind."* PCG nurse member 32, text unit 186- 188

However, they all described actively developing infrastructures to seek the views of other nurses in order to represent them to the Board. Most of the nurse members held open meetings for the nurses working in the PCG. In two PCGs, the nurse members had also established a formal advisory group of nurses from different services to help inform their views. The practice nurse member met with a group of other practice nurses to share and discuss the Board activities. Two nurse members were clear that they only felt able to put forward views that had the authority of support from other nurses:

> *"You have to take the personal element out and you have to make sure that you are backed up by other people before you speak. You are not there for individual hobby horses which is why I quite like having a nurse forum because they bring things up and I can take those to the Board."* PCG nurse member 4, text unit 552-555

While other Board members recognised that the nurse members were actively networking with other nurses, it was viewed as a liaison activity not one that strengthened the nurses' leadership authority:

> " *They've* [the nurse] *worked within their particular remit and set up nursing liaison meetings which has been more than the GPs have done in terms of communication with their particular constituency.*" PCG GP member 21, text units 202-204

Authority bestowed by peers did not aid nurses to be seen in leadership roles and was not regarded by GPs as important. The authority derived from expert knowledge will now be considered.

7.5.2 Expert Knowledge as a Source of Authority

The expert knowledge referred to by informants fell into three types: medical knowledge, knowledge of the patient experience and knowledge of the business aspects of health care services. These will be examined in turn.

7.5.2.1. Expert Medical Knowledge

Informants disputed the extent to which the GP members derived authority from the use of expert medical knowledge. Some informants acknowledged that the GP members' knowledge and experience of providing medical care within a local health and social care system was a source of authority that no other member group had:

> *"It's an absolute eye opener to have the GPs there. To hear how unhappy the local GPs are, for example with the Mental Health services, of trying to get support for their patients and referrals for their patients. You sit there and you really do know you've got the GPs talking to you about this."* PCG lay member 23, text units 195-199.

These informants pointed to particular PCG responsibilities, such as the PCG role in managing the medicines budget, where the authority of the GP members was acknowledged as based on expert medical knowledge:

> *"Their* [the GPs] *clinical stuff on prescribing is excellent and they really take it very seriously and they look in detail at the costs and benefits of particular drugs and I'm really impressed by the way they do that. They issue guidance round all the constituent practices, it's excellent."* PCG lay member 25, text units 302-305

Some nurse members also had knowledge and expertise in prescribing medicines, which they discussed using within PCG sub-committees. No other informant discussed their contribution in this arena.

A few informants argued that some GP members drew significant authority for their leadership roles not just from their clinical knowledge but their detailed knowledge of the operational systems across all NHS health care and local authority social care:

> *" So, you know, if you're looking at the chair, the clinical governance lead GP, those two individuals and also the vice Chairman, the quality is incredible. Their knowledge of the NHS, their knowledge of the gaps in the NHS, their knowledge of how to interplay with Social Services, it's very much the expert voice".* PCG Chief Executive 6, text units 166-169

In contrast, other informants challenged the use and value of the GPs medical knowledge in the Board business. Non-clinician informants noted that the Board discussions rarely touched technical depths that needed medical knowledge and expertise:

> *" Well, they* [GPs] *have clinical expertise obviously, but the times when the level of discussion of clinical issues are such that I struggled to follow, has been almost non existent, inevitably because that 's not what you're doing."* PCG lay member 14, text units 322- 325

Non-clinicians pointed out that the GP members' expert knowledge was often based on very individualised experiences. Consequently, informants were critical of the individual patient focus of the GPs rather than the population perspective required for Board work. Their medical experience was therefore accorded less authority in these situations:

"So, if that morning they've had a bad experience - it could be anything, a referral to hospital that's taken three months - than that is the vision that they bring with them to the Board. It's not, ' one patient's wait's too long', it's 'all patient waiting lists are too long'. So it's very directly affected by immediate events, and they don't always stop and analyse the bigger picture." PCG chief executive 6, text units 49- 52

7.5.2.2. Knowledge of the Patient Experience and Health Care Needs

A further disputed aspect of expert knowledge was the authority drawn from knowledge of the patients' experiences. The GP members pointed to their everyday clinical interactions with patients as a source of their expertise. They also argued that their long term commitment and involvement with their practice population gave them an added expertise in understanding of health needs in the PCG, in a way that no other group had:

"The other thing is that we as GPs in the main have worked here for many years and know our practice populations to a different degree. So that we have seen generations of a family and understand the impact of a variety of issues for them." PCG GP member 2, text units 79-81

Some lay members and managers disputed the extent to which GP members were able to bring all the service users perspectives to the discussions:

"*They* [the GPs] *don't know about the community much. They don't work with groups. Perhaps their life has been all face to face, one to one work. And they hold very strongly to the idea that, because of that, they know what the needs of the community are. And to find out the needs in some other way seems to them less strong".* PCG lay member 34, text units 182 –186.

The nurse members disputed whether the GPs held sole authority through knowledge of the patient health needs. They argued that nurse members held knowledge of the patient experience and health needs at least equal to the GP:

> *" We are meeting patients on a daily basis and see the practical issues that need overcoming, so I think it's been helpful in the Board".* PCG nurse member 19, text units 79-80

Many of the nurse members were in fact resident and users of services in their PCG area. None of the GP members implied they were local residents to the PCG. Despite the nurses' repeated claim for the value of their knowledge, no other informants mentioned that the nurse members held any form of expert knowledge either clinical or operational.

7.5.2.3. Knowledge of the Business Aspects of Health Care Provision

The nurse members argued that the difference between themselves and the GPs was the level of knowledge about commissioning and financial business management:

> *"I haven't got that command of the money* [i.e. the financial systems] *and I have felt that a disadvantage. And they* [the GPs] *have that and they had the fund-holding background as well."* PCG nurse member 17, text units 169- 171.

However, the manager informants disputed GP assumptions of expertise and therefore authority in all business aspects of primary care. They argued that this was their area of expertise:

> *" Well, I think the issues have been to do with* [GPs as] *expert in what! Certainly in providing the services on the ground, they are experts in that in their area and certainly in some clinical issues, however, issues like premises development, they certainly are not expert. A GP may only have that experience once in a working life-time."* Health Authority Director 11, text units 59 –63

The one area of business expertise sought from the nurse members was in the employment of nurses. However, as mentioned earlier (section 7.3) this was an expertise the frontline nurse members rarely had.

The extent of the GP authority to lead in the PCG, based on expert knowledge was therefore challenged by other member groups on the Board. However, they were not challenging that the doctors were in lead roles, albeit seen as a shared lead role by some. The source of authority that the GP members had that no other group had was their membership of the medical profession and it is this aspect that will now be discussed.

7.5.3. Membership of the Medical Profession as a Source of Authority

The source of authority that set the GPs apart from other Board members was their membership of the medical profession, a membership based on expert knowledge and exclusive rights for many activities. The nature of this authority had a number of facets, not all of them easily discernible.

7.5.3.1. Cultural Authority

Cultural authority was derived from the social mores of doctors holding higher status and consequently more authority than other members. In the main, it formed an almost un- discussed backdrop to the relationships on the Board:

> *" I was the last one in and I joined them in November before we went live in the April. I've learnt a lot about medical people since then, lets say. When you are a patient, and I have been a patient of many services, you tend to look up to the doctor and things like that and you feel more on a level with the nurses*". PCG lay member 1, text units 135- 139

Informants did refer to it obliquely in describing GP members' assumption of status through behaving in arrogant ways to the other Board members, and in not letting them speak or not listening to them when they did. GPs were described as behaving in very egocentric ways that demonstrated their individual status. Examples were given from many PCGs where every GP was reported to speak on an item even though they were repeating what other GPs had just said. Other examples described GP members arriving late at meetings and then interrupting and hijacking the agenda to discuss their burning issue. However, the underlying cultural authority of doctors was hard to discern in the empirical data, perhaps

because many of the informants had long experience of working with doctors and took it for granted:

> *"I've spent many years working with GPs. So for those people coming in from the outside, I guess it would come as quite a shock to work with people who can be prima-donna-ish at times. And you can understand why it happens, you know, 'I'll make you better, so I've got this level of importance'. And you know, the patients are always very grateful and that does encourage people to behave, you know, as a prima-donna when things don't go their way."* PCG Chief Executive 6, text units 235- 249

The assumption of expert knowledge by the doctors, irrespective of the topic, as described in section 7.3.2 provides other examples of the expectation of cultural authority. Despite the fact the managers, the lay members and the nurse members disputed the claim to expert knowledge in these areas, the implication was that it was the status of the person who claimed expert knowledge that bestowed authority rather than the knowledge per se:

> *"And the nurses do have this difficulty in being able to communicate their views, over and above GPs."* PCG Chief Executive 6, text units 73

7.5.3.2. Authority with Peers

The PCGs had no direct bureaucratic authority over the GPs located within their geographical areas because the contractual relationship between GPs and the NHS was negotiated at a national level. In contrast the PCG did have the authority to directly influence acute and community Trust services and their staff through the commissioning local service and financial framework agreements (SAFFs). Nevertheless, items concerned with general practice dominated the PCG priorities and agenda (section 5.10). Most informants were clear that the GPs had a unique leadership role, which was to influence other doctors particularly other GPs. The GP members were seen to have the authority of peer status through their membership of the medical profession in general and the occupation of general practice specifically. This belief in the weight of authority through a peer relationship contrasted with the PCGs' lack of bureaucratic

authority to dictate the behaviour of GPs. The GPs themselves were aware of the value of clinician-to-clinician discussion:

> " *We are looking at stuff that is done in secondary care. So we* [the GPs] *are looking at quality issues. It's always been the Health Authority's way of doing things as a block contract. 'Here's the money do what you like with it, as long as you stay in budget, we don't really care' sort of attitude. We* [GPs on the Board] *are much more keen on, obviously keeping in budget, but actually looking at the quality issues involved in what the hospitals are doing. So we've been talking to the consultants about the real detailed clinical issues.*" PCG GP member 29, 74-81

The extent to which GPs successfully managed to influence hospital consultants during the lifetime of the PCGs was very variable. Most of the PCGs repeatedly recorded in their Board Minutes the difficulties in getting hospital consultants to address the problems expressed by GPs. This suggested that the consultants did not necessarily recognise the GPs as peers or that medical peers did not normally have this type of authority. One nurse member recounted episodes that illustrated this issue:

> "*We had quite a lot of meetings with consultants at the* [name of hospital] *which was very amusing. Because they would be invited and when they wanted something they would come along. And they'd sit there, you could see them thinking, ' I don't know what I'm doing here', because they felt so important* ". PCG nurse member 32, text units 578-583

Most of the GPs, the lay members and the managers internal and external to the Board commented repeatedly on the value of the GP members in addressing and potentially influencing their peer GPs:

> *"We've certainly seen the value in clinicians* [GPs] *talking to clinicians* [GPs]. *Talking about service development, about delivery of care, and in trying to encourage change. They're very good at being able to talk the same language".* PCG Chief Executive 6, text unit 270-272

Informants presumed that GP peer level conversations gave the issue under discussion credibility. They also categorically stated GPs would respond to peer

GPs about issues that they would refuse to discuss with managers or simply ignore:

> *"In fact the GP members have been working doing that* [promoting the use of protocols and audit on coronary heart disease to GPs] *and felt that they had to do it, because the practices will take it better from another GP than they would from management".* PCG Lay member 23, text unit 109-111

However, the extent to which the GP members saw themselves as either wanting to influence or having the authority to influence the behaviour of their peer GPs in PCG practice was disputed. One nurse member commented that her promotion of clinical governance in the local general practices was successful because the GPs in the PCG practices did not view it as unwarranted interference from other GPs. Certainly, there were a number of testimonies to the challenges faced by the GP members in trying to influence GPs in PCG practices on issues related to clinical practice:

> *" I think they* [the GP members] *got some stick from their colleagues about various things, particularly around prescribing I think.....I went to a few of their meetings with local GPs - they got some stick. The first thing the clinical governance group did was an infection control audit and they got a lot of stick about that. The issue around sterilizers and equipment costs and how to replace out dated equipment and whose going to pay for it and so on and so forth. I don't think they have a particularly easy ride with their peers."* PCG Lay member 34, text units 365- 374

Similar difficulties were reported when GP members promoted changes to the contractual relationship between GPs and the NHS:

> *" Nearly all our practices have gone on to PMS* [primary medical services] *this year. So that was actually very interesting, because there was lots of anxiety about the contract. So that was quite rocky actually for the GP members, who drove that through with their colleagues really".* Chief Executive PCG 38, text units 309-314

One PCG chief executive was very clear that the GP members in her experience actively avoided having to confront their peer GPs in PCG practices about any issues, but particularly related to poor clinical practice. She was adamant that in her experience the GP members defended the rights of general practitioners to remain independent of collective and peer influence:

> *" There were GP members, who were LMC members, who did not want to deal with the quality issues in primary care and poorly performing GPs. And that was because they had been involved in defending those same crap GPs to the end just because they were GPs and nothing else."*
> PCG Chief Executive 39, text units 57-60

No informant discussed a leadership role for nurse members in influencing nurses or general practitioners working in the PCG area.

7.6. Anatomy of the Leadership Roles of GP and Nurse Members

The empirical evidence supports the study proposition (section 5.2.1) that only the GP members would be viewed as influential in leading the work of the PCG. The GP members agreed that they were in leadership roles, particularly those in named positions on the Board. However, they were also aware that their leadership role was constrained and to some extent illusory because the NHS corporate body dictated the agenda and its out-posted officials determined the priorities. In identifying this issue, they revealed a multiplicity of tensions:

- Between central and local policy decision making in a state financed service (Hill 1997)
- Between professionals and managers in bureaucratic organisations as suggested within theories of conflict (Parsons 1954)
- Between dominant and challenging interest groups in the decision making process (Alford 1975)

Unlike other studies exploring doctor -manager relations in decision-making, this study focused solely on GPs who worked in independent businesses, semi-detached from the corporate NHS. Informants provided examples of GP Board members who remained semi-detached from the PCG, not engaging or interested

in a leadership role and therefore not experiencing all of these tensions. They exhibited the behaviours identified by Ashburner (1993a) and described by Ranadé as 'back bench' board members (Ranadé 1986). Backbenchers were reported to only engage in the topic areas concerned with their own interests and for the most part kept a watching brief over those interests in the Board. This study did not interview any GP Board members who were not active and further investigation would be needed to test whether that was how they saw their role in the PCGs.

In contrast the nurse members were not viewed as leaders although they themselves declared they had an equal leadership role with the doctors. They provided contradictory and sometimes confused views. While some of the nurse members could articulate a corporate role on the Board, most had difficulty reporting a role in which they led or significantly influenced ideas and decisions. Even when they did claim influential roles, these were attributed elsewhere by other informants.

Parsons suggested that the professionals drew their source of authority from their specialised, expert knowledge, not their place in a bureaucratic hierarchy (Parsons 1954). Informants supplied some examples of where the GP members were drawing on expert medical knowledge. However, the medical claim to be sole holders of knowledge was challenged by other groups. The experience of the nurse members was that it was not the knowledge but the status of the 'knowledge holder' that gave authority. The nurse members were further challenged in their claims of expert knowledge, in that other Board members expected them to be expert in the employment, services and management of a nursing workforce. By virtue of their position in the bureaucracy of a Community Trust or in general practice, this was knowledge they did not have.

While other Board members laid claim to aspects of the GPs knowledge, only the GPs held the cultural authority that membership of the medical profession gave them. Medical profession membership provided them with another potential form of authority: that of the authority of a peer relationship to other members of the medical profession. Managers and lay members viewed this as the most

significant element of the leadership role of the GPs in the PCGs. The GP members themselves had mixed and ambivalent views about the extent to which they wanted to use that authority to influence other doctors or promote the interests of the corporate NHS agenda. There were obviously those who were keen to use it when it chimed with general practice interests to try and influence hospital medical practices.

Some GP members were engaging with issues from the corporate NHS agenda. In this they displayed characteristics of "boundary spanners" between general practice and NHS corporate managers i.e. pivotal actors in the management of inter-organisational relationships who operate as cultural brokers between different groups (Williams 2002). However, the extent to which they were prepared to use their peer authority with other GPs in promoting the NHS management agenda was questionable. Observations were made that the GP members were working with practices interested in change not those reluctant to change. The example of the practice nurse Board member leading on issues of clinical governance suggests that there was reluctance for GPs to allow other GPs' influence in their practice. This issue was identified previously when the Medical Audit Advisory Groups had to use facilitators other than GPs to try to establish elements of quality assurance in local practices (Humphrey and Berrow 1993). There was also evidence in this study that GP members actively opposed any engagement designed to influence other GPs or make judgements on their professional practice. Meads has suggested that GPs in some PCGs acted primarily as a defence union (Meads et al 2000). In one PCG in this study the GP members used their peer relationship not to promote the corporate NHS agenda but to display peer solidarity and block it. The evidence in this chapter provides an insight into aspects of the relationships between doctors and managers, and between dominant and challenging interest groups. These will be explored further in the next chapter.

Chapter 8: Challenges to the Leadership Roles for GP members

8.1. Introduction

The GPs had structured support for their leadership role in the PCGs. The central policy gave them the majority of places, the named leadership positions and the development of primary care as a prime objective. However, as the previous chapter demonstrated, the GPs members argued that facets of the leadership role were illusory and other informants described an ambivalence to a leadership role amongst the GPs . This chapter explores these complexities in more detail, examining first of all the relationship between the GPs and then between GPs and managers.

8.2. Relationships between General Practitioners

Informants from all PCGs reported that the influential role of some Board GPs did not go unchallenged by other Board GPs or GPs in the wider PCG. GP members themselves reflected on their own occupational culture and pointed out that each GP was likely to hold different opinions from the next. They tended to describe this as resulting in spirited discussions. The other informants reported witnessing very acrimonious disagreements between GPs, to the point of physical exchange on one occasion:

> "*Well, there have been those meetings* [non public Board meetings] *where the boys 've* [GP members] *really gone for each other. There was one* [meeting] *where two of them were squaring up to throw punches even. Yeah, really!* " PCG nurse Member, 3, text units 560-563

One male GP member noted that the female GP chairperson had reduced the amount of open conflict between GPs on the Board in comparison to the all male local LMC. Half the Boards had no women GPs as members and they were in the minority on the others.

There appeared to be three sources of tensions. The first source stemmed from differing political attitudes to the NHS. The second source derived from different attitudes to a population perspective as opposed to a GP practice perspective. The third source lay in the competing business interests between individual general practices.

8.2.1 Past Involvement in Commissioning as a Source of Tension

PCGs were instigated following a period of experimentation with greater GP involvement in commissioning both with and without fundholding mechanisms. The use, or not, of these mechanisms was often portrayed by informants as an ideological decision about the concept of an internal market in a public service. The result was that different groups of GPs were involved in different forms of commissioning that stemmed to some extent from their political beliefs. The advent of the PCGs meant that GPs from these former factions came together in often uneasy groupings:

> "*There was a fund holding* [GP] *consortium and a commissioning group of non fund-holders* [GPs], *two distinct groups which joined together* [to form the PCG], *so there was certainly degrees of suspicion between the different groups at the start, but I think those have gradually been resolved.*" PCG GP member 29, text units 116-120

The situation was not helped by the fact that one of early tasks of the PCG was to disaggregate services purchased previously only by fundholding GPs, such as practice counsellors, and broaden the access to these for other practice populations.

> " *We managed to inherit physiotherapists from fund holding and then extend it to be available to everybody".* PCG GP member 19, text unit 156

Many fundholding practices saw reductions in levels of access to these types of services for their particular practice patients. Informants reported a variable impact on general practitioner relationships following this process.

8.2.2 Population Perspectives as a Source of Tension

General practice has an occupational culture that concerns itself only with the individual practice and the patients registered to that practice. General practitioners traditionally have had no inclination to concern themselves with any other practice or patients. This aspect of its culture is derived directly from the fact that each practice is a stand-alone business. Some GP members noted that during the period prior to the inception of the PCG there had begun to be small changes to this culture. The concept of practices working collaboratively to provide out of hours services and in multi-funds meant that looking outward from a practice was not such an alien concept. However, some GP members had shifted further in their willingness to engage with a wider population and service needs than many of their peers and indeed practice partners. The GP members pointed to the resulting tensions:

> *"I felt personally that I am there as the Chairman of the Board and I am responsible for all the residents of the geographical area and responsible for the entire population of the area. I had been working like that. So I had some problems there as well from the LMC, as nobody wanted to accept my way of thinking*". PCG GP member 26, text units 44 –52

This different orientation was reported to cause tensions not just with the wider community of GPs but also with partners in a practice:

> *" There was a schism between the perception of the medical world that I have and the perception that my partners have. And that brings friction into the practice without a doubt. I would have a view of something which is totally foreign to them at various times."* PCG GP member, 9, text units 174-179,

This GP member noted that his involvement in the PCG had also helped his practice partners become more outward looking from the practice than previously. Others noted, however, that a PCG population wide perspective could increase antipathy between practices as it often revealed the level of inequity of resources between practices such as Health Authority subsidised practice staff and Community Trust attached nursing staff.

8.2.3 The Business of General Practice as a Source of Tension

General practices in each PCG, as independent businesses, were in competition with each other for patient registration and other financial and service support opportunities from the wider NHS. Some informants noted that Board GPs were viewed by other GPs in the PCG practices as gaining advantage as a direct result of their position. They were not viewed as altruistic representatives of general practice but as there to further their own practice interests to the detriment of other practices:

> " *I picked up a lot of anxiety from GPs in other practices, who are not on the Board, about the role of the Board. 'And what are these people doing there and were they just feathering their own nests?' and so on.*" PCG lay Board member 14, text units 289-292

Indeed, some of the GP members were clear that their original motivation to be Board members was both to help improve primary health care in the widest sense and also ensure their own practice did not miss any opportunity:

> " *I think both myself and my partners felt that there ought to be representation of the practice there. And the practice is a relatively large one and so it is our duty in a way.*" PCG GP member 9, text units 14- 16

One Health Authority Director highlighted the problem of how GP members were viewed as benefiting by other GPs. But he also noted that the GP members came from practices that were more willing to volunteer for new developments compared to others. The potential for conflicts of interest were significant as the GP members were being asked to make decisions about the allocation of public funds in which they sometimes had a vested interest. These decisions ranged from finance for new developments specifically in general practices, the allocation of the ancillary staff budget to general practices, the provision of therapy and nursing services to general practice and primary care, and to decisions about practice vacancies. One lay member observed how unaware the GPs members had been of their own potential conflicts of interest:

" When a single handed practice became vacant, we were asked to recommend what should happen to that practice. Either recruit a single hander, or have it taken over by a neighbouring practice or whatever. And I said, 'four of you here have got conflicts of interest. You might want to take it over. You might want to prevent somebody else from taking it over. You might not want a competent single hander because that might draw patients away from you. So none of you lot can vote, it's left to the non-clinical people to decide'. And that was quite interesting, I think it was the first time they had come across in governance terms the real significance of conflicts of interests". PCG lay member 25, text units 208-219

Two of the PCG chief executives indicated that principles for dealing with GP members' conflicts of interest in particular Board decisions had been established in prior organisations such as multi-funds. These principles, they stated, had been carried forward into the PCG. However, it was not clear how long it took other PCGs to clarify their principles for dealing with conflicts of interests.

Analysis of the Board minutes found only one example in which a potential conflict of interests of GP members was recorded. In this, GP members were excluded from a decision on allocating additional project funds to general practices.

The relationship of the GP members with the LMC highlighted another aspect of this conflict of interest. Informants in some PCGs reported that the LMC were very concerned that the Board members did not usurp their role of representing general practitioners and their interests with the wider health service. In one area, it was reported that the GP members had come into conflict with the LMC for not ensuring wider consultation with GPs on PCG decisions. One GP member reported that the LMC had a very particular view of whose interests the Board GPs should represent, which he did not necessarily agree with:

" The LMC has been in existence for 89 years, and since the LMC started they always had the role as the GPs voice. They felt that the GPs elected for the PCGs should be more interested in GPs than anything else. In

other words, 'if there is anything that could be found in favour of GPs you should fight the Board and get it'. That was not my concept [of my role] ". PCG GP member 26, text unit 67

In all the PCGs, some GP members were reported to also be LMC members. One lay member speculated on the extent of the influence of the LMC in the PCG through the GPs with a seat in both places:

"There are a group of people at the heart of this LMC who were very instrumental in setting up the PCGs in this area. And it means that there is very rarely an issue where the PCG and the LMC are in conflict. I have never understood how far it means that it's all fixed beforehand. I mean, how far the real agenda is set in the LMC and is represented by these particular GPs as they function in the PCG". PCG lay Board member 14, text units 505-516

These types of tensions were not described between the nurses on the Board or with nurses outside the Board. All the nurses were employees; no reference was made to any nurse as a partner in a general practice business, or the relationship between them, the PCG and the nursing unions.

8.3. Relationships between General Practitioners and Managers

While there was tension between some GPs and a questioning of the role of GP members as leaders, this was insignificant in comparison to the level of tensions in the relationship with managers.

There was evidence of a generalised animosity from the GPs towards managers. Informants reported that GPs tended to have an underlying negative attitude towards NHS management:

" I think amongst GPs it's a certain kind of, distrust is too strong, underlying thing about management generally. Its not actually about the staff in the Trust, they get on well with the actual staff. I think it's more about a management thing. I think there's probably distrust of Health Authority staff as well." PCG lay member 23, text units 398-401

There appeared to be a difference in the type of relationship between the GPs and the PCG managers and those with other NHS managers. This section considers first of all the relationship with the managers in the Health Authorities and the Community Trusts and then those with the managers in the PCGs themselves.

8.3.1 The Relationships between GPs and Managers in Health Authorities and Community Trusts

The greatest negativity, and on occasion hostility, from the GPs was reserved for managers in the Health Authorities. Board GPs in all four Health Authorities described health authority managers in pejorative tones, using words like; " *authoritarian*", "*hierarchical*", "*autocratic*" and "*obstructive*". They also used language illustrative of conflict such as '*wrestle*' and '*battle*' to describe their relationships with the Health Authority and its managers. A Director in one Health noted the antipathy to the Health Authority:

> " *The GPs certainly came on the* [PCG] *Board with the expectation that they were the knowledge holders and should develop primary care both at the micro level and at a more macro level of across the board. There was a point where they really were very unhappy that the Health Authority should have any interest or involvement in primary care development. It was really contentious.*" Health Authority Director 11, text units 70- 78

Many of the GP members attributed the PCG's slow progress and the lack of visible success directly to the Health Authority's bureaucratic behaviours:

> " *Unfortunately, our Health Authority is a very hierarchical body which has constantly I think, interfered and slowed down the development of the PCGs in a rather negative way*". PCG GP member 9, text units 31-34

The bureaucratic nature of the NHS was a source of deep antipathy for the GP members. However, the senior managers in the Health Authority portrayed themselves as behaving in a rational manner and saw the problems arising within and between the PCGs:

> *"It took some months for us to agree how to devolve the Health Authority staff and funding to the PCGs. And we had a particular problem here because we have got X PCGs and we couldn't divide people in X way. And so it took time for the PCGs to agree to work with each other on a Borough basis and as soon as they got to that point then we were able to devolve to each PCG".* Health Authority Chief Executive 20, text units 16-21

Some of the GP members' hostility to the Health Authority managers was a result of their recognition that they were dealing with bureaucrats in the lower echelons of the NHS while decisions were made in the higher echelons:

> *" When we were in the multi-fund we were autonomous, with decisions straight from ministerial level. Now it is all incredibly bureaucratic, filtered through the different levels of the NHS. We do not see the minister directly. So everything has to dribble from the bureaucratic lead and we wait with baited breath for it to dribble its way down to the local Health Authority, who sit there waiting for edicts from on high."* PCG GP member 2, text units 25 –29

The antipathy to working with the lower levels of the NHS was demonstrated in other PCGs where the GP chairperson led members to try and out-manoeuvre the Health Authority by lobbying local MPs and making direct contact with the NHS Executive:

> *"We* [the PCG] *are constantly having to write to John Denham* [Health Minister at the time] *and they* [the Health Authority] *are constantly writing to John Denham and we both get letters back saying different things. So an example of that is that we are going into Trust status. We had thought the government would not countenance a Trust of more than about 300,000. Now we are being told by the Health Authority, actually you have got it all wrong and they can produce a letter, which says, 'the government probably will let us do that'. And we can produce a letter which says, ' the government officers say you can't do that'."* PCG nurse member 4, text units 322 -330

In another PCG, the Minutes of each meeting during 2001 documented in detail GP members' concern and then stronger negative feelings at, first of all, the Health Authority's slowness in making decisions about devolving budgets and staff to the PCG and then, changing that decision to reduced amounts.

Despite the Health Authority Directors presentation of themselves as acting in a logical and rationale manner, informants from the PCGs could give a number of examples that indicated a general reluctance to support the PCGs:

> *"We have not had support from the Health Authority at all. And I think it was summed up when a senior person from the Health Authority came to speak to us at our last Board. And he was saying they would not support our move to go from PCG to Trust status because, ' it's going to fail'. And ' why do you say it is going to fail?' we asked. ' Well, you are going to fail because we don't support you'!"* PCG lay member 23, text units 362-366

Some of the GP members also described the managers of the Community Trusts in pejorative terms. They were less combative in their language than about the Health Authority managers but many of them used negative terms such as "*unresponsive*", "*incompetent*" and "*awful*". These GP members described the Community Trust managers as members of large bureaucracies that were inflexible to the needs of the general practices and their patients:

> *"Negotiations with the Community Trust over an integrated nurse team pilot is another example. Again the problem is the bureaucracy, it's Neanderthal. The Community Trust, it's a huge organisation and you shift the rudder and you don't get any change in direction for a long time*". PCG GP member 9, text units 147-165

The Community Trusts managers reported that many GP members treated them with suspicion, anticipating that the Community Trust was attempting to influence or run the PCG. Community Trust managers recounted that their offers of resources, premises and to attend PCG meetings had been refused and examples of the rejection of such offers were found documented in Board Minutes.

Some informants presented the hostility to managers in both organisations as the residue from a long history of poor relationships with successive managers and a history of lack of investment in primary care development. One PCG chief executive reported GP members contrasting their long term investment in a local practice against the short term commitment with no results by successive managers:

> *" The thing that doctors find, you must have heard them saying this, they bring a continuity of experience. They will have been there for years and years some of them. What they don't like is the constant organisational change for which they see no benefit. It destroys the relationship. They have a constant throughput of new people who come asking the same questions again and again and deliver nothing and move on. And that's their experience of health service management."* PCG Chief Executive 38, text units 268 -277

One lay member observed that the GP members perceived Health Authority managers to repeatedly block their clinical autonomy through denial of access to finance:

> *" The GPs see the Health Authority managers as obstructive. They have worked together before a lot, haven't they? So they do have those barriers, that feeling that they* [the GPs] *are there doing all this work and that they are constantly being frustrated in what they are doing by managers saying "no we can't pay you for that" or "you cannot do that' and' you must not use that drug' and 'we are not going to authorise that' or 'we are not going to commission this*". PCG lay member 23, text units 414 - 420

However, it is not clear whether these tensions became outright conflict through the work of the Board. Only two documented examples of resistance to the Health Authority were found. One PCG Board recorded in its Minutes their refusal to agree to a Health Authority decision prohibiting the prescription of particular expensive medications. Another PCG documented their decision not to contribute further to the development of a Health Improvement Plan because

there were no resources allocated to achieving the plan. In two of these PCGs, informants reported that the PCG had demanded and been given, despite resistance, symbolically important Community Trust buildings as their Headquarters.

There were certainly no examples of managers initiating or describing themselves in particularly adversarial terms towards the GPs. The Health Authority managers tended to describe the GPs in terms of one group amongst many to work with. Two of the Health Authority managers described the establishment of GP led PCGs as part of a longer term, non-adversarial, government policy to change how primary care services were delivered. In particular, they interpreted the GP involvement in the PCGs as a mechanism to reduce the resistance to the incorporation of general practitioners in the wider NHS:

> " *This and the PCTs has been about buying off the GPs and keeping them on board, because actually we do need to get GPs in ten years time into a different place.* " Health Authority Chief Executive 30, text units 246-248:

Similarly the Community Trust managers described themselves as actively placating the GPs in order to be able to collaborate:

> " *But in one PCG* [of four covered by the Community Trust], *the associate director has managed to befriend them. But I think maybe because she adopts a non-threatening stance. And she doesn't challenge them when they represent a different recall of incidence or events".* Community Trust Chief Executive 5, text units 309- 314.

This is not to say that managers did not reciprocate some of the animosity expressed by the GPs:

> "*Those managers* [in the Health Authority] *were dismissive and rude about the behaviour and attitudes and style of GPs, particularly the people who were on the Board at the time".* PCG Chief Executive 39, text units 313 –315

8.3.2. Relationships between the GPs and PCG Managers

In contrast to their attitude to the Health Authority and Community Trust managers, the GP members' attitude towards the PCG chief executives was very positive:

> " *Our chief executive is excellent. We could not have a better person - with his help and guidance and with the full support of the Board, I feel that we have done a good job*". PCG GP member 26, text unit 28

They saw these managers as '*their*' managers who helped them implement their decisions. The GP members described the good relations with their chief executives as deriving explicitly from them not having Health Authority management backgrounds:

> "*Working with our chief executive hasn't been a problem. He'd been involved in fund holding and overseen lots of funds. So he'd been used to dealing with clinicians and working with them in a setting, which was led by clinicians again in a direct way. He hasn't got a health authority background.*" PCG GP member 19, text units 131 –134.

The separation the GP members saw between the wider NHS and the PCGs was underlined by one GP member who described their chief executive, having worked briefly in a NHSE Regional Office, as "*leaving the NHS*" to return to work in primary care. The PCG chief executives agreed that it was their backgrounds in working with general practitioners that made the GP members view them differently to other managers:

> " *They* [the GPs] *saw me as one of them because I came from a Primary Care background as a general practice manager. I understood their issues, I'd been around for a long time and I definitely hadn't been a NHS career manager*". PCG Chief Executive 39, text units 90- 93.

The PCG chief executives described themselves as actively working to ensure they had co-operative relationships with their GP members, particularly the chairperson. They pointed out that their skill was to manage the Board so that conflicts did not occur either with themselves or the Health Authority. One

example given was by the PCG chief executive who was unable to engage the GP members in addressing poorly performing GPs in the PCG. Rather than engage in open conflict, she worked with public health doctors outside of the PCG to address the issues. She then reported to the Board the PCG success in improving local GP practice provision. Interestingly the presentation of this success was such that the lay member of that PCG attributed the success to the GP members:

> *"I think the [*Board*] GPs were really serious. Interestingly, they saw it [*the PCG*] as a way of dealing with these issues that people have known were around for a long while. There was one particular practice that the public was complaining about for many years. And they just moved in and they had everybody in, the tax inspectors, the health and safety inspectors they just brought in the lot and the place has been transformed. It's extraordinary. But they weren't afraid to tackle that. I was pleased with the way that they were willing to get their hands dirty".*
> PCG lay member 34, text units 262- 271

8.4. The Sources of Tension between GPs and Managers

The GPs and the managers attributed the origin of uneasy relations between the two groups in very different ways but both found the source in the occupational culture of the other. This section will consider the issues first from the GPs' perspective and then from the managers.

8.4.1 The GPs' Perspective on the Sources of Tension

The GP members contended that orientation of managers was the source of the tension. They contrasted their own concern with the needs of local patients to the managers' concern with the needs of the NHS as an organisation. They pointed to their long-term commitment to a practice population as of greater worth than the short term commitment of the managers to an area. They saw their interest in patient level clinical issues as of greater local importance than the managers' focus on the interests of the NHS corporate bureaucracy. One GP member illustrated this in an example over cervical cytology screening rates:

" *So what they* [the Health Authority managers] *are doing is saying is 'well the easiest way of increasing the figures is by looking at list inflation and if you can get ghost* [i.e. still on the practice list of patients but has moved away or died] *women off the list, then we increase the target figure for the Department of Health and we are seen as being OK'. But the clinical view is that is a waste of time. We should be looking at: what is the local death rate? What is the local rate of colposcopies? How are we going to reduce those? And not how are we going to feed some government department by producing an artificial increase in the figures."* PCG GP member 9, text units 50-65

The GP members repeatedly argued that the managers were concerned with addressing the policy imperatives from higher in the bureaucracy, including re-organising the lower levels of the bureaucracy, and this left no space to address local issues:

"*A huge effort goes into making managers do what the central government want them to do. They are exhausted. They can't focus on local innovation because they are running around in circles doing things that are being directed from above*". PCG GP member 2, text 34-38

The GP members described the managers as interested in the process of bureaucracy, and contrasted this with their own action and outcome orientation. Lay members and GPs from every PCG reported that Board GPs had resigned because of the lack of tangible progress in the PCG. Some Board GPs presented themselves and their work on the PCGs as the only element that had made any difference in contrast to the managerial processes:

" *If you said to me "what has the patient actually noticed, because of the PCG?" Absolutely nothing! I've been able get some resources into the practices with a couple of schemes for governance, but that's only because I've worked hard within our PCG. The other PCGs haven't managed to get anything through the Health Authority.* " PCG GP member 21, text units 74-79

Most of the GP members described success in terms of achieving funding for specific developments in general practice such as a funded general practitioner and practice staff education programme, improved IT connections for general practice, levelling up of practice staff funding between practices.

8.4.2 The Managers' Perception on the Source of Tension

The managers, like the GPs, pointed to the differences in occupational cultures as the major source of tension. They observed, however, that the GPs exhibited not one but two occupational cultures: 1) that of general practice as a small independent business and 2) that of the profession of medicine.

8.4.2.1. The Occupational Culture of General Practice as Independent Contractor

The culture of general practice as an independent business was the element that the managers argued gave rise to the greatest tension. They commented that it set the general practitioners apart from the NHS managers, and for that matter, from the majority of professionals delivering services within the NHS. The managers argued that the GPs brought their occupational independence into the PCG work and refused to concede that it was part of the large corporate bureaucracy:

> *"Within the PCGs, the GPs debate for a month whether they are going to accept the policy handed down from the centre or not. And this is just wasting time, because at the end of the day they have no choice. The GPs challenge that view and don't necessarily accept that they are part of the NHS as a whole".* *Health Authority Director 11, text units 78- 87*

The managers were united in contrasting the GPs as involved in small businesses with themselves as involved in a large business. Managers pointed out that general practice as a business rarely employed managers as executives. This lack of comprehension created initial tension in those PCGs with management teams and certainly underscored hostilities to the Health Authority:

> " *GPs are small organisations, very small organisations. They have to run it as a small business. But in terms of the NHS, it's organisational cultures and structures, they are generally quite a long way away from that larger organisational discipline".* PCG Chief Executive 38, text units 57-67

The PCG chief executives argued that many Health Authority managers held themselves to have the moral high ground because they saw the GPs as motivated only by their own income, not the needs of the patients:

> " *You had NHS managers, who as soon as you mentioned GPs and money in the same breath, smirked. What that showed was that they were salaried, they didn't understand the way the GPs constantly emphasised reimbursement and money. And that was because they didn't understand the GPs were running a business".* PCG Chief Executive 39, text units 338

The GPs themselves were aware that their business culture set them apart although it was not the culture they chose to highlight in the interviews:

> "*The GP Chair of our PCG was the one GP wheeled out to talk to prospective lay members. And the very first thing she said is, ' None of you will know this but GPs are small businessmen running their businesses in competition with each other'. And I kind of looked and I think we all did and that was a tiny taste of what was to come in terms of a kind of commercial culture that I still find mind boggling*". PCG lay member 14, text units 95-101

One lay member observed that the GPs had a frame of reference that was more akin to that of "*accountants and lawyers not other professionals working in the public service"* PCG Lay member 14, text units 119-122.

Managers argued that a direct consequence of the business culture was that GPs viewed each issue in terms of their own practice first and foremost:

> " *I think there's still very much a tendency for GP members, who are effectively small businessmen, to view everything that you present from a*

point of view of how does it effect me. So the decision is driven, not by the policy itself, but by the effect and impact it will have on them as a business person." PCG Chief Executive 6, text units 18-22.

Managers pointed out that the independent nature of each practice meant that many GP members found it completely alien to develop a collective sense of responsibility for primary care services. PCG chief executives pointed to examples of GP members disowning any involvement in Board decisions when challenged by other GPs in the PCGs.

8.4.2.2. The Occupational Culture of Medicine

The managers argued that decision making processes were completely different between managers and GPs and this led to significant friction. Their occupational culture was for maximum consultation and involvement, usually through written papers, before group decision making. This was a practice that many of the GPs found problematic:

"Doctors are used to being quite autonomous in their decision making process and so on. They are used to taking the can for everything, being the last resort in terms of responsibility and they do feel that very strongly. And how ever much people say,' no, its a team decision now', they don't believe it. That's not what they have been brought up with and they don't believe it". PCG Chief Executive 38, Text 437 –442

Conversely, the action orientated attitude of medicine challenged the managers:

" GPs are not very keen on talking about things. They are very keen on actually doing service development. So that has been a bit of a cultural challenge to stop talking about things and get on and deliver." Community Trust Chief Executive 12, text units 50-54

GPs did not necessarily see the need to establish the Board as a co-operative decision making group, whereas managers emphasised this as an important first task. The medium for transfer of information for managers was written reports and memoranda: the GPs preferred oral methods. One of the GP members

recognised this difference between the occupational groups arguing, " *he who reads the papers calls the shots*". Attention to the process of decision making meant that the managers had formal, but unwritten, rules of behaviour in meetings that the GPs were considered to not comply with. They pointed to infringements such as: the GP chairperson failed to control the other GP members' contributions, the GP members ignored the chairperson and the agenda, and that they broke into separate, simultaneous discussions and interrupted other speakers.

> "*The GPs don't know about the way of chairing meetings and knowing what level of detail to allow the discussion to get into before you try and draw it to a close. I suppose managers take that for granted, they are not skills you fall into naturally*". Health Authority Chief Executive 20, text units 172 – 174

In contrast, most of the GP members drew attention to the skill of the GP chairperson of their Board in facilitating involvement from all Board members.

8.4.2.3. Racism in the Tensions between Managers and GPs

One further issue was mentioned by only two managers but is worthy of note. They argued that racism played a significant role in the attitudes of some white NHS managers towards GPs from black or minority ethnic groups. They both noted that GPs from black and minority ethnic groups were often grouped in particular geographical areas and were often over represented in running single handed practices. One argued that the disdain that NHS managers expressed for GPs was particularly reserved for those from black and minority ethnic groups, although she also highlighted issues related to the professional hierarchies in medicine:

> " *The [Health Authority] managers found it very frustrating to be along side GPs because they did not act like managers. And it brought up into quite stark relief, the fact that it was still inbred, certainly in this part of the world , quite strong feelings about , which I would go as far as to say, some people were racially motivated and in it was a kind of class thing . They thought that the people who make the decisions are not the people*

at the bottom pecking order of the health professional hierarchy. So more sway was given to a very senior consultant in neuro-surgery, whereas, the GP was not seen to have that kind of standing". PCG Chief Executive 39, text units 39-42

The issue of race overlapped with issues of antipathy to single handed general practices expressed in the NHS Plan. A number of the Board GPs commented on what they believed was an unwarranted wholesale criticism of single-handed practice. One manager reported that many GPs from minority ethnic groups had argued that the plans to reduce single GP practices with General Medical Service contracts was a form of institutional racism:

" *X PCG, it's a deprived population, very high ethnic mix, 70% single handed practitioners, they have poor facilities to work with. Compared to the other PCGs they feel like a poor relation not having money, feeling like they've never really been supported to change things in the past by the Health Authority. And now they are arguing that the National Plan is racist, because its talking about a big percentage of single handed practitioners being in PMS contracts. And they are saying, 'lots of Asian doctors are single handed practitioners in cities. It's racist, they are targeting us in particular'. So I think they feel the establishment is constantly getting at them".* Community Trust Director 20, text units 175-181

The GP participation in PCG Boards brought involvement from some groups in the medical profession that were not usually so visible in decision making bodies. A lay member specifically commented that after years of sitting on different types of committees concerned with health in her Borough, the PCG was the first where the membership represented to some extent the local population both in sex and ethnicity:

"Its the only health body I've been on that wasn't totally dominated by white men. I found that very refreshing, it was like walking into a normal (PCG area) *gathering. ."* PCG Lay member 34, 234-236

8.5. The Role of the PCG Chief Executives

The PCG chief executives tended to report themselves as managing the fracture lines between the occupational cultures of the GPs and the NHS managers so that they could work to the imperatives of both groups. One PCG chief executive argued that there was no culture clash between the Board GPs and the Health Authority managers because both she and her managers actively worked to ensure it could not happen. Another argued that she ensured that she adapted to the culture of the GPs so there was minimal use of written papers at the Board. Interestingly, the Board Minutes of this Chief Executive's PCG demonstrated that there were supplementary papers and reports to nearly every agenda item. Perhaps this demonstrated a public presentation of events to the Health Authority rather than the actual activities of Board participants or perhaps the reality was different from her recall. Some PCG Chief Executives indicated that trying to manage the cultural gulf between the two groups could be difficult and they were often accused of having divided loyalties. They reported pejorative comments made to them by individual GPs in "*turning into a Health Authority manager*" and conversely having their "*knuckles rapped by the Health Authority when the GPs were taking issues outside the Health Authority* "i.e. outside the formal lines of the bureaucracy. Where the interviews with PCG Chief Executives were close to the establishment of the PCT, they contrasted their own attitudes to working with the GPs with the incoming Chief Executives. These were all from Community Trust or Health Authority backgrounds and were observed to bring a different attitude to the GPs with them:

> " *Whereas, the new Chief Executive of the PCT has come from a Trust and is much more confrontational with the GPs than I was. I can see it's going to be a real struggle. The GPs are already giving her hell.* " PCG Chief Executive 36, text units 130-131

Some of the GPs members also referred to the change of culture that the PCTs would bring. Few of them were positive and saw it as part of their continuing struggle against the corporate NHS:

> " *Well, the PCT is back to the old Health Authority days isn't it? Where you have one doctor who is paid an annual wage to sit quietly in the*

corner and not say anything. It is very difficult if you are one against the managers. They can ignore you or ask you to be quiet. Or say that, ' this project has taken ten months to work up. So now you as an individual are ruining it'. " PCG GP member 35, text units 96- 101.

8.6. Leadership in Collaboration or Conflict

The evidence demonstrates that there were ongoing tensions between the managers and the GPs, rather than conflict per se as suggested in the study proposition (section 5.2.1). While there was little evidence of outright conflict, difficult relationships provided a backdrop to the dynamics of leadership in the PCG. The tensions had different manifestations with managers in the various sections of the local NHS bureaucracy. The neo-Weberian theories of bureaucracies argue that conflict arises between professionals and managers because they draw on different sources of authority. The evidence would suggest in this chapter that the friction came from multiple sources rather than one source. The GPs claimed expert knowledge and membership of the medical profession as one source of authority. They also claimed expert knowledge in running a health care business. The managers derived their authority by virtue of their position and its attendant budget in the local sections of the corporate NHS. They too claimed expert knowledge in running a health care business. While the managers could contest authority based on knowledge, they could not contest the cultural authority derived from medical profession membership, nor could they contest the occupational autonomy of general practice as an independent business. Consequently, there was an underlying friction in the relationship but the managers actively avoided overt conflict. In this they mirrored the behaviours of hospital general managers to hospital doctors observed by Harrison et al (Harrison et al 1992). As Pettigrew et al (1992) noted from their analysis of managers and medical consultants, it was the managers who worked to maintain fragile relationships between themselves and the GPs.

The GP members had no such qualms about openly reporting their negative attitude to the local managers of the corporate NHS. They also recognised that

they had shifted from holding a purely general practitioner perspective so that they formed a bridge between general practice and the NHS corporate managers. They did not see themselves as in conflict with the PCG chief executives. Likewise the PCG chief executives were acting as bridges between the imperatives of the corporate NHS and the imperatives of the GPs. The PCG managers resembled one group of managers that Pettigrew et al (1992) observed in their study of strategic change who experienced a lower level of conflict with the medical staff than other managers. Pettigrew et al described these as "*semi-immersed*" in the world of the clinicians and noted they had previously been administrators.

Chapter 9: Challenges to the Leadership Roles for Nurse Members

9.1. Introduction

Earlier chapters described the lack of perceived influence the nurse members had in the work of the Board, despite having named leadership roles. This chapter explores the relationship between the nurse members and others to understand this apparent contradiction. It considers first of all the relationship with their peers, then with the managers and finally, with the doctors.

9.2. The Relationship between Nurses

The relationship with other nurses in the PCG was complex. The nurse members came from a range of occupational roles and, unlike the GP members, did not have an existing method of networking with all the nurses in the PCG. Only one as a local union representative appeared to be part of an established local network. The nurse members emphasised their expectation of representing nursing views on the Board. However, they reported limited visible interest from the other nurses in the PCG to express their views to Board members: Only three nurse members cited examples of direct approaches from nurses in the PCG to ask them to raise their problems on the Board.

> " *There is a distinct lack of nursing presence at the open meetings and the stakeholder meetings and even as observers at the Board*". PCG nurse member 17, text 301-303

Their relationship with the nurses in their own service was important to them not just to gain views but to function as a Board member. They described a variety of relationships with their work place nurse colleagues that ranged from outright hostility to very practical support. In the most supportive relationships, team colleagues reorganised or took on work in order to help release the nurse member for Board meetings:

"I'm supposed to do four and half days a week and half a day PCG, but it doesn't work like that. It's only through the good support of my colleagues that I'm able to get time back for anything. The only way it works is through your colleagues picking up for you all the time". PCG nurse member 8, text units 410- 421

Some nurse members described support from colleagues as long as they only conducted Board activities outside working hours and did not try to re-negotiate work time commitments. Others described a lack of support from work colleagues to the point of friction. This was not the result of any perceived advantage gained from Board membership but rather a negative view of the impact on the workload for team colleagues:

" I think originally there was some opposition from fellow members of staff, a resentment really. They think 'oh no it's one less person to man the pumps, or to cover '. There was not an awful lot of team spirit where I was based. And I thought, 'oh, no what have I done here?' because there was quite a lot of antagonism. " PCG nurse member 4, text units 443 – 450

Most of the nurse members emphasised the importance of their relationship with the other nurse member and with nurse members in other local PCGs. In some of the Health Authority areas, the nurse members from all the PCGs formed a network. Those nurse members who experienced a period of time as the sole nurse on the Board reported that this was particularly hard:

"So then I was doing it on my own for quite a long time and it was very difficult. I wasn't sure whether I wanted to continue with it quite honestly." PCG nurse member 40, text units 122-125

However, relationships between nurse members could also be problematic. One nurse member reported that friction between PCGs in the negotiations for the new PCTs were reflected in the relations between nurse members from different PCGs. There were also examples of tension caused by the nurse members being managers:

" It hasn't felt supportive from other Board nurses necessarily, it almost felt a bit competitive to be honest, which I felt a bit surprised about that. Maybe it was a bit naive of me. Certain Board nurses who are managers want to take over and get their agenda dealt with." PCG nurse member 18, text units 378- 385

The GP members did not discuss their relationship with each other in such terms, although there was some close working with others through the LMC and in the core executive groups. Unlike the GP members, no one commented that the nurse members might have conflicts of interests on Board decisions, even those members who were directly employed by general practices.

9.3. Relationships between Nurses Members and Managers

In contrast to the GP members, the nurse members did not immediately relate a generalised antipathy to managers in the way that the doctors were reported to do, but that did not mean their relationships were harmonious either. This section will consider first of all the relationships with managers in the Health Authority and PCGs, then with the Community Trust managers.

9.3.1 The Relationship between the Nurses and Managers in the Health Authorities and PCGs.

The Health Authority Managers mentioned the nurse members in passing and made observations about their involvement in the PCG but there was no sense that they had any particular relationship with or interest in them. In a reciprocal fashion the nurse members hardly mentioned the Health Authority Managers, but when they did it, it tended to be in negative tones. This was usually when they were relating issues of conflict between the PCG Board and the Health Authority, such as over future configurations for the new PCTs. They rarely discussed contact with the lead nurse in the Health Authority.

The nurse members had mixed views about their relationship with the PCG chief executives. Some of them referred to an element of tension in their relationship,

describing them as " *ex-health authority staff who try and dominate things*" PCG Board nurse 18. They recounted situations where they were having difficulties persuading the chief executive that they had opinions of value based on their clinical expertise:

> " *The fight I felt I was having with the chief executive was all about trying to bring supervision into clinical governance, in terms of practice nurse development. That's something that I feel strongly about, in my specialist nurse role, I know it works, you know. But that issue was always a problem. The chief executive didn't want to hear me*". PCG nurse member 8, text units 346- 9.

Similarly another nurse member had taken to writing to the PCG chief executive to request that items were placed on the Board agenda because her verbal requests were ignored.

However, nurse members also described some PCG chief executives as supportive and '*nice*' to them. They found the administrative staff, in those PCGs that had them, also supportive to the point where one nurse member described how they were synthesising documents for her into one page briefing sheets.

The PCG chief executives tended to focus their interview responses on the doctors: their relationships with the nurses were of the second order. They appeared to range from indifference to benign support to covert conflict. Those that were indifferent viewed the nurse members as inadequate in their knowledge of the wider operational and management processes of the NHS and therefore of little consequence:

> " *The lay member was much more effective than the nurses. Using election rather than selection meant that the nurses weren't up to being Board members. They didn't participate effectively, they didn't seem to understand complex issues, and they didn't understand that the overall issue was about how to get money and how it was distributed across the area*". PCG Chief Executive 36, text units 146 –149

The PCG chief executives tended to sound most positive about the relationship when describing nurse members engaged in clinical governance tasks with the PCG general practices. Those chief executives presenting a benign relationship described how they enabled the nurses to participate as Board members. Sometimes the tone of this 'support' verged on patronising:

> *"I have to work very hard at times to give the nurses a voice. Literally by sometimes intervening during the discussion by the GPs and just saying, "Right, we need to find out what the nurses think". And on the odd occasion when the nurses have been shouted down, in actually deliberately making a point and saying "You know, nurse X has raised a very good point and I think we ought to discuss that."* PCG Chief Executive 6, text units 64- 72

In some of the PCGs, support from the chief executives was noticeably lacking as they failed to ensure that the nurse members had the infrastructure to enable them to function as a Board member. Many of the nurse members worked in open plan offices where they shared telephones and the fax machine and did not have workplace access to email. In one Health Authority, it took all the PCG Board nurses lobbying together for some months before the PCG chief executives addressed their lack of access to email.

There was ambivalence in some of the PCG chief executives attitudes to the nurse members. On the one hand they described helping them to participate in the Board, on the other they questioned their role as a Board member. One viewpoint was that as front-line nurses employed in a bureaucratic service, their participation on a Board was inappropriate for their status in the bureaucracy:

> *"My own view is the nurses who are actually employees of the Community Trust that's potentially problematic. Because we then get people, working in a directly managed organisation, representing an interest and* [they] *may not always be representing it in a way that their professional managers would want."* PCG Chief Executive 38, text units 144 -146.

The chief executives demonstrated their ambivalence by consulting with the nurses' managers in the Community Trusts rather than the nurses. In this they were contesting the authority of the nurses Board members. As time progressed the PCG managers and the Community Trust Managers developed more visible ways of collaboration, thereby diminishing the contribution of the nurse members:

> *" The chief executive was coming to the board and letting us know that they've already had discussions in the Trust with, and then you hear their names. And it's actually the Director of Services they've been speaking to, who in turn has spoken to my manager's manager and it's all at that level".* PCG nurse member 8, text units 152-156

On occasion, some of the PCG chief executives reported that they had acted in ways to ensure the nurse members remembered their place in the wider Trust bureaucracy:

> *Early on the nurse was a) sometimes getting involved in things that were inappropriate and b) that there was a danger of confused messages to nursing staff, because it was coming from a very particular angle and was not being informed or directed by the appropriate line management. It's been worked through partly, because the nurse manager is now part of the PCG team, and partly by meetings where some of it is thrashed out. On one or two occasions when things were going on inappropriately, it was handled where, with the permission of the chair, it went through to the line manager rather than the PCG".* PCG Chief Executive 38, text units 148-153

The PCG Chief Executives did not see the nurses as having authority legitimatised either by their profession, their expert knowledge or their position in a bureaucracy. Challenge from the nurses to the PCG managers was therefore poorly received:

> *" I said, 'Do you mean to tell me you are actually taking money from the nursing staffing budget because you have over spent on IT?' It was couched in very complicated terminology but that is what they were doing. I think it's - what do they call it – the 'savvy' of NHS managers,*

which I possibly haven't got. At times, I don't mind not having it. I think it's good to say, 'What do you actually mean?' Although I can see it does annoy them every time I do it " PCG nurse member 15, text units 475-483

The reported support from PCG managers for the nurse members was in fact a thin veneer.

9.3.3 The Relationship between the Nurse Members and the Community Trust Managers

The majority of the nurse members in the study PCGs were employees of a Community Trust. The relationship between these nurse members and the tiers of Community Trust managers was complex. The Trust manager informants had mixed views about the nurse members that ranged from indifferent to critical. Some reported themselves to have very little contact while others reported that they actively tried to help address the information gaps that they perceived in the nurse members. Most of the Trust managers reported that they viewed the majority of nurse members as resistant to change, with a more limited view of the NHS modernisation agenda than themselves.

The nurse members also reported a range of views about the Trust managers from appreciative to critical. They did not express indifference to the managers, rather the Trust managers loomed large throughout the interviews. The nurse members reported a spectrum of attitudes from the Trust managers towards themselves from indifference to attempts to control their views and behaviour. Some observed that the senior Trust managers did not believe clinical nurses should be Board members. The nurse members described a lack of support from their employing managers in passing on information and helping to organise staff cover so that they could attend Board activities. Most of the nurse members depicted their managers as actively trying to prevent them participating through withholding the finance for locum staff replacement costs:

" *No one in the Community Trust gave us any cover, any admin' support, or any anything. Then to put the boot in, they took the money. Yes, they*

took the locum money, which was immoral to my mind but they did it, and the Health Authority coughed it up straight to the Trust". PCG nurse member 15, text units 405- 409

While Trust senior managers saw their meetings with the nurse members as positive support, the nurse members reported these as thinly disguised attempts to influence their behaviour. They described being '*summoned*' and '*dragged in*' to these types of meetings as though they had no choice but to obey. Once there, they portrayed the information flow as one way from the managers in a manner that brooked no dialogue or dissent:

"And the Chief Executive of the Community Trust hauls us [nurse members] *in every 2 or 3 months to talk to us, or rather talk at us to be quite honest, which none of us enjoyed very much".* PCG nurse member 4, text units 639- 641

Lay members, GP members and nurse members in all the PCGs recounted incidents where nurse members had difficulties with Trust managers subsequent to expressing a different view to theirs:

" It' s been a very difficult situation for the nurses to be in because they'd been leant on by their Trust Chief Executive and made to feel traitors or in jeopardy from their Trust". PCG GP member 21, text units 201-203

Differences of opinion were reported on issues as wide ranging as: plans for the new PCTs, formulae for allocating nursing staff to general practices; holding meetings with nurses in the PCGs without Trust managers present. Nurse members recounted having difficulties with Trust managers:

" I was asked by the Board for my opinion (about a Trust strategic plan). *And I have to say that I felt there were some problems and said so. And that did not go down well with the Trust and there was very much a sub text "well you will remember, won't you, that you work for the Community Trust". Now I'm old enough and I don' t have great career aspirations so I just think 'tough'. But I think it would be very hard for people much younger or not sure where they are going in life".* PCG nurse member 4, text 181- 193

One senior Trust manager informant reported that they had had discussions with the PCG nurse members in that area to reassure them that it was acceptable to express different views to the managers. However, a nurse member in the same area reported that differences of opinion were not tolerated. These tensions and covert conflicts could become more pronounced when nurse managers were also nurse members:

> *"I'd just got a parking ticket, and one manager* [in the Trust] *said they would pay for it and then this one* [manager and nurse member on the same Board] *said, 'no, we won't'. One of the things we bring to the Board is the parking problems. We have to get that sorted out as a community because it causes nurses so much stress. And I'm being told by my colleague,' no, she won't help'. I'm like, you know, I can't believe this. And I got into trouble when I raised the nursing shortage issues. So those sorts of things have been quite difficult. Its a bit of a power thing I think.*" PCG nurse member 18, text units 409 –414

Many of the nurse members reported that they actively avoided coming into conflict with their Trust managers. They described having to behave in ways that took account of their very different places in the two organisations, using terminology such as performing " *a balancing act*", and walking on " a *bit of a tightrope".* Some of them reported curtailing their contributions at Board meetings that were attended by Trust managers. This phenomenon was observable in one set of PCG Minutes. Other nurse members reported that they felt unable to raise issues, which challenged the Trust services and managers, at any Board meetings

> " *So issues like about workforce, there not appearing to be any attempt to recruit new staff when we have really loads of vacancies, things like that. I really wanted to bring those kind of things up but I couldn't*". PCG nurse member, 40, text units 59-66

The only nurse member criticism of Trust managers recorded in the Minutes was from a nurse member who was not employed by the local Community Trust.

Another strategy to avoid conflict was to keep away from the Trust managers when they knew they had differences of opinion:

> *"I have meetings with nurse members. And from this difficult PCG, the nurse is doing her own thing, and has limited understanding and is not growing in her understanding. She doesn't turn up to the meetings. So there's a gap in communication there. And you try and have face to face contact, and she doesn't turn up".* Community Trust Director 5, text units 261 –7

The overarching impression was that the nurse members and Trust managers had conflicting viewpoints. However, in this relationship it was the nurses who acted to accommodate to the managers, unlike the relationship between the doctors and the managers where the managers accommodated to the doctors.

9.4. Relationships between Doctors and Nurses

The relationship between the doctors and nurses had the potential to challenge the adoption of leadership roles by the nurse members. The perception of this relationship is discussed in this section from three points of view: the doctors, the nurses and the other informants

9.4.1 Relationships between Doctors and Nurses: The GPs' Views

The participants were all asked directly whether, as suggested in the nursing press, the GPs dominated the nurse members. The GP members stated that they and their colleagues did not dominate the nurses. They used two types of evidence to support their perceptions. The first type of evidence was that the nurse members held lead responsibilities within the PCG:

> *"No. As a matter of fact we have got a very good relationship on the Board with the nurses. You will be surprised that we gave the practice nurse the lead for clinical governance, and the eyebrows were raised when I said, 'we are pleased to offer so and so to be the lead for the clinical governance'. And she is doing an excellent job. And the district*

nurse she raises her voice now and again and then we accept it." PCG GP member 26, text units 160-162

The second type of evidence was that the nurses contributed to the Board discussions and voiced their opinions. A number of them also noted that the quality of chairing of the meetings was a factor in ensuring that all members of the Board contributed, although not necessarily the main factor:

> *" No, in our instance I would say that the Chair is very good at ensuring that everybody has their voice heard and in addition our nurses are very vocal and are able to speak up on all occasions.* PCG GP member 2, text units 85-87

One GP Board member noted that it was not just the quality of the chairing that was important but that the chair of their Board was a woman. He was clear that she set a tone of participation for all and contrasted it with his experience on an all male LMC:

> *" We have the benefit of having a female Chair which is quite useful She is very facilitative in committee work otherwise you end up with doctors shouting. I think females are much better at communicating. It has helped our style. The LMC locally is very definitely different through being male dominated".* PCG GP member 19, text units179-182

One GP Board member confirmed that the style of GP behaviours towards each other in meetings made it difficult for some nurse members:

> *" As a Board we are an outspoken, argumentative bunch and certainly, two of the four nurses who have been on the Board have fitted that really quite nicely, the other two have been quiet wenches, and not said very much".* PCG GP member 21, text units 199-200

Some of the GP Board members noted that the nurse members employed within the Trusts tended to only speak on certain types of topics raised at the Board, and contrasted that with themselves and with nurses employed in the GP practices. One GP Board member attributed this to the nurse members only having a narrow range of interests:

"I think we as GPs are able to see the overall impact on practices and see the issues much more widely. Although, of course, one of our nurse members is a practice manager so she has a similar sort of view. But in the main the nurses only see things within their own professional role and their organisational role". PCG GP member 2, text units 74-77

Some of the GP members were less categorical that they did not dominate the nurses and more aware of issues that might impede nurse members from contributing. These issues included their employment position, their lack of experience in Committees, and their lack of time to be as involved in the Board:

" I think it's been more a case of the nurses developing the confidence to put forward their views and I think that's something that will improve. But I think they have had difficulties because some of them, for example, are employed by a GP. And also being used to having involvement on Boards and talking in front of groups of people is not always something that people are used to and prepared to do. And I think perhaps not being self employed as well they have had difficulties finding the time to do as much as they would like to do." PCG GP member 29, text units 187-198

Two of the GP members commented that working with a wider group of professionals, including the nurses , had been one of the positive aspects of the PCG in comparison to the previous GP only commissioning arrangements.

9.4.2 Relationships between Doctors and Nurses: The Nurses' View

Most of the nurse members reported that they joined the PCGs Boards aware that they were in the minority to the GPs and therefore the GPs could dominate the proceedings. Some reported that having worked closely with GPs, they were aware of a GP culture that would not readily look for independent contributions from the nurses:

" Oh, I think I knew it would be very GP dominated, you're weighted by both the sheer numbers, by the personalities and by the stereotypical

attitudes about nurses really that sort of revolve around general practice". PCG nurse member, 15, text units 77 –80

The early period after the establishment of the PCGs was reported by most nurse members as the most difficult in their relationship with the GPs. During this period they related that the GPs dominated the discussions, reached decisions outside Board meetings and, while very pleasant to the nurse members, did not look for any contribution from them:

> *"To begin with it was bad. It got better. When it started up first, there was the seven GPs and myself and the other nurse. And they had already been meeting before they officially became a Board and so they established a cosy little club for themselves. And then we entered. They were exceptionally nice, but it was a little bit 'pat on the head'. You know ' two little nurses' coming in. Until they got to know me better and realised I'm not a' pat on the head' type*". PCG nurse member 17, text units 97-103

Some nurse Board members reported being frequently close to resignation in this early period, while informants from half the PCG sample reported that nurse members had resigned in the first six months:

> " *The two nurses we had at the beginning for a variety of reasons which were historical and personal, didn't manage to work with the GPs on the Board. That's all I can say, they didn't. And they left.*" PCG lay member 23, text units 355-357

However, three Board nurse members were categorical that from the outset they had no difficulties in their relationship with the doctors and the doctors did not dominate them. They were more than aware of the potential for low expectations of their input but had not experienced that in their Board membership. One of these nurses had joined the PCG Board a year after its inception after the previous nurse members had left the area. She was employed by a Community Trust and viewed her own and the PCG managers as the groups who attempted to dominate her activity on the Board. The second of these nurse members had been part of a commissioning group with the GPs prior to the inception of the PCG.

She, too, was employed by a Community Trust and reported significant problems in her relationship with the managers. She recalled that not only were the GPs welcoming but they were supportive over some of the problems with her managers. The third nurse member was employed in a general practice. Early on she had been made lead for clinical governance in the PCG. She had invested a significant amount of her own time in undertaking very operational activities with the general practices of the PCG to introduce the concepts of clinical governance.

The remaining nurse members described relationships between themselves and the GPs that were much more problematic in quite subtle ways. Two underlying dimensions created tensions in the relationships between doctors and nurses and challenged the concept of nurses as leaders: firstly, the assumptions of the inferior position of nurses to doctors and secondly, differences between nurses as employees and the GPs as independent business professionals. These will be discussed in turn.

The assumption of the less important position of the nurse was reflected in the reports of the GP members not recognising the nurses members had any opinions of value. Consequently, the nurse members reported that they had to constantly challenge this view and assert their right to participate. One of the PCG chief executive reported that in her PCG the GPs did not initially view the nurse members as having equal responsibilities to the GPs for running the business of general practice and therefore did not accept their right to air their views. The nurse members described challenging the GPs' attitude to them by:

- Asserting their opinions,
- Questioning the doctors' views and decisions
- Voicing their disagreement with the doctors in the meetings.

These nurse members recognised that they had to be assertive in making the GPs and the rest of the Board hear their views, although, as in this example, the level of assertion could be tempered through apology:

> *" Our Board has a stormy history and it has a number of strong characters on, which if you weren't fairly confident and perhaps have a 'sod you then' attitude, and that doesn't sound very professional, but sometimes you have to be confident enough to go in and say ' you have got to listen to me, I'm sorry'.* PCG nurse member 4, text units 502-505

Some of the nurse members and some of the lay members commented on the age of the nurse as significant, noting that they observed younger nurse members to be more assertive. Those nurse members who discussed age did so in terms of a younger generation of nurses educated to challenge doctors while their own generation of nurses were taught to obey doctors. The evidence in this small sample belies that generalisation. The one nurse member who all other informants in her PCG described as very assertive in challenging the doctors (to the point where the lay member described the GPs as being in awe of her) was very close to retirement age.

Most of the nurse members recognised that to assert their opinions they needed to be sure they understood the issues and context; consequently they invested time and energy in the first six to twelve months learning about those areas they felt weakest in. They also described learning, mostly through experience, how to construct their oral contribution in a way that was more likely to be heard:

> *"There have been quite sharp exchanges sometimes. You have got to know what you are going to say and prepare it and be quite clear, they* [the GPs] *can be quite unmerciful if you don't explain yourself very clearly, which is fair enough.* PCG nurse member 15, text units 496-498

Some nurse members described it as an ongoing struggle to have their voices heard. Others were clear that there were only certain parts of the PCG agenda that they engaged with because it was a) of more interest to them and/or b) they knew they were knowledgeable enough about it to feel confident in their views:

> *"If I don't know about something I keep my mouth shut and there is a lot I don't know about or its couched in very complicated language. And quite frankly, a lot that I won't say I don't care about but a lot of the agendas of*

PCGs is GP agenda. And I don't necessarily want to get involved in all that". PCG nurse member 33, text units 282- 284.

Although some nurse members chose to become involved in only some areas of Board work, others were more systematically offering different viewpoints to the GPs:

" *The nurses hold their own, they hold their own. And the only time one of them said 'oh, I agree with the doctor', all the doctors cheered.*" PCG lay member, 1, text units 142

However, these nurse members were aware that despite successfully challenging the doctors' views as to their place on the Board this did not necessarily change their views overall as to the position or visibility of nurses in primary care:

"*On the sub groups on clinical governance we find constantly that you would think that nurses and practice nurses out there didn't exist when it comes to issues around money for education and training. We constantly have to remind them* [the GPs] *that they are not the only people involved in delivering health care*". PCG nurse member 17, text units 120-127

One of the nurse members concluded that, despite challenging the status quo over the lifespan of the PCG, she remained excluded from much of the decision-making. She was also the one nurse member who argued that as a woman she experienced exclusionary sexist attitudes from the male GP members:

" *I've always felt that we* [nurses] *were rather tokens on the Board, and it's a bit of a male doctors club. We've had a few workshops and things to try and develop the Board, and then I have felt quite included. And to some extent the sexism was less obvious so I have had some quite interesting and meaningful conversations with doctors then. But when we are just in a Board meeting, I still feel a bit token like and I still feel there's an awful lot of stuff going on that I haven't got the faintest idea is going on*". PCG nurse member 40, text units 59- 66

There was only one other comment by a nurse member concerning gender. She noted that a female GP in the Board chair position ensured that Board meetings were conducive to nurse participation rather than discriminatory.

The second dimension of tension was between the culture of the majority of the nurse members as state employed professionals and the culture of the GPs as independent professional business people. Many of the nurse members employed by the Community Trusts found the underlying assumptions about general practice as a business difficult to comprehend and to work with:

> " *The doctors and money situation really always seems to be at the forefront. It always seems to be about them beavering away and working out systems to line their own pockets, it's quite a different culture from being an NHS employee all your life, it's really hard to come to terms with".* PCG nurse member 40, text units 139- 141

Even those nurse members who worked in general practice found examples where the business culture of the GPs was discordant:

> " *I think I've seen it all, but every now and then something comes up. This was at a public Board meeting, the GPs sought clarification as to whether they could claim an item of service payment for 'flu vaccine that was given by a district nurse. And I just found that absolutely staggering that they thought they should be getting paid for something they hadn't done."* PCG nurse member 15, text units 150-155

Some of the nurse members had never had to deal with the business culture of general practice before and challenged aspects of it in the meetings of the Board:

> " *Yes, It* [the GP business focus of the meetings] *did make me angry and I didn't actually keep it quiet that I was finding it difficult, I did voice my view on the board, so people knew that I was finding it difficult".* PCG nurse member 8, text units 68-70

These PCG nurse members reported that the meeting agendas were filled with items related to the business of general practice. They reported attempting to challenge the focus by trying to get additional items on the agenda and by

constantly raising the issue of the wider population and workforce perspective. These strategies received a variety of responses from being ignored, to *'friendly running battles with the chairman'*, to something that could be interpreted as more acrimonious:

> *"I think the GPs need to be reminded that we are actually there for the patients in (*PCG name*), which we do say quite often in meetings. One of the GPs said that I should have it tattooed on my forehead. "* PCG nurse member 3, text units 100-102

One nurse member reported that her PCG Chairperson and Chief Executive had in fact attempted to stop her challenging the GPs on the Board. In this Board, individual meetings were held with all the Board members by the Chairperson and Chief Executive in order to discuss how their Board membership was developing. The nurse member reported that they had told her she was too outspoken and that this was counter productive on the Board. The Chairperson had told her to change her Board behaviour. The nurse member reported that her reply was to agree to differ.

The majority of the nurse members stated that at the time of the interview they had good relationships with the doctors on the Board and that their views were listened to, not necessarily agreed with, but definitely heard.

9.4.3 Relationships between Doctors and Nurses: the Views of Managers and Lay Board Members

The other informants held mixed views about the relationship between the GP members and the nurse members. Generally, the managers inside and outside the PCG observed that the GP members did not expect the nurse members to have an opinion or one of value on PCG issues:

> *" It's been very difficult for the nurses to take an independent view which has been taken seriously by the doctors".* Health Authority Director 11, text units 44- 46

Some managers observed that it was not just that the views of the doctors dominated the PCG but the behaviour of the GP members implied that the nurse members were almost invisible. Some managers analysed this as the GP members perceiving nurses as people who followed orders rather than had an independent input:

> *"There does seem to be this strange relationship there between the GPs and the nurses. It's like the traditional relationship between the GP and the nurse, the GP tells the nurse what to do. It's a bit like that in the GPs not hearing the nurses* ". PCG Chief Executive 6, text units 208-210

Some of the PCG chief executives confirmed the nurse members' viewpoint that the GP members were dominant during the early period of the PCG but that this changed during the life of the PCG:

> *"They* [the nurses] *were intensely frustrated for a great period of the first year, because they felt that they were not acknowledged to the degree they should be. They felt they were outnumbered. They had never done anything quite like this before. They were not used to the style. They felt they had come into a group of GPs, all of whom knew each other and were used to working together. And that they were the outsiders".* PCG Chief Executive 39, text units 178-183

One PCG chief executive was adamant that the GP members intimidated the nurse members and subjected them to blatant sexism. She pointed out that the GP members accepted challenges from the lay member but would not accept them from the nurse members. The lay member in this Board agreed that the nurses had been dominated by the GP members but cited the reason as the lack of nursing issues on the agenda. The nurse member in this PCG reported that she had good relationships with the GP members and they were very supportive of her. The dissonance of accounts is an issue that occurred repeatedly in this area of inquiry.

One Health Authority Director, who had a medical background, analysed the relationship not just through the occupational assumptions of medical dominant and nursing subordinate roles but also through assumptions of male dominance

over females. She and the PCG chief executive discussed in the previous paragraph were the only two managers who mentioned the gender distinctions. This Health Authority Director also drew class distinctions between the two groups in her analysis:

> "*If you start being told you are going to be a doctor from the age of 18, you do get quite socialised and if you are a man as well! Well, we have had some problems about sexism in the Boards. I think it's the whole package isn't it: you are nurses, so doctors think you're handmaidens. You're earning a quarter of what the doctors are earning. You are more likely to be female, yeah all of that, what a package*!" Health Authority Director 30, text units 144-159

Some of the managers and the lay members attributed the weaker position of the nurse members to their lack of knowledge on many of the financial and health planning issues, combined with their lack of experienced in corporate governance. Some managers commented that the behaviour and attitudes of the nurse members implied they were in a subordinate position to the GP members. The Community Trust managers, who had been nurses, were particularly critical of the nurse members they observed in this respect:

> "*I was genuinely someone who believed this had to be practicing nurses. They would have the impact. But honestly, with practicing nurses, there is still, and I can't believe it but it's true, this subordination*". Community Trust Director 5, text units 387-389

The managers external to the PCG were more likely to describe the nurse members as being dominated by the GPs. The PCG chief executives were more likely to describe a difficult relationship in which they, the chief executives, facilitated an improvement in over time. In contrast the lay members were more likely to describe nurse members who were assertive and made their opinions known without any help from Chief Executives:

> "*Certainly the first one* [nurse member] *who was the Locality manager wasn't dominated by anybody, she was very assertive. The two we've got now are much younger; they are quite senior in the community trust, but much younger. They're not dominated, they will say what they think, and*

it's just that their range is rather more focused". PCG lay member 25, text units 337-342

The contrast between the lay member perceptions and the managers' perceptions of this relationship is most notable. One explanation could be that the lay members, also in the minority and struggling to have their voice heard, recognised behaviours in the nurses that the managers did not see.

In contrast to other views, one Trust Director was exercised by the developing alliances between the nurse members and the GP members:

" *And some of them* [nurse members] *are going native and becoming friends with the GPs as well*". Community Trust Director 7, text unit 100

The nurse members, like the GPs, had mixed views as to whether they were interested and willing to put themselves forward for a place on the professional executive committee and Board of the PCT. Some of the nurse members were keen to continue their involvement into the PCT because they had enjoyed their experience on the PCG and were proud of the achievements to date. Some of them felt that their knowledge and position on the Board had been hard won and should not be lost. There was a concern amongst most of them that new nurse members of a professional executive committee should gain from their learning or at least should be made aware of the types of knowledge that they would need. Some of the nurse members were clear that the experience had been costly to them personally, either in time or self-esteem, and they would not be pursuing a place on the professional executive committee.

9.5. The Board Membership Role Undertaken in Conflict or Collaboration?

This chapter demonstrates that the nurse members were enmeshed in complex relationships with both the managers and the GPs. The tensions experienced between the managers and the nurses were different from those between the managers and GPs. Conflict theorists argue that professions use their professional membership as their authority to lead and that conflict with the

managers' authority derived from their position in a hierarchy. This was broadly true for the managers and GPs relationships. However, managers from different points in the NHS hierarchies viewed the nurse members in different ways. They were almost unnoticed by the managers in the Health Authority, and as such reflected Robinson and Strong's observation of the invisibility of nurses and nursing in the policy making of the NHS (Robinson and Strong 1989).

Managers from the Community Trusts viewed the nurse members' position as problematic and a challenge to their authority. The nurse members' position through the Board technically gave them authority beyond their place in the line-managed bureaucracy. The ambiguity of their position provoked mixed responses from the managers: from ignoring them, to hostility, to attempting to control them and occasionally to support them. The overarching impression was that the front line nurse members presented a challenge to the established order of the hierarchy and as such the managers within the hierarchy attempted to find ways of reducing the challenge. This contrasts with the analysis of Robinson and Strong (Robinson 1992) in which they argue that the invisibility of nurses was an accidental by product of the power struggles between medicine and managers. The nurse members recognised the tension between themselves and the managers in their own organisation. They identified the different strategies employed by the Trust managers to control them and expressed little surprise, although they were outraged at the withholding of finance for locum cover. The nurse members mainly reported avoiding overt challenges with their managers, using tactics of passive resistance and accommodation to the situation. Some nurse members reported that other nurse members allied themselves with the GPs in order to challenge the Trust managers. The nurse members contrasted with the GPs in that they were employees, whereas the GPs were not. As one GP pointed out this resulted in a significant difference:

> " We *couldn't care about the Trust managers, unlike the nurses*". PCG GP member 9, text unit 73.

While the nurse members recognised the tension with their own managers, none of them reported a tension with the PCG managers. The PCG managers appeared to be supportive their Board members but were often acting in ways

that negated a leadership role for nurse members. The roles that the PCG managers particularly valued in the nurse members were not ones of leadership. The PCG managers were not involved in overt conflict but in alliances with other managers that challenged the authority of the nurse members.

One proposition of this study suggested that the increased numbers of female doctors in general practice would mean that roles would not be so closely associated with gendered occupational divisions. The study was however unable to comment on the impact of increasing numbers of female GPs because they were in the minority on the PCG Boards. The assumption that greater numbers of women would be reflected on the Boards was flawed and will be discussed further in chapter 10.

Chapter 10: Doctors and Nurses in the Driving Seat of PCGs?

10.1. Introduction

Four propositions were made at the beginning of this study . They were that:

1. The doctors and nurses would not equally hold leadership roles. The dominant structural interests expressed in the Board activity would be medical and specific to the general practitioners
2. There would be conflict between the professionals and the managers as to the role of professional leadership in the activity of the PCG. This conflict would be experienced differently for GPs and nurses
3. The increasing numbers of women GPs would mean that gendered experiences of Board membership would be less clearly associated with occupational groups
4. The nurses would have a differential experience of leadership according to a) their position in the bureaucracy of the community health services or general practice, and b) their clinical relationship to general practitioners

The study revealed a complex web of roles and relationships between managers and professional Board members and between GP and nurse members in the decision-making arena of the PCGs. The concept of leadership roles for professionals was simultaneously supported, challenged and subverted. The first propostion was supported :doctors and nurses did not equally hold leadership roles. The study revealed great complexity in distinguishing the dominant structured interests in the Board activities. It is this issue that will be explored in the first section of this chapter (10.2) by considering Alford's framework of dominant, challenging and repressed interests in policy determination as applied to the empirical evidence of this study.

The second proposition was supported, in that the professional and manager relationships were characterised by tensions and, sometimes, open conflicts. However, there was also evidence of collaborative working relationships and distinctions in the relationships involving managers from different tiers of the

bureaucracy, as well as different experiences for the nurses. The second section of this chapter (10.3) considers the neo-Weberian thesis of conflict based on differing sources of authority in the light of the empirical evidence of the study.

The third and fourth propositions were derived from theories concerned with the division of labour in the health service and the socially structured occupational relationship between nurses and doctors. The third proposition was not supported. Although women occupy half of all general practitioner positions in the UK this was not reflected in the PCG Boards. Women doctors were in the minority on the PCG Boards. The experience of leadership for the nurse members was shaped by their structured occupational relationship with doctors, gender was one component but there were many ohters that were equally significant.. The dominant position of medicine on the PCG Boards was socially structured and consequently it was hard to discern the element of the fourth proposition concerned with individual nurse members' clinical relationship with GPs. The third section of the chapter (10.4) considers the structured dominance of medicine and to what extent subordinate group theories explain the roles and experiences of the nurse members.

The absence of nurse Board member informants who held management posts meant that part a) of the fourth proposition could not be fully explored through contrast with nurse members who were front line clinical nurses. The experience of the clinical nurses, however, was influenced by their position as employees in a bureaucracy. The clinical nurse Board members and the interests of nursing were invisible in the work of the PCGs in ways that could not be explained solely by their occupational relationship medicine. The fourth section of the chapter (10.5) considers explanations for these observations that include neo-Weberian conflict theories between professionals and bureaucrats. It argues that the position of nurses has to be viewed not just in terms of the relationship with medicine but also in relation to the aspirations of managers

The chapter then considers the findings in the context of the emerging policy context, reflecting on lessons from the process of this study for future research. It

concludes by an examination of the nature of the policy of leadership roles for clinicians in PCG Boards.

10.2. Dominant, Challenging and Repressed Interest Groups

Alford (1975) developed a theoretical framework that has been used repeatedly in UK health policy analysis. He argued that the inertia and repetitive announcements of crises in American health care provision was the result of the interplay between three sets of structured interests. The dominant structured interest was the preservation of the professional monopoly of medicine. The challenging interest was to break that monopoly, drawing on the imperatives of a corporate organisation. The repressed interest was that of those not served by current arrangements either of the professional monopolists or the corporate rationalisers. The evidence from this study suggests that the assignment of all groups to one type of structured interest is an oversimplification that limits the analysis and understanding of the dynamics in decision making in the UK health arena. Alford's typology based on one structured interest, preservation of professional monopoly provides too broad a brush to understand the nuances of the power relationships in the interstices of local decision making for policy implementation in the UK.

None of the groups studied in this research fitted neatly into only one category of structured interest group. The GPs in particular were a poor fit. The GPs' dominant position on the PCG boards was politically structured. The membership regulations for PCGs were negotiated between the medical profession and the politicians to give GPs the majority of the seats and the most powerful of those seats (Anon 1998b). The GP members viewed themselves and were seen as leaders in these decision making bodies. However, they presented themselves as leaders of a challenging interest to two structured dominant interests within the NHS: the professional monopoly of the acute sector consultants and the corporate business agenda of the NHS. The GPs' defining interest was the maintenance of the professional monopoly of general practice, not of medicine. They came to the PCGs to continue the pursuit of the GPs' agenda, which was to both increase funding to primary care and make secondary

care more responsive to patient problems as perceived from a general practice perspective. The GP members neither saw themselves nor were seen as a unified interest group with doctors from other provider sectors. The Minutes of the Boards repeatedly recorded complaints at hospital consultants' disregard for GPs and their patients. Alford (1975), in his American analysis presents a medical profession homogeneous through its opposition to challenges to its monopoly over the production and distribution of health care. Ham (1981) noted in the UK context that dominant structured interest was not a generalised professional monopoly but the monopoly of the elite strata of medical school and hospital consultants in the specialities of general medicine and surgery. In this study, the medical profession was split and structured through a number of socio-economic factors that resulted in differing interests. GP members were often reported to hold conflicting viewpoints, but they were unified in attempting to change the current hegemony of hospital medicine. Alongside this unifying aim, the repeated references to the involvement of the LMC in PCG business would suggest that the collective professional interests of GPs continued to be as well organised as when observed in previous governance bodies (Alsop and May 1986). Further evidence for this was provided by Sheaff et al (2003) who suggested from their study in four PCGs in 1999 that the LMC had negotiated behind the scenes within the GP community to identify the GP Board members before going to election.

Alford (1975) did not posit a thesis of more than one structured dominant interest but the GP members argued that they were dealing with the hegemony of the acute hospital sector and the structured power of the corporate NHS to determine the resources for health care. Ham (1986) argued that the introduction of general management into the NHS had created a mechanism whereby the issues of the corporate rationalizers were now more powerfully placed on the agenda of local decision making bodies. Klein argued that the political history of the NHS was that of relationships between two dominant structured interests in the NHS (Klein 1983,1995, 2001). The GPs did not offer a view of themselves as dominant in the face of the corporate NHS managers. Rather they portrayed themselves as David to the Goliath of the corporate NHS: David-like through their championing of the patient and using their intellectual abilities, Goliath-like

in terms of its bureaucratic size and lack of intellectual abilities. The GPs did not view their interests as dominant or supported by the corporate NHS managers despite the continuous presence of a health policy stream since 1986 that proclaimed the importance of general practice to the NHS.(Department of Health and Social Security 1986).

The behaviour of GP members demonstrated three sub-groups:

- Archetypal professional monopolists who came to the PCG Board with a purely watching brief to ensure that their general practice interests were preserved. They did not engage in the corporate business agenda of the PCG.
- Modified professional monopolists who came to the PCG Board to actively challenge the dominance of both the acute sector consultants and the corporate managers of the NHS. This challenging interest was designed to defend and promote their own monopoly
- Boundary spanners (Williams 2002) who actively worked to the corporate business agenda of the NHS, taking on the mantle of corporate rationalizers on some issues and at some points in time. However, this did not mean they were trying to break the professional monopoly of general practice.

The potential to span the boundaries of interest groups has been noted before. Elston (1991) in her review of the validity of the de-professionalisation of medicine thesis (undertaken at the point of the introduction of the internal market in the NHS) suggested that some members of the medical profession were also members of the 'corporate rationalisers' interest group (p76) but acted to invoke new forms of professional control rather than managerial fiat. Contemporary accounts of the entrepreneurship of GPs in developing total fundholding and GP consortiums would suggest that these GP members were not alone in their boundary spanning activities (Colin-Thomé 1996, Paynton 1996).

The managers from different elements of the local NHS were also differentiated in their attitudes and behaviours to the GPs as professional monopolists. The

more distant the managers were from working directly with the GP members the more likely they were to resemble archetypal corporate rationalizers. Many of these described the creation of the PCGs as one step in a longer term strategy to break the professional monopoly of GPs as independent contractors and make them salaried employees of the NHS. The managers working closely with the GPs presented themselves as boundary spanners (Williams 2002) across the structured interests. They supported the professional monopoly of the GPs in some instances but also worked to the corporate business agenda of the NHS, which challenged that professional monopoly. They contrasted themselves to other NHS managers in this. Neither group within the GPs or managers had "gone native" to the other interest group but they were able to span the boundaries of the two interest groups (Williams 2002).

Alford (1975), and subsequent policy analysts using his framework, chose not to consider the presence of other groups of health care workers in the policy arena. Rendering large groups such as the nurses invisible may have produced a neat, tripartite model but it fails to account for all the dynamics within the policy arena. At the very least, it fails to acknowledge the diversity of interests in the labour costs and labour relations of the health care sector. Only by ignoring the scale of the health care labour force could Alford separate out the community as a separate interest group rather than one that also contained significant numbers of health care workers who experienced and witnessed the failures of the health care system.

The nurses in this study, like the doctors and the managers, demonstrated that occupational groups are divided between different structured interests. Unlike the GPs however, they were neither homogeneous in their occupational interests nor organised as a single interest group. The nurse members portrayed themselves as a challenging interest group. However, they could not articulate a unifying aim beyond their collective intent in taking up the places at the table and aspirations to articulate their own and their patients' experiences. At the same time as they had their interests repressed, the nurse members were active in both challenging the professional monopoly of medicine and general practice, supporting the professional monopoly of general practice, and challenging the

corporate rationalizers in the provider Trusts and the corporate NHS. The nurse members were always boundary spanners across the structured interests in order to attempt to place their own interests onto the agenda. The nurse members operated alone and in alliance with the GP members, the PCG managers and the lay members depending on which structured interest they were pursuing. However, the GPs and the managers rarely portrayed the nurse members as allies with a shared structured interest. The absence of the nurses and other health care workers from most analysis of the politics of policy makes it hard to test these observations against other empirical work. Participant accounts by nurse leaders in professional organisations detail their pursuit of mutual interests both with the medical profession and sections of the government and Department of Health to influence single issues in the interests of nurses (Clay 1987, Jones 2004). Dingwall et al (1988) argued that nursing was successful in promoting its interests only when these synchronised with the interests of the government of the day.

North noted that, "*the original tri-classification* [by Alford] *of interests is somewhat inflexible when fitted against the complexity of local markets*" (North 1995 p124). This thesis contends that the assignment of sectional interests (professionals, managers and the community) in health policy to one of three types of interest groups (dominant, challenging or repressed), as suggested by the Alford framework, is an oversimplification of a complex set of relationships and interests that exist at a local level in the NHS.

10.3. Conflict through Competing Sources of Authority for Leadership

Neo–Weberian theory posits conflict and tension between professionals and officers of a bureaucracy. In this study covert, and sometimes overt, tensions were a very tangible feature of the relationships between the professional groups in primary health care and managers in the NHS. Tension in relationships was a strong feature of the study although there were some professionals and managers working collaboratively between the structured interest groups for mutual benefit i.e. the boundary spanners (Williams 2002). The neo-Weberian thesis contends

that the tension arises through the different sources of authority each group draws upon. In this study, an added dimension was that the national policy guidance for PCG Board membership gave the doctors and nurses, but not the managers, the authority of a leadership role. Tension and conflict in relationships through contested sources of authority had some resonance in this study. However, it did not adequately explain the different types of relationships between the GPs and managers from different tiers within the NHS bureaucracy or the differential experience of nurses and doctors in their relationship with managers.

The neo-Weberian conflict thesis suggests contested authority through individual encounters in time and place. However, in this study the GP members presented an almost visceral antipathy to the managers in the corporate NHS bureaucracy. This thesis argues that a history of opposing perspectives has shaped attitudes between GPs and NHS managers. Commentators from within general practice have pointed to repeated examples of corporate and local NHS bureaucracy marginalizing primary care medicine (Fry 1977, Tudor-Hart 1988). Klein (1995) reported the bitter resistance of GPs to the General Medical Services Contract of 1990, which they saw as an infringement on their autonomy and the ascendancy of managerialism. Glennerster (1994) recorded the reluctance of Health Authority managers to support the establishment of GP fundholding, while contemporary accounts by GP fundholders were redolent with criticism of corporate NHS managers and bureaucracy (see for example MacLean 1996, Edmonds and Sloane 1996). The GP members in this study saw their contemporary tensions with corporate NHS managers as a continuation of past challenges to their expert knowledge, their autonomy and, significantly, their claim to NHS resources. It is noticeable that, in all the empirical studies of NHS Boards, the only two that reported a situation where the non-executive members seriously challenged the executive members were Boards on which the majority of the medical non-executives were GPs (Taylor 1977 and Ashburner 1993a).

The corporate NHS managers presented the tensions as the result of the GPs protecting their business interests and enhancing their individual practice income and services. While they viewed the GPs as leaders within the PCGs, they also

viewed them as a group to be managed into accepting the authority and imperatives of the bureaucracy. Those managers working in close proximity to the GPs actively avoided open conflict with them. The PCG managers in particular operated in ways that recognised both the GP business imperatives and the corporate NHS imperatives. This did not, however, affect their primary acculturation to their own group. Both groups expected the other to act in ways that supported their own priorities and these were not identical. Inevitably there was discord. GP members were most positive about PCG managers' when they acted on the directions of the GPs, in a manner reminiscent of administrators rather than managers. They were most critical about them when they acted in ways that demonstrated their allegiance to the NHS bureaucracy. PCG managers were most positive about the GPs when they supported their priorities, most critical when they considered the GPs were viewing issues through their own business interests and the collective interest of general practice. However, even when a PCG manager acted in direct opposition to the views of the GP members on the PCG she did so in a way to avoid open conflict. It is difficult to differentiate in this study whether the managers acted in these ways because they recognised the cultural authority of the GPs or because they recognised that they were outside the bureaucratic jurisdiction of the NHS. Given the evidence from other studies, which detail how general managers working with doctors employed in the same service actively avoided conflict (Harrison et al 1992), one must conclude that cultural authority played a significant role. As Hunter has pointed out, despite shifts in recent years in the relationships between doctors and managers within the NHS, doctors alone continue to hold public confidence in their judgement to "make life and death decisions" and all that flows from that (Hunter 1994 p19).

Shaeff et al (2002) argued from a study of four PCGs that the GP members who were active in the PCG business were evidence of the start of a professional 'restratification' i.e. a minority group forming a leadership elite within the medical profession. This conclusion mirrors the assumptions of the managers in the present study. The managers believed that the doctors held the authority, which managers did not have, to lead their peers. There was an assumption that membership of the medical profession gave the GP members the authority to

judge the quality of service and clinical practice of other GPs and that taking up a leadership role on the Board indicated that GPs were willing to take on this role. There is, however, nothing in the occupational history of general practice that suggests GPs have seen themselves as assuming any authority towards each other (Klein 2001). In fact the evidence from the Medical Audit Advisory Groups in primary care suggested that GPs actively resisted taking up such roles or letting other GPs attempt such roles (Humphrey and Berrow 1993). The managers' assumptions in this study were made at a time when a number of medical scandals had created a policy window that allowed the Labour government to establish a raft of managerially driven processes for the judgement of clinical medical practice (Salter 1998). Despite the fact that the GP Harold Shipman was being tried for the murder of fifteen of his patients at the same time as the data collection for this study, at no point did any of the GP members refer to the case or its implications for their role on the Board. There was no indication that the GP members saw themselves as leaders of other GPs or were willing to assume authority to make judgements on the clinical activity of their peers.

The managers and others did not view the nurse members as joint leaders with the GPs in the PCG, despite the assertions of the nurses to the contrary. In fact, the Board was structured in ways that made it unlikely that the nurses could be leaders, for example, the national constitution of the PCGs ensured that nurses were a minority group (Department of Health 1998c). Nurses in the UK have not achieved a professional monopoly or the cultural authority claimed by medicine (Salvage 1992, Witz 1994). Nevertheless there were active tensions and conflict between the managers in both the PCGs and the Trusts and the nurse members. The source of the tension was the attempts by the nurse members to assert the authority of their expert knowledge against the managers' assertion of authority from bureaucratic position. Theorists have not identified this as an aspect of the power dynamic in the NHS. When nurses have been considered, it is usually accepted, following the analysis by Trevor Clay (1987) and Jane Robinson (Robinson 1992), that the diminution of authority of nurses in the NHS was an accidental by-product of the attempts by the government and Department of Health to control the medical profession. The analysis offered here suggests

that, rather than accidental, the diminution of nurses' authority has been actively pursued by managers throughout the elements and tiers of the NHS. What is not clear and would need further investigation is the source of the motivation to subordinate the nurses. Is the motivation to ensure the power and status that accompanies a large staff budget in a bureaucracy remains with the managers, or is it one element of the corporate rationalizers' struggle with the professional monopolists as to who controls the subordinate group?

10.4. Relationships between Doctors and Nurses

The empirical data of this thesis is drawn from an arena that is not direct clinical activity and this distinguishes it from other published studies that have considered the relationship between doctors and nurses. There was technically no division of labour to be made between occupational groups sitting on a governance body, unlike in clinical care settings. Identifying which profession was ultimately responsible for the clinical care of the patient, which is the usual litmus test of power, did not apply in this arena. So how did the doctors behave towards the nurses and how did the nurses respond in this context?

The doctors' behaviour was not ostensibly a repertoire of dominance: it did not need to be. The national negotiations had ensured the GP members the numeric dominance and the most influential positions. The doctors declared they were not dominating over the nurses. They explained the limitations they perceived regarding the nurses' contribution in ways that did not devalue the nurses or place them in a subordinated role. They variously attributed the limitations to nurses' employee status, to their inexperience and to their lack of knowledge of business issues in the NHS. There was, however, no suggestion that the structured position of nursing should be changed. In some of the PCGs, the GP members were reported by others as positive or at least neutral to nurses actively participating in aspects closely linked with a leading GP or in an aspect of marginal interest to the GPs. However, overall others reported a range of GP attitudes and behaviours that did indicate a view of the nurses as subordinates. These included:

- Considering the nurse members' views as irrelevant so not seeking them or hearing them once expressed,
- Excluding the nurse members from the behind the scenes decision making fora,
- Not tolerating opposing viewpoints from nurse members,
- Belittling contributions by nurse members,
- Being positive when nurse members undertook administrative tasks.
- Expecting nurse members to take a subordinate role to the GPs,

The overall impression was that the GP members acknowledged a space for the nurse members but generally did not engage with them. It was noticeably in this small sample that the nurse member who reported the most exclusionary and negative attitudes from the GP members was a member of the only Board with no women GPs. The only female GP chair of a Board was singled out as actively managing meetings and the Board in ways to include the nurses. Despite the fact that women represent a significant percentage of practising GPs (Royal College of General Practice 2004), they were in the minority on the PCG Boards in this thesis. There is no published data to confirm if this was representative of the national situation. However, some studies in other European countries have identified that female doctors are less likely to be in leadership roles than males (Kvarner et al 1999). This raises questions for further research: to what extent do women GPs participate in arenas beyond their practice and what factors influence that participation? Further research would be also be needed to explore any correlation between the presence of women GPs and the participation of nurses on these and subsequent Boards and Professional Executive Committees in PCTs.

While the dominance of medicine in the constitution of PCGs was an example of Lukes' (1974) third dimension of power i.e., structured into the institution as the natural order of things, it was not hidden from the nurses. The nurse members were more than aware that they were in a situation that was structured against their effective participation and that assumptions would be made by GPs that they were subordinate. However, the nurses also worked in posts that placed

them at different degrees of proximity in clinical work to GPs. This meant some were very familiar with GP attitudes to nurses and others less so. This variation, combined with the range of attitudes from the GP members, resulted in an array of responses from the nurse members. These responses were either in a mode of resistance and challenge or in a mode of accommodation and mediation of their position. In this, they reflected what Clarke et al (1975) described as a repertoire of strategies by subordinate groups to cope with as well as resist the dominant group. Some of the nurse members resisted the subordinate role to which they had been assigned by insisting on voicing their opinion. A few of the nurse members went further and challenged the subordinate role by voicing different opinions to the doctors and insisting on their right to be participants in the sub-groups with financial responsibilities. Some of the nurse members accommodated themselves to the assigned subordinate role but mediated that role in ways that maintained their own self-esteem. They took on roles and areas of work that were of marginal interest to the GPs in that PCG. These were rarely associated with the core financial business of the PCG. However, they were purposeful activities that had the potential to add value to the PCG Board work either with other health professionals or with the wider public. What is not clear from this thesis and would need further investigation is what characteristics in the nurse member and/or her work role might correlate with each mode of response to an assumption of a subordinated position.

The literature also suggested that a subordinate group creates its own culture, sometimes a counter culture, to the dominant group. The time frame of the thesis and the lifespan of the PCGs were too short to determine whether a culture specific to nurse PCG Board members was in the process of being created. The occupational diversity of the nurse members meant that it was hard to determine whether they brought a specifically nursing culture with them. These features also make it hard to discern any evidence of other elements of "oppressed group behaviour" (Roberts 1983).

10.5. The Invisibility of Nurses and Nursing in the Policy Arena

Understanding the relationship and responses between the medicine and nursing in this arena is further complicated because it was not an exclusive relationship: the managers were also significant. It is suggested that one effect of this triangle of relationships was to render nurses and nursing almost undetectable in the PCGs. The parts the nurse members played in the PCGs and the issues of nursing were invisible both in the Minutes of the Boards and also in the accounts given by other informants. It is suggested that this was neither accidental nor the product of incompetent nurse members. Rather the combination of structured mechanisms and the agency of the other interest groups, the doctors and the managers, produced this effect.

The national negotiations of the Board membership as detailed in Chapter 1 demonstrates the hegemony of medicine. The constitution of the PCGs reflects both Lukes' (1974) first and third dimension of power: the exercise of power in observable conflicts of interest and the latent conflict through the acceptance of a less influential position by the nurses. Other indicators suggested that the primacy of medicine remained a feature in the assumptions of the government and the civil service, for example, the Department of Health set a lower financial remuneration for nurse members than for GP members (Department of Health 1998d). Only the threat of legal action from one of the nursing unions, the CPHVA, on the grounds of sex discrimination changed this (Kline 1998).

Once on the Board, a number of mechanisms structured a less visible and influential position for the nurses. Firstly, the majority of the nurse members were disadvantaged by their lack of a communication infrastructure that the managers and the GPs took for granted in their work. Secondly, many of them were denied access to the finance for locum cover to release them from their clinical work for Board activities by their employing managers or the managers in the Health Authority. Thirdly, the business agenda for the PCGs was structured to primarily address the issues of general practice. The agenda for the PCGs was set from the corporate NHS priorities (Department of Health 1998). While these were not necessarily the priorities of the GP members, they were

primarily concerned with the business and financial aspects of the clinical activities of general practice. The agendas of the PCG Boards were dominated by discussion of the General Medical Services budget, the prescribing budget for general practice and the budget for acute sector service commissioning. The majority of nurse members in the study, and nationally (Cook 2004), came from the Community Trusts and not general practice. They had little knowledge of, and in some cases little interest in, controlling the financial flows into and from the business of general practice.

The effect of the GPs' and NHS managers' focus on financial issues associated with medical practice was to ensure that issues of concern to the nurse members were rarely placed on the Board agenda. Sometimes issues like the local shortage of nurses in the community nursing services reached the agenda. However, during the lifespan of the PCGs the central government had major policy initiatives that promoted nursing. These included;

- New types of nurse led services (Department of Health 1997, Department of Health 2000a),
- New roles for nurses that were previously medical roles (Department of Health 1999c),
- The creation of nurse consultant posts (NHS Executive 1999d),
- Expansion of the legal right for nurses to independently prescribe prescription only medicines (Medicines Control Agency and the Department of Health 2000).

There was a singular absence of these types of items on the PCG agendas and minutes in the study. The National Tracker Study of 69 PCGs portrayed a similar picture. Although the majority of chief executives and chairs reported that investment in nursing services was a high priority, less than a third had any development underway (Dowswell et al 2002). The nurses may have gained a seat *at* the decision making table but their collective occupational interests did not make it *onto* the table.

The nurses and nursing were invisible in the accounts given by other informants and in the records. In most instances, this was dissonant with the account the nurse member gave of their involvement and activities. There are problems in all interviews where participant informants present a public persona that is positive and restrict information that might suggest the contrary (Robson 2002). In Goffman's terms, this is the presentation of the front stage persona and the obfuscation of the back stage so that the individual's status is maintained or enhanced (Goffman 1959). However, there were examples in this study in which the nurses had named and publicly recorded leadership roles but doctors, managers and lay members attributed the activities of that PCG business stream to either doctors or managers. The empirical data revealed that the nurses' accounts of themselves were not just a public presentation to maintain status and self esteem.

To note the invisibility of nurses and nursing in the policy world is not new. Robinson and Strong highlighted this phenomenon in the policy research undertaken to examine the impact of the introduction of general management on nursing (Robinson 1992). They offered " the black hole theory" in which they argued the internal preoccupations of nursing locked nurses into a gravitational force that made them invisible. This was the social equivalent of an astronomical black hole from which they were unable to extricate themselves and others were unable or unwilling to look in (Robinson 1992). Seen through the lens of subordinate group theory, this internal preoccupation can be interpreted as a mechanism to accommodate to the situation and create an alternate culture to the dominant group. Robinson argued that in part the lack of well-educated nurses accounted for the inability of nurses and nursing to escape from the black hole. This view seems to suggest that the problem of the invisibility of nurses and nursing stems to some degree from their own agency.

Celia Davies (1995) has offered an analysis that challenges this almost victim-blaming stance. She locates the occupation of nursing in a world shaped by two social institutions: profession and bureaucracy. She argues that these two institutions are inherently masculine in their cultural codes and as such actively devalue occupations and activities that embody feminine attributes. Critiques of

this analysis have suggested it has dealt in stereotypes without considering the empirical realities (Latimer 1996), or the active agency of nurses in the structure of their occupational world (Wicks 1998). It is hard to discern social institutions in the UK that do not demonstrate the hegemony of masculinity, however, the nurse members in this thesis became invisible in ways that the female GPs, managers and lay members did not. How can this be accounted for?

This thesis suggests that the position of nursing was significantly influenced firstly, by the occupational strategies of both medicine and managers and secondly, by the health service managers' struggle for power and influence with the medical profession. Both occupational groups need the nursing workforce to occupy a subordinate position to their own. For medicine, the subordination of other occupational groups, particularly nursing, is an important mechanism for maintaining professional monopoly. For health service managers, their bureaucratic power and status is derived from the size of the budget and the numbers of staff they directly control. The control of the nursing workforce as the largest staff group in most health organisations is therefore important in order for many managers to maintain their position. Authority derived from senior positions in the bureaucracy enables managers to interact with doctors in different ways to managers lower in the bureaucracy, both in collaboration and in conflict.

However, this does not fully explain why issues related to nursing did not appear in the Minutes and agendas. It is possible that they were just crowded out by the need to attend to general practice issues. Nevertheless, the government policies and legislative changes towards nursing just before and during the data collection period gave the managers mechanisms whereby they could extend their influence over health care and diminish that of medicine. The legislative changes enabled some nurses to provide medical services autonomously of doctors. This was potentially a substantial tool for local corporate monopolizers to challenge the monopoly of medicine. However, items related to this new legislation rarely reached the PCG Board discussions and, in the light of their potential use to the managers, this was surprising. Ham (1986) had already demonstrated that the introduction of general management in the NHS had allowed the corporate

rationalists to place their items on Board agendas, which had not happened previously. So, it is unlikely that if the managers chose to pursue these issues they would not reach the agendas. So why did these items not reach the PCG?

It is suggested in this thesis that these legislative mechanisms have the potential to make some nurses emulate the expert knowledge base of the medical profession and therefore move outside of the mainstream NHS bureaucratic structures. It is suggested that the need to ensure nursing remains subordinate to local health service managers might explain the absence of the government policy for nursing from PCG agendas. These conclusions are illuminated by an aspect of White's (1985) thesis on the relationships between nurse managers and the other interest groups internal to nursing: generalists and professionalists (detailed in section 2.5). White argued that nurses who moved into managerial positions, assimilated the values and behaviours of managers in the NHS. She contended that the managers preferred the generalist nurses, as they did not challenge their authority. When viewed through a lens of competing power bases, the interpretation of the relationships alter. The managerial group of nurses has gained the only source of authority that brings nurses and nursing status in the eyes of others, that is a budget holding position in the bureaucracy. The nurse managers may or may not prefer generalists to professionalists but what they need is the numeric volume of the generalists under their control to derive the accompanying budgetary status. This analysis suggests that the status and authority of nurses would be in direct relationship to the size of the operational budget they held. The absence of budget holding nurse members in the thesis sample was a weakness in the design as discussed in section 5.7, although difficult to overcome given the small numbers nationally (Cook 2000). Further study would be required to compare the status and authority of budget holding and non-budget holding nurses with places on decision making bodies such PCT Boards, Professional Executive Committees and Foundation Trust Boards.

These conclusions do not negate the influence of a gendered culture of the overarching social institutions. Rather they illuminate one aspect of a complex set of social relationships. Likewise, the study is unable to make comment on

the impact of social class on the mechanisms that made the nurses invisible. Some informants alluded to the issue through the indicators of occupational remuneration levels and educational attainment. However, the study did not systematically collect data on these factors to draw conclusions on the impact. Further study is required that systematically records and compares proxies, indicators and features of social class in the UK for women and men from the different occupations and holding office in decision making bodies.

10.6. The Current Context

Despite the fact PCGs had some unusual characteristics and a brief life span in the organisational turbulence of the NHS, they embodied policy themes that have continued after their demise in PCTs and Foundation Hospitals. In summary these were:

- The devolution of decision making to a local level,
- The incorporation of general practitioners in the mainstream of the NHS through commissioning of other health services, developing locality wide primary care and clinical governance processes,
- The presence of doctors, managers, nurses and lay people on governance bodies.

Policy themes of devolved decision making have been set out in the '*Shifting the Balance of Power*' papers (Department of Health 2001,2001c, 2002) and re-iterated in the overall plans laid out for 2004-8 (Department of Health 2004). Klein (2001) has argued that as the policy arena at the local level opens up, so the central government control increases through performance management techniques. The tension between these two policy elements was well illustrated in this thesis of the Primary Care Groups. The empirical data also indicated that the activities of the intermediary layer(s) of bureaucracy between the Department of Health and the local level increased tensions. These tensions fed into the general practitioners' negative views towards the bureaucracy of the NHS to the point where many of those who empathised with the wider agenda of corporate rationalisation were sceptical and disaffected. This dissonance between

increased local decision making and increased central control has the potential to disengage those GPs who span the boundaries between interest groups in the new and emerging governance arrangements in the NHS. The Primary Care Trust commissioning managers cannot afford local GP disengagement because of the central role of GPs in the cost containment of the hospital sector, the increased care delivery in primary care and the maintenance of public confidence in their actions. The new GMS and the expansion of PMS contracts for general practice has also moved detailed decision making on general practice finance from national negotiations between the Department of Health and the BMA General Practice Committee to the PCT level (Neal 2004). This study demonstrated that the managers who worked most closely with the GPs took a boundary spanning perspective towards the professional monopolists and avoided outright confrontation. It therefore seems unlikely that without significant number of GPs becoming boundary spanners to the corporate rationalists, the managers will be effective in shaping local GMS and PMS contracts to address PCT wide resource and access equity issues.

These issues overlap with the second policy theme, that of incorporating GPs in the mainstream of the NHS. It has been suggested that incorporating doctors into the management activities of the NHS offers a mechanism for asserting authority over the medical profession (Harrison and Pollitt 1994). The GPs continue to have a strong numeric presence in the governance and commissioning activities of the PCT (Department of Health 2003c). However, the study demonstrated the ambivalence of GPs to both engaging in the priorities of the mainstream NHS and also to assuming authority to question the clinical practice of peers. Even amongst GP Board members, there were those who did not engage in the PCG activities and behaved as archetypal professional monopolists. This ambivalence was demonstrated more recently in the reticence to hand over the provision of out-of-hour services to the local PCTs (Pati 2004). It is also demonstrated in the re-emergence of individual general practices holding commissioning funds on behalf of their patients rather than remaining as part of a collective commissioning endeavour within a PCT (Rutter 2004, Lewis 2004).

It is suggested in this thesis that the tensions and conflicts observed between GPs and Community Trust managers are likely to become more evident as GPs gain greater power and authority in the local health economy through this initiative. The presence of three very different sub groups (boundary spanners to the corporate rationalists, modified professional monopolists and archetypal professional monopolists) suggests that practice based commissioning will gain ground. Many GPs are likely to draw on their collective memory to contrast their experience of GP fundholding against their frustrations at participation in the PCGs, documented here. They are likely to opt for a return to a mechanism that will be under their control to pursue their dual aims of developing their general practice services and making the hospital sector more responsive. The tensions and conflicts between GPs and managers, evident in the commissioning networks surrounding GP fundholding (Flynn et al 1996), look set to re-emerge. An early marker of the increase in GP authority, vis-à-vis the community managers, will be the speed with which those areas, with practice based commissioning, re-attach their community nurses back to the general practices from their geographical patch coverage, an arrangement which has regained ground since the demise of GP fundholding (Anon 2003). This example of the triangle of relationships is linked to the third policy theme.

The third policy theme was the presence of multiple stakeholder groups on governance bodies. The continuation of this theme is demonstrated in the revised Parliamentary Directions for the PCTs (Department of Health 2003c) and in the membership policies of the Foundation Trust Boards (Department of Health 2002c). The policies ostensibly support a structured position of greater numeric strength for lay members. In principle, the community is no longer a repressed interest group. However, anecdotal evidence suggests the cultural authority of the medical profession remains a deterrent to challenges from lay members in PCTs (Edwards 2004) and the powers of governors on Foundation Boards were subject to much pruning before legislation (Smith 2003). Although the number of places assigned to the medical profession in PCTs and Foundation Hospitals precludes overall numerical dominance, the wider medical hegemony is not necessarily diminished. The membership guidance for Governing bodies of the Foundation Trusts does not specify places for nurses,

rather including them in a general staff allocation, but it does specify places for the medical director and representatives of any local medical school (Department of Health 2002c). The government membership directions for Professional Executive Committees (PECs) offer the possibility of equal numbers between nurses and GPs. There are no nationally available figures on the balance of constituent groups in the PECs or their representation on the PCT Board. However, a scrutiny of several London PECs with their membership posted on the internet suggests that the local negotiations of the PEC constitution has resulted in the maximum number (allowed by the government directions) of places for the GPs, combined with the Chairperson position, in contrast to the minimum number of places for nurses. The numeric assignment of places is a very tangible demonstration of potential power and influence on a governing body.

Although this thesis could not identify the precise mechanisms that operated to reduce the nurses to invisibility, it provided further evidence of their presence. The invisibility is a consequence of a tapestry of structured elements. The hegemony of the medical profession provides one set of threads, interwoven with the subordinating activities of medicine and health service managers in the maintenance of their position. The class and gender divisions between occupational groups are another set of textured threads, often difficult to separate in the wider tapestry of relations. These divisions are not easily altered. The route of social mobility through a university education for nurses has been deflected. The academic level for nurse registration has been set as a diploma and even that has been challenged (Meerabeau 2001). The underlying social class background of current cohorts of medical students remains similar to past generations despite initiatives to alter it (Seyan et al 2004). The enormous increase of people from developing countries entering nurse training and nurse positions during the late nineties to meet the shortfall of UK applicants (Buchan 2004) is likely to increase occupational divisions based on country of origin and race. However, writ large across all of these is the division of gender and the hegemony of the masculine in society. While there are increases in men entering the occupation of nursing (Department of Health 2003), it remains overwhelming a female occupation particularly outside of hospitals (Drennan et al 2004).

Although there is discussion of the feminisation of medicine in the UK, female doctors are prepared to publicly acknowledge the need for their occupation to be seen as masculine in order to retain its power (Laurence 2004, Heath 2004). Against this tapestry of social mechanisms, it is unlikely that nurses with only clinical responsibilities will be viewed as more authoritative or influential in governing bodies than their predecessors described in this thesis.

Before addressing the final unanswered question of the thesis, it is worth reflecting on the process of undertaking this study in order to emphasis two issues that future researchers in this field should not lose sight of in designing their studies. An assumption was made in the beginning of this study that, given half the GP population of England was female, this ratio would be reflected in the PCG Board membership. It was an incorrect assumption. Careful consideration of the levels of participation of women in corporate and public bodies should inform future theoretical propositions and study design on decision making in the health service.

Although it was recognised in the initial period of study design that an empirical study focused on a specific policy initiative was at risk of a changing policy environment, it was not appreciated how fast those policy shifts would occur. The initial guidance for PCGs indicated that the governance body with the greatest autonomy would be a PCT, however, there was no indication that in less than eighteen months significant numbers of PCGs would disband and be replaced by PCTs. For this study, the PCGs became a very specific case study in one period of time. The interviews conducted with some key informants as they left the PCG became a strength in this study. However, the levels of organisational turbulence and disruption had the potential to make data collection impossible. Researchers planning to study social phenomena in particular health policy contexts should be alert the possibility that the context may be short lived, although the underlying elements may well endure in a new iteration.

10.7. Doctors and Nurses in the Driving Seat?

There remains one question as yet unanswered in this thesis on the leadership role assigned to doctors and nurses in the PCGs. Were the findings of the thesis were just an example of the real, but imperfect, world of policy implementation (Hogwood and Gunn 1984) or whether it was ever really intended that doctors and nurses should lead the PCGs?

It is suggested in this thesis that the policy statements of a leadership role for both GPs and nurses in PCGs were symbolic and has to be viewed within the context of the period that they emerged. Edelman (1985) first drew attention to the use of policy as a symbol of generalised values to the electorate by politicians. It is suggested here that the policy was intended to symbolise a diversity of values to the public, the GPs and the nurses.

The Labour government was, first of all, using the policy to symbolise to the public at large their support of the professionals over the managers. A major strand of the attack on the Conservative government by Labour in opposition had been the inexorable rise of the numbers and costs of managers in comparison to those of doctors and nurses since the introduction of the internal market (Webster 2002). It is suggested in this thesis that the policy was used to symbolise Labour's difference from the Conservatives. It demonstrated to the electorate that Labour drew on the expertise of professionals to lead the health service rather than the managers who had been leading the NHS through the well-publicised, pre-election crises of waiting lists, hospital bed shortages and professional exodus. In announcing the Labour party's plans for in the 1996/7 election campaign, the shadow Health Secretary stated that the value of the GP in the proposed locality commissioning groups was that "*they were the health professional closest to the patient*" (Anon 1996). In short, Labour drew on the cultural authority of medicine to augment public confidence in its ability to address the ills of the NHS.

However, this does not explain the symbolism of the nurses in these policy statements. The inclusion of nurses was symbolic in two ways. The first,

symbolised the value the Labour Party placed on nurses at a significant point in the general election campaign of 1997. The initial Labour Party manifesto for the health service did not include nurses (Anon 1996). The resulting negative press publicity for the Labour Party, together with polls that showed that about 40% of the 400,000 strong nurse work force were undecided in how to vote at the general election in April (Kenny 1997), rapidly brought generalised statements from the Labour Party of the inclusion of nurses in locality commissioning activities. (Anon 1997a). The second was to symbolise the value the Labour Party placed on women. The creation of a named Minister for Women in the Cabinet (Prime Ministers Office 1997) and the transfer of the Women's Equality Unit to the Cabinet Office (Cabinet Office 1998) were two public symbols of the importance the Labour Party placed on this issue. At the time the detailed PCG guidance was being drafted, all government departments had adopted the use of the Women's Equality Unit's guidance for ensuring that all policies reflected equality of opportunity (Cabinet Office 1998). The inclusion of nurses, culturally defined as female, was a symbol of the visibility of women throughout Labour's policies. The cultural association of a gendered division of labour between doctors and nurses made this deceptively simple shorthand for equality of position for women.

At the same time, the Labour government was using the policy to symbolise to the medical profession as a whole and general practice in particular that it acknowledged the importance of having its members in a pre-eminent position in decision-making in local services. Klein has argued that the Labour government "had flattered the medical profession into acquiescence, with the threat of battering held in reserve," (Klein 2001 p 211) to its policies for national equity in the efficiency and the quality of the clinical activities. It is suggested in this thesis that this particular policy statement was one element of that flattery.

The Labour government also used this policy as a symbol to the nurses of the value they placed on nursing in the NHS. It is suggested that the Labour government was also using flattery as a technique with the nurses. An analysis (Davies 2004) of a national policy for nursing, which was produced in the first year of the PCG's existence, confirms that the rhetoric of flattery was very

evident in this period. The government needed the acquiescence of nursing not only to the expansion of its work roles into new types of service and previously medical domains but also crucially, to containment and curtailment of its aspirations for increased financial rewards. This was particularly relevant in the first years of the Labour government when the Chancellor had spending plans of less than 1.1% real growth (Klein 2001).

It has been noted many times that it is the local level negotiations and power plays that shape the degree of implementation of a national policy (Hill 1997). This was true in this study, where the extent to which doctors and nurses were considered and considered themselves to be leaders in the PCG was shaped by very local power relationships internally and externally. So, were *"Doctors and nurses in the driving seat of Primary Care Groups"*? (Department of Health 1997 5.1) The extent to which individuals believed the policy statements in the first place depended on their previous experiences in health care politics arenas and the health services. However, this policy was also symbolic of the claim to decentralise decision making without a return to *"the old centralised command and control systems of the 1970's"* (Department of Health 1997, Foreword). In reality, the performance management policies of the centre combined with the accountability to another intermediary layer of the NHS meant effective decentralisation of decision making to the local level of the PCG was very unlikely (Klein 2001). The disjuncture between the policy symbolism and the implementation was all too apparent to many of the study participants, and is perhaps best summed up by the GP who agreed that the experience had been one of being in the 'driving seat' but without any control on the direction or speed. In his words: *"The driving seat has no wheel and no pedals"*.

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Glossary and Organisational Acronyms

AHA	Area Health Authorities (1974 – 1981)
AMAC	Area Medical Advisory Committee (1974 – 1983)
DGM	District general manager (1983- 1991)
DHA	District Health Authority (1981 –1995)
DHSS	Department of Health and Social Security (1970-1981)
DMT	District Management Team (1974-1981)
FHSA	Family Health Services Health Authority (1991-1995)
FPCs	Family Practitioner Committees (1974 –1991)
HA	Health Authority (1995 – 2002)
GMS	General Medical Services
RHAs	Regional Health Authorities (1974 – 1995)
LMC	Local Medical Committee (1949- present)
PCG	Primary Care Group (1999-2002)
PCT	Primary Care Trust (2000 –present)
PMS	Primary Medical Services
SHHD	Scottish Health and Home Department (pre- 1974)
StHA	Strategic Health Authority (2002- present)

Appendices

Appendix 1: Summary of Membership of Local Decision Making Bodies in the NHS 1948-2002

Table 1: 1948 -1974 Health Service Decision Making Bodies at a Local level

Local level organisation	Responsible for Health Services	Mandatory advisory committees	Membership details	Legislation guidance
Group Hospital Management Committees (HMC)	Hospitals other than teaching	Medical Advisory Committee	Appointed by the Minister of Health.	1946 National Health Service Act Schedule 3 gave membership details of Regional Boards
Boards of Governors of teaching hospitals	Teaching (medicine) Hospitals	Medical Advisory Committee	Appointed by the Minister of Health.	1946 National Health Service Act Schedule 3 gave membership details of Boards of governors
Local Executive Council	General medical and dental service, pharmaceutical services and supplementary ophthalmic services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee Local Optical Committee	25 members with a statutory minimum of 4 medical members. Members representatives of the Local Authority Health Committee, the Local medical, dental, pharmaceutical committees. The chairman was appointed by the Minister for Health	1946 National Health Service Act
Local Authority Health Committee of a Council of a county or county borough	Home helps, home nursing, health visiting, ambulances, environmental health		The majority had to be Council members. Encouraged to co-opt doctors, nurses and midwives as members (source McEwan 1959)	1946 National Health Service Act Local Government Act 1958

Table 2: 1974 - 1983 Health Service Decision Making Bodies at a Local level

Local level organisation	Responsible for Health Services for	Mandatory advisory committees	Membership details	Legislation statutory instruments and guidance
Area Health Authority	Hospital and community health services in Districts. Note the District management teams were only formed of executive managers	Area medical advisory committee Area nursing & midwifery professional advisory committee Area pharmaceutical advisory committee Area dental advisory committee Area optical advisory committee	Members 16-19 Chairman appointed by secretary of state Some appointed by Regional Health Authority 6 nominated by Local Authority 1 consultant 1 GP 1 nurse/midwife/ HV 1 medical school representative 1 trade unionist	White paper "National service Reorganisation: England. Cmd 5055 and DHSS Management arrangements for the reorganised NHS. HMSO 1972 National Health Service Reorganisation Act 1973 DHSS HRC (74)9 1974 provided model constitution for professional advisory machinery HC(80)8 Health Service Development : management structure . 1980 HC(81)6 1981
		Community Health Councils		
Family Practitioner Committee	General medical and dental service, pharmaceutical services and supplementary ophthalmic services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee Local Optical Committee	Members 20- 30 Equal numbers of professional and lay members, to include 1 nurse and 4 nominated from AHA 4 nominated by the local authority	DHSS HRC(74) 9

Table 3 : 1983- 1991 Health Service Decision Making Bodies at a Local level

Board	Responsible for Health Services	Mandatory advisory committees	Membership details	Legislation guidance
District Health Authority	Hospital and community health services	Medical advisory committee	Members 16-19 Chair appointed by the secretary for state for social services Some appointed by RHA 6 nominated by Local Authority 1 consultant 1 GP 1 nurse/midwife/ HV 1 medical school rep 1 trade unionist	Health Services Act 1980 DHSS 1980 Health Service development, structure and management, Health Circular (80) 8 DHSS 1982 Health service development: professional advisory machinery HC (82) 1
Family practitioner committees	General medical and dental service, pharmaceutical services and supplementary ophthalmic services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee Local Optical Committee	Members 15 Equal numbers of professional and lay 1 nurse 4 nominated from HA 4 nominated by the local authority	1984 Health and Social Security Act
		Community Health Councils		

Table 4: 1991- 3 Health Service Decision Making Bodies at a Local level

Board	Health Services responsible for	Mandatory advisory committees	Membership details	Legislation guidance
District Health Authority	A purchasing authority of hospital and community health services	None	Boards of Directors up to 11 5 non-executive appointed by RHA up to 5 executive including DGM and director of finance plus a non executive chair appointed by secretary of state (if a medical teaching area then a medical school representative in addition)	NHS & Community Care Act 1990 NHS Review Working Papers 1989 HMSO
NHS Trusts	Hospitals or community health services or a combination	None	Boards of Directors. Executive members must include a general manager (chief executive), a finance directors, a medical director and a nurse director plus up to 5 non-executive lay members including the Chair appointed by the secretary of state	NHS & Community Care Act 1990, section 5
Family Health Services Authority	General medical and dental service, pharmaceutical services and supplementary ophthalmic services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee Local Optical Committee	Members 11. Chairman appointed by Health Secretary. Chief executive RHA appointed other members, from local representative committees and other professional bodies. 5 lay members, 1 nurse in a personal capacity 1doctor, 1 dentist ,1 community pharmacist	NHS Review Working Paper 8, Implications for Family Practitioner Committees. 1989 HMSO
GP fund holders	Purchasing of hospital and community health services for practice patient populations	None	No requirement for Board structures	NHS & Community Care Act 1990
		Community Health Councils		

Table 5: 1995 - 8 Health Service Decision Making Bodies at a Local level

Board	Health Services responsible for	Mandatory advisory committees	Membership details	Legislation guidance
Health Authority	A purchasing authority of hospital and community health services General medical and dental service, pharmaceutical services and supplementary ophthalmic services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee Local Optical Committee (Under section 44 National Health Service Act 1977)	Members up to 11 5 non-executive appointed by RHA plus a non executive chair appointed by secretary of state Up to 5 executive including District General Manager and Director of Finance (If a medical teaching area then someone from the medical school to be included)	The Health Authorities Act 1995 NHS Executive. Ensuring the effective Involvement of Professionals in Health authority Work HSG (95) 11
NHS Trusts	Hospitals or community health services or a combination	None	Boards of Directors. Executive members must include a general manager (chief executive), a finance directors, a medical director and a nurse director plus up to 5 non-executive lay members including the Chair appointed by the secretary of state	NHS & Community Care Act 1990, section 5
GP fund holders	Purchasing of hospital and community health services for practice patient populations	None	No requirement for Boards	NHS & Community Care Act 1990
		Community Health Councils		

Table 6: 1998 -2002 Health Service Decision Making Bodies at a Local level

Board	Responsible for Health Services	Mandatory advisory committees	Membership details	Legislation guidance
Health Authority	A commissioning authority of hospital and community health services Family practitioner services	Local Medical Committee Local Dental Committee Local Pharmaceutical Committee ,Local Optical Committee)	Members up to 11 . 5 non-executive appointed by Regional Office plus a non executive chair appointed by secretary of state Up to 5 executive including chief Executive and Director of Finance. (if a medical teaching area then the medical school to be included)	The Health Authorities Act 1995 NHS Executive. Ensuring the effective Involvement of Professionals in Health authority Work HSG (95) 11
Primary Care Groups at level 1 and 2 are sub-committees of the Health Authority at levels 3 and 4 are free standing A	Family practitioner services Providing community health services Commissioning hospital and community health services		Members up to 11 6 – 8 GPs 1 lay 1 social services rep. 1 or 2 nurses Elected chair by GP members	Health Act 1999 Department of Health 1998, *Governing Arrangements for Primary Care Groups.* HSC 1998 230.. Department of Health 2001,. *Shifting the Balance of Power in the NHS*
NHS Trusts	Hospitals or community health services or a combination	None	Boards of Directors. Executive members includes a chief executive, a finance directors, a medical director and a nurse director plus up to 5 non-executive lay members including the Chair appointed by the secretary of state	NHS & Community Care Act 1990, section 5
		Community Health Councils		

Appendix 2: Letter of Invitation to Participate

Royal Free and University College Medical School
UNIVERSITY COLLEGE LONDON

Department of Primary Care & Population Sciences
Holburn Union Building,
Highgate Hill, London N19 3UA
Tel : + 44 (020) 7288 3522 **Fax:** +44 (020) 7281 8004
email v.drennan@pcps.ucl.ac.uk

Dear

Clinical Leadership in Primary Care Groups

We are writing to request your help with a study of clinical leadership in Primary Care Groups which is currently being undertaken in this medical school. The purpose of the project is to explore the part played by clinical professionals (GPs and nurses) on PCG Boards and assess their input to PCG development and strategy. The findings of the study will provide valuable information for planning the future evolution of PCTs.

We are undertaking brief interviews with a range of Board members (including GPs, nurses, lay members and chief executives) in 8 PCGs within the London region, chosen to represent a wide cross-section of populations and localities.

As a [*insert type of PCG member or informant*] we would be extremely grateful if you would agree to help us with this study by reflecting on your experience of PCG work. The interview would take approximately 20 minutes and could be conducted over the telephone at whatever time most convenient to you. With your permission, the interview would be audio taped and subsequently transcribed. All interview data are, of course, regarded as confidential and will be seen only by the research team.

Any subsequent publications or reports will be presented in such a way that anonymity is assured both for individual participants and PCGs.

We will contact you within the next week to find out whether you are able to help us with the study in this way. We fully appreciate the many pressures on your time, but hope nevertheless that you will be able to give a positive response.
Thank you very much for your consideration.
Yours sincerely

Ms Vari Drennan
Senior Lecturer in Primary Care

Dr Michael Modell
Professor of Primary Care

Appendix 3: Aide Memoire for Interviews

Aide memoire for topic areas in interviews with PCG Board Members - adapted to each type of informant group

- Motivation for becoming a PCG member?
- Describe your role to date and then compare it to expectation
- Explanation for difference? Probe for what has helped or hindered?
- What would you describe as the benefits and problems of having a majority of clinicians on the Board? Why? Examples
- During the creation of the PCGs, the government and the professional press seemed to suggest certain roles for the clinical professionals on the Boards such as providing expert voices – would that be accurate ? Probe why or why not?
- Are these distinct from the non- clinicians roles? Is there a difference between the doctors and the nurses in these roles? Why?
- Types of relationships between clinical and non-clinical Board members?
- In the professional press, prior to the establishment of PCGs there were a number of concerns raised about the potential difficulty of relationships of clinician board members with their peers in the PCG area -has this been your experience? Why?
- Also a number of concerns were expressed about the domination of the GPs - has this been your experience? Probe reasons
- Drs and nurses in the driving seat - would this reflect your experience? Probe reasons?
- Given all you've said - how would you advise on the future composition and preparation of PCT members
- Will you be continuing as a Board member in PCTs?

N.B Check background information

Aide memoire for topic areas in interviews with non- PCG Board Members - adapted to each type of informant group

1. Involvement with PCGs to date?
2. Have PCGs and Board members operated as you anticipated –explore reasons
3. From your experience what has been the benefits of working with PCGs formed of a majority of clinical members? - Probe for explanations
4. Conversely could you identify problems in working with PCGs formed of a majority of clinical members ? - Probe for explanations
5. During the creation of the PCGs, the government and the professional press seemed to suggest certain roles for the clinical professionals on the Boards such as providing expert voices - are there particular roles you have observed the clinical professionals taking?
6. Are these distinct from the non- clinicians roles? Is there a difference between the doctors and the nurses in these roles? In what way and why?
7. Relationships between clinical and non-clinical members on the Boards?
8. In the professional press, prior to the establishment of PCGs there were a number of concerns raised about the potential difficulty of relationships of clinician board members with their peers in the PCG area -has this been your experience? Why?
9. Also a number of concerns were expressed about the domination of the GPs - has this been your experience? Probe
10. Drs and nurses in the driving seat - would this reflect your experience? Probe for reasons
11. Given all you've said - how would you advise on the future composition and preparation of PCT members
12. Anything else?
13. Own background?

N.B Check background information

Appendix 4: Coding Framework for Analysis of Data

REPORT ON NODES from N5
Background coding on current role, occupation, gender, length of time in PCG area, occupational background.

(1) **/board members original motivation**
(1 1) /board members original motivation/strategist
(1 2) /board members original motivation/loyalist
(1 3) /board members original motivation/back bencher
(1 4) /board members original motivation/specialists
(1 5) /board members original motivation/representatives
(1 6) /board members original motivation/mixed
(2) **/board members subsequent motivation**
(2 1) /board members subsequent motivation/strategist
(2 2) /board members subsequent motivation/loyalist
(2 3) /board members subsequent motivation/back bencher
(2 4) /board members subsequent motivation/specialists
(2 5) /board members subsequent motivation/representatives
(2 6) /board members subsequent motivation/mixed
(3) /non-exec members perception of their roles
(3 1) /non-exec members perception of their roles/Confusion
(3 2) /non-exec members perception of their roles/rubber stamping exec decisions
(3 3) /non-exec members perception of their roles/influential
(3 4) /non-exec members perception of their roles/non-influential
(3 5) /non-exec members perception of their roles/representative
(3 6) /non-exec members perception of their roles/clinical leaders perceive a difference in their role to others
(3 7) /non-exec members perception of their roles/nurses view role same as gps
(3 8) /non-exec members perception of their roles/gps view role same as nurses
(3 9) /non-exec members perception of their roles/gps view role different to nurses
(3 10) /non-exec members perception of their roles/nurses view role as different from gps
(3 11) /non-exec members perception of their roles/others perceptions of clinicians role contrast/diff to their own
(4) **/source of leadership authority in clinicians**
(4 1) /source of leadership authority in clinicians/clinical knowledge of GPs
(4 2) /source of leadership authority in clinicians /knowledge of GP practice by Gps
(4 3) source of leadership authority in clinicians /knowledge of gp practice by nurses
(4 4) source of leadership authority in clinicians/clinical knowledge of nurses
(4 5) source of leadership authority in clinicians/bureaucratic position of nurses
(4 6) source of leadership authority in clinicians cultural authority of Gps
(4 7) /source of leadership authority in clinicians/clinician to clinician relationship
(4 8) source of leadership authority in clinicians/health and social care business management expertise

(4 9) /source of leadership authority in clinicians different between drs and nurses
(5) **/clinical leadership activities**
(5 1) /clinical leadership activities/strategic
(5 2) /clinical leadership activities/operational
(5 3) /clinical leadership activities/political
(5 4) /clinical leadership activities/peer/collegial
(5 5) /clinical leadership activities/Across discipline
(5 6) /clinical leadership activities/only in own discipline
(5 7) /clinical leadership activities/GP effectiveness
(5 8) /clinical leadership activities/nurse effectiveness
(5 9) /clinical leadership activities activity in Gp interests
(5 10) /clinical leadership activities/activity in nurse interest
(5 11) /clinical leadership activities/nurses confined to nursing
(5 12) /clinical leadership activities/promoting user/community voice
(5 13) /clinical leadership activities/learn to behave like managers and less like clinical nurses
(6) **/elitism or pluralism**
(6 1) /elitism or pluralism/dominant interests evident
(6 2) /elitism or pluralism/challenging interests evident
(6 3) /elitism or pluralism/repressed interests evident
(6 4) /elitism or pluralism/oligarchic elite
(7) **/Gps as elites**
(7 1) /Gps as elites/medicines internal stratification
(7 2) /Gps as elites/structured powerful position
(7 3) /Gps as elites/LMC involvement in PCG
(7 4) /Gps as elites/cultural authority of medicine
(7 5) /Gps as elites/GP as independent contractor
(7 6) /Gps as elites/GP practice v population
(7 7) /Gps as elites/small practices v group practices
(7 8) /Gps as elites/conflict of interest
(7 9) /Gps as elites/tension between Gps
(8) **/relationship between Gps and managers**
(8 1) /relationship between Gps and managers/overt conflict with HA managers and beyond
(8 2) /relationship between Gps and managers/overt conflict with local trust managers
(8 3) /relationship between Gps and managers/covert tension with HA managers and beyond
(8 4) /relationship between Gps and managers/ convert tension with trust managers
(8 5) relationship between Gps and managers/co-operation with managers of all degrees
(8 6) relationship between Gps and managers/co-operation with PCG managers
(8 7) relationship between Gps and managers/contrast cultures
(8 8) relationship between Gps and managers/tension with all managers
(8 9) relationship between Gps and managers/racism
(9) **/managers attitudes to GPs**
(9 1) managers attitudes to GPs/ adversarial
(9 2) managers attitudes to GPs/avoid conflict
(9 3) managers attitudes to GPs/accept them as most powerful
(9 4) managers attitudes to GPs/collaborative
(10) **/nurses and managers relationships**

(10 1) /nurses and managers relationships/nurses in conflict with HA managers and beyond
(10 2) /nurses and managers relationships/over conflict with local trust managers
(10 3) /nurses and managers relationships/covert tension with HA managers and beyond
(10 4) /nurses and managers relationships/covert tension with trust managers
(10 5) /nurses and managers relationships/collaboration with all managers
(10 6) /nurses and managers relationships/collaboration with PCG managers in contrast to others
(11) **/nurses and doctors**
(11 1) /nurses and doctors/domination of nurses by GPs
(11 2) /nurses and doctors co-operation between nurses and doctors
(11 3) /nurses and doctors/recognition of clinical authority of nurses by doctors
(11 4) /nurses and doctors recognition of bureaucratic authority of nurses by doctors
(11 5) /nurses and doctors/invisibility of nurses to doctors
(11 6) /nurses and doctors/support to nurses from doctors
(11 7) /nurses and doctors/accommodation by nurses to subordinate role
(11 8) /nurses and doctors/conflict between nurses and doctors
(11 9) /nurses and doctors/challenge and resistance to doctors form nurses
(11 10) /nurses and doctors/creation of a counter culture by nurses
(12) **/nurses and nurses**
(12 1) /nurses and nurses/cultural authority of clinical nurses recognised by other nurses
(12 2) /nurses and nurses/bureaucratic authority of nurse managers recognised
(12 3) /nurses and nurses/wider nurse forum
(12 4) /nurses and nurses/nurse manager support
(12 5) /nurses and nurses/nurse manager control
(12 6) /nurses and nurses/suspicion of nurse managers by clinical nurses
(12 7) /nurses and nurses/nurses support nurses against GPs
(12 8) /nurses and nurses/nurse managers fail to support clinical nurses
(12 9) /nurses and nurses/Nurse managers repress clinical nurses
(12 10) /nurses and nurses/inter nurse tribe hostility
(12 11) /nurses and nurses/regional level support
(12 12) /nurses and nurses/peer clinical nurse support
(12 13) /nurses and nurses/apathy from peers
(12 14) /nurses and nurses/succession planning for board nurses
(13) **/method issues**
(13 1) /method issues/telephone
(14) **/selection processes**
(14 1) /selection processes/rules for nurses
(14 2) selection processes no contest for places
(14 3) /selection processes/Gp rules
(15) **/PCGs performance**
(15 1) /PCGs performance initiatives
(15 2) /PCGs performance successes
(15 3) /PCGs performance prescribing
(16) **/pcts**
(17) **/process and context**
(17 1) process and context/change over time
(17 2) process and context/increased knowledge of health services
(17 3) process and context/increased knowledge over time of GMS
(17 4) process and context/high level of time commitment

(17 5) /process and context/comparison of experience
(17 6) /process and context/importance of the chair
(17 7) /process and context/PCG v HA
(17 8) /process and context/PCG work well with HA
(17 9) /process and context/PCT imminent
(17 10) /process and context/change in board members
(17 11) /process and context/central gov policy impact
(17 12) process and context/decision making outside the board
(17 13) /process and context/chief exec has OD activities

Appendix 5: Example of Summary Documentary Analysis for One PCG

Element	Key aspects
Presentation and detail of the minutes	Speakers occasionally identified but action points and who to action them always identified
Attendance patterns	Never less than 5 GPs Mostly only one nurse 1-3 PCG officers 1 CHC observer throughout Community Trust Associate Director co-opted half way through the year Acute Trust representative attended one meeting only Health Authority officers never attended
Agenda	Agenda usually followed this format: • PCT development • Commissioning • Finance • GMS • Primary Care Investment Plan • Premises • Prescribing • Chief executives report
Decision making	Many decisions formally voted upon – e.g. voting on timing to move to PCT, co-option of Community Trust manager
Non public decision making meetings	Non-public Board business meeting two weeks before public Board meeting
Conflict of interests	Not referred to
Sub Committees	Only four referred to • Clinical governance Committee, • GMS group • Community • Communications
Finance and Commissioning	Discussed at every meeting • GMS under spend • Commissioning deficits • Prescribing overspends
PCG specific new service developments or initiatives	PMS/ Salaried GPs scheme reported to being developed IT Beacon status for a group of practices reported
Clinical governance	A quality initiative with other PCGs to develop standards on common disease management Developing a patient survey – only to the point of piloting it in two board members practices Coronary Heart Disease activity baseline assessment in some PCG practices.
Health Improvement Plan	Only referred to in terms of as a Health Authority activity not as a PCG activity.
Community and lay member involvement	Lay member vice chair, chaired meeting in absence of GP chair once Reported to speak at each meeting

Clinical Board member involvement	Views and activities of at least two GPs reported in every meeting. Action points on agenda always referred to the chief executive or a GP member. Nurses never recorded as having a lead action out of any meetings. Three references to nurse Board members: • One reported to have joined HA wide commissioning group on community services commissioning • One asked for a hand held personal computer as did not have access to a computer at work • Reported to hold a Nurses forum
Relationships with other health and social care organisations	Relationships with Local Authority not mentioned Relationship with Community Trust –Co-opted manager half way through year but only to public Board meetings Relationship with Health Authority (HA) reported as very difficult to the point it appeared acrimonious: • Repeated reference to slow decision making by HA in budget setting e.g. 3 months late on grading of its officer posts • Repeated comments on lack of public health consultant input to PCG • Reported repeated delays in devolving HA monies and posts to PCGs • Reported HA changing decisions on devolving posts and monies • Repeatedly questioned HA stance on not placing more emphasis on locality issues in PCT development plan Relationship with Acute Trusts: • Reported indignation at refusal of consultants in one hospital to take new diabetic referrals from GPs raised – but follow up not reported on in subsequent meetings