THE EFFECT OF CHANGE ON THE NATIONAL HEALTH SERVICE GENERAL MANAGERS' INFORMATION NEEDS

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Abstract

The research enquiry using a sample of 20 NHS organisations with similar revenue and population characteristic profiles sets out to identify the information needs of the NHS General Managers and in doing so highlight the information that they need to meet their organisations' key success factors. The research identifies through the enquiry process the General Managers' information needs and describes the categories of those needs, the pressures and influences of the General Managers' working environment on those needs and the links to the influences that have been reflected in their information needs. In particular the external influence of the Department of Health and the business environment has not only changed the General Managers' information needs but affected the balance of power between the stakeholders, which in turn has affected those information needs. These organisational and environmental changes, health policies, stakeholder demands, and changes in the balance of power between the stakeholders has resulted in a change in the way in which the General Managers work with information, which has in turn increased the need for more accurate, timely and complex information.

The research analyses the General Managers' understanding of their roles in the General Manager/patient/doctor relationship and analyses the potential areas of conflict arising when the patients' interests clash with the market-led (business) interests of the healthcare organisations and the diverse needs of the Provider, Purchaser and Regional Executive General Managers. These problems together with the effects of organisational resistance, organisational culture clash and system requirements and its effect on the information needs of the General Managers were examined for associated links with the difficulties that the General Managers experience in defining their information requirements.

The research provides an understanding of the links between a market-led healthcare environment, the General Managers' information needs, and their attitude towards information as well as an understanding as to whether the patient, a key stakeholder, has benefited in the healthcare empowerment stakes as a result of the re-delineation of the General Managers' information needs and the impact upon their decision making.
The information needs identified as a result of the research have shown them to have become business orientated with financial targets as a key measure and clinical performance (outcomes) increasingly being seen as the other key factor as an indication of success for the organisation.

The hypothesis (Null Hypothesis) of the research asserts that it is not possible to link a market-led healthcare environment, the General Managers' information needs, their attitudes and behaviour towards information, and patient empowerment in such a way as to develop a model of information needs that is common across the Purchaser, Provider and the NHS Executive organisations. However, the research has developed as a first step, a series of outline models of information needs that will lead to a more complex and common model of information needs across the General Managers' organisational groups that will allow, when assessed against key success factors, a judgmental view of the ability of both the General Managers and their organisations to deliver their aims and objectives.

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The Research Proposal

This introduction sets out the hypothesis, research proposals and methodology used to secure information to support the following dissertation. The methodology chosen is discussed and critically evaluated using appropriate research to support both it and the evaluation chosen. Over the years, the Executive Information Management Group (IMG) of the National Health Service (NHS) has developed many ways to advance its information services and yet the NHS organisations still have difficulty in evaluating information for the purposes of determining their success factors (IMG July 1987, 1990). The NHS is over-flowing with information that is in the form of clerical data, statistical data, and textual information but is often complicated by soft information in the form of rumour and opinion. Unlike large Private sector companies, which have clear performance indicators to show how well they are performing, most NHS organisations do not. These private sector companies have profits, share prices, return on investment and increase in sales as indicators of the well being of the company. The NHS, over the last twenty years, has attempted to develop a number of indicators that could be used to demonstrate the performance of the individual organisations. These indicators ranged from the number of beds in use to quality outcome indicators obtained by patient satisfaction questionnaires. Recent discussion papers suggest that clinical outcomes will be the next challenge that NHS organisations will have to meet in measuring their performance (BMA 1998), (IHSM 1998).

The Aims & Objectives of the Research

It was proposed to look at the information requirements and their attitudes when making decisions of the General Managers from the NHS Organisations, which in the prevailing climate were labelled "Purchaser", "Provider", and "Regional Executive" organisations and whether or not their decision-making has assisted patient empowerment in meeting patient healthcare needs. These labels originated from the prevailing climate in which the healthcare sector had been affected by the policies of the previous Conservative Government (1979-1997). This Government had been under the influence of a consumerist philosophy, and as a result initiated a series of reforms aimed at updating the healthcare system to meet the "real" needs of society. One form of this updating was the movement of healthcare from a monopolistic one to a market-led one, in which market forces influenced the type and cost effectiveness of the service provided.

In summary the six main aims and objectives of this research are: i) to define the General Managers' conception of management information in the NHS; ii) to identify the General Managers' understanding of their own roles in the manager-patient relationship, their organisation and how that affects their information needs; iii) to explore the problem of identifying the information needs of the General Managers and their difficulties in defining their own information requirements and the nature of those needs; iv) to understand how General Managers work with information within their existing work environment; v) to analyse their attitudes to information and their needs in a rapidly changing environment and vi) to develop both a theory and recommend practice for change in the area of the General Managers' information needs.

The conceptual framework of this research addresses several questions:

- The question of changes in the balance of power between the consumer and service providers and how that affects the information needs of General Managers.

- The question of changes in the patients' and the General Managers' roles and their effect on information needs.

- The changes in the balance of power between the patient, the Purchaser and Provider and how that affects the information needs of the General Managers.

- The changes in healthcare environment from one of monopolistic to market/ business/client demand led and its effect on the General Managers' information needs.

- Whether or not the NHS environment has moved from a "free healthcare for all" ethos to a business orientated ethos and, if so, its effect on the General Managers' information needs.

Other aspects of this research are:

- To examine the information requirements of the General Managers in the market climate and their attitudes and behaviour when making decisions. Additionally to question whether or not the environment affects this informed decision-making and their information needs.

- To question whether or not the General Managers information needs are linked to patient empowerment thereby enabling patients to meet their individual healthcare needs.

- To identify a model of information needs this will allow a judgmental view of an organisation's performance as to whether or not it is successful.

- To seek to clarify the General Managers' understanding of their own role in the General Manager/patient relationship. This will explore how General Managers view their own responsibility and accountability for the patients' interest and how that influences their need for information and the actions they take towards fulfilling those needs. It will also shed light on the potential areas of conflict when patients' individual interests clash with the business interests of the hospital.

- To explore the problem of identifying the information needs of the General Manager. This will look especially at the rapidly changing environment of the NHS and the continually diversifying needs of the "Provider" orientated General Managers as opposed to the "Purchaser" orientated General Managers.

- To determine the attitude to information of the targeted General Managers. This will include a study of the problems of organisational resistance and organisational culture clash associated with information needs and system requirements. De Long (1988) argues that the adoption of executive support systems by senior managers will help them develop enhanced business models to test alternatives and to make effective decisions, whilst at the same time citing that more than 50% of traditional Executive Information Systems fail within two years.

- To research into the difficulties, which General Managers have in defining their own information needs. This will study a number of reasons, for example: the inability to express their needs; their not being sure of their information needs; or simply asking for something which they subsequently realise is not what they actually want after they are given it.

- To understand how General Managers work with information in their existing work environment, what information they use and the effect on the managers of

continually evolving stakeholder demands within the organisation, together with the evolving organisational and consequential environmental change.

- Develop theory in this area and recommend practice for change.

The research will attempt to enhance the understanding of the concept of management information in the NHS through general and health specific literature. The literature review will look at the nature of the concept of information and at its supporting mechanisms. It will also seek to identify the concept of the new healthcare and its implications for information.

Null Hypothesis

The Null Hypothesis is that there are no links between organisational climate, management attitudes, behaviour, the working environment and patients' empowerment to the information needs of the General Manager. Therefore, a model of information needs for the General Managers cannot be identified.

The business literature will be utilised in order to give a definition of the concept of consumerism that will guide the research. This literature will help to identify the underlying issues and important aspects of consumer participation and social responsibility of service providers (Chapter 5: The General Managers' Concept of Management Information in the NHS, Consumerism P93-95). The literature regarding managerial/organisational culture will be reviewed in order to understand the power and influence within the organisation, and how that might affect influence over healthcare provision (Chapter 6: The General Managers' View of their Own Roles Power and Influence within the Organisation P117). An examination of the manager-patient/doctor relationship over time will be carried out. This will help in providing an understanding of the shift in the roles of the General Manager, doctor and patient (Chapter 7: The General Managers' Views of their Information Needs. Information Acquisition and value P131-134). A study will be made of the change in health policy in the Purchaser and Provider environment as this has resulted in new values and norms for General Managers.

The literature review encompasses a range of different disciplines:

Information Needs. The main sources of literature are: UNESCO, Journalism quarterly, selected readings on communication and journals with articles on the concept of information needs, sources of information and business information and EIS systems (Chapter 7: The General Managers' Views of their Information Needs, Information Acquisition and Value P131-134) which can be found at the Sheffield Business School part of the Sheffield Hallam University, Sheffield University and the Leeds Metropolitan University (Chapter 3: Managing Information within the NHS, Types of Information Need P56-58).

Business management - books on business management, the internal market in the NHS, which have been utilised from the London School of Economics and the London Business School, King's Fund, Sheffield Business School, and the Institute of Management (Chapter 8 The General Managers' Working Environment P164).

Health -King Fund College publications, Health Management Journals, Department of Health publications, (Chapter 6 Benefits of the Change of Influence P125-P127) Government papers and the research published by the Information Management Group of the NHSME on information and common basic specification for data models.

Thesis abstracts-ESRC archives and University libraries.

Principal methodological approaches

The principal methodological approach used in the research (Chapter 4 Research Methodology P62-67, P73-74, Managerial Ethics, Culture and Consumerism, P75-77) is a qualitative one as the aim of the research is to identify and analyse specific characteristics. Data was collected through the questionnaire method by structured, detailed interviews with General Managers (population sample 20) from the Purchaser, Provider and the Regional Executive organisations within the NHS. Checkland's methodology can be considered as an appropriate approach to this methodology of Soft Systems Methodology. (Checkland & Griffin 1970).

The size of the sample will be 5 from Regional Executive organisations of the NHS, 5 from Purchasers' organisations, and 10 from NHS Provider trusts. Each Purchaser, Provider and

Regional Executive organisation was considered as a detailed case study. The focus was on specificity rather than generality.

The selection of the 20 General Managers was carried out in two stages:

1. The General Managers from the Purchasers and Providers were targeted in different Regional areas to increase the broad spectrum of populations that they served.

2. From the five selected regions, one Purchaser (District Health Commission) and two Provider Trusts as well as the General Managers from the Regional Executive organisations were selected to enable as wide a possible spectrum of the population served by the Provider organisations.

Validity and Reliability

To ensure the validity and reliability of the research, a small-scale pilot study was conducted to explore the efficacy of the draft questionnaire and the responses it provoked from the target population. The perceptions of the sample population with regard to style, pertinence and effect of the questions in relation to the information sought and the market environment were elicited. This ensured construct validity. The resultant framework was used throughout the interview process with the sample population of General Managers, thereby maximizing the reliability of the data. At the end of each interview, the responses from the interviewee were checked for completeness and accuracy in order to safeguard the data's qualitative validity. All 20 General Managers were approached and permission obtained before the interviews.

The research will bring a better understanding of General Managers' perception of their information requirements, how they use that information and its role in achieving the patients' best interest and the nature of the conflicts faced by the General Managers. This will fill the gap between theory and practice in General Management. It will also for the first time add to the body of knowledge on the way forward for information management within the NHS under the market-led strategy that it has adopted. There have been many publications relating to aspects of management and information over recent years, but no research into the wider understanding of information needs of General Managers and the business environment of the present day NHS.

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History of the NHS

It is important to discuss the concept of the NHS from an organisational perspective, taking into account the effect of the resource allocation strategy of the government of the day and from the point of view of the role of management within the organisation, to enable an understanding of the present environment in which the research is taking place. It is also important to understand some of the forces that have shaped the role and function of management in the NHS from its creation to the present day. This introduction places such changes within their context and charts the nature of governmental policy toward the NHS. It concludes that the transformation can be characterised by the movement from a health service that was administered, to a health service that is managed.

Creating the Environment for the NHS

(The philosophy and the politics.)

That the UK has such a system of healthcare is not the result of chance nor can it be said to be the outcome of comprehensive, rational planning. On the contrary, the healthcare system which has emerged within the UK has been the result of an incremental process emanating from the political decision making process.

Over the last one hundred and fifty years the battle against ill health has been waged on four main fronts and in three over-lapping phases. Initially, during the second half of the nineteenth century, emphasis was upon preventive measures and was more specifically focused on environmental improvements e.g. housing and sanitation. Toward the end of the century, a new trend can be discerned in favour of a more personal approach to health with particular attention being addressed to the protection and improvement in the health of children. The early years of the twentieth century saw improvements in medical science that led to an increasing curative approach to the plight of the sick through the ever-growing use of drugs and the application of technological advances. The final phase can be said to date from the introduction of the National Insurance Act, 1911, which provided increased access to health services (Savage and Robins 1990). For many writers it was this piece of legislation, more than any other, which paved the way for the enactment of the National Health Services Act, 1946 (Palmer 1983) .

The first four decades of the twentieth century were ones of progress, but progress of a limited kind. Despite the virtual eradication of the diseases such as cholera and typhus, access to health still depended upon the availability of the services and the ability of the individual to meet the fees charged.

Increasing official scrutiny of healthcare was evident from the 1920s onwards in the form of numerous reports and studies, which took as their subject the inadequacies of the medical care available to the public and the requirement that such care should be placed on a more orderly basis (Forder 1971). Planning may be viewed as a response to the growing threat of war which became more apparent after 1933 and the realisation of the need to make provision for the many civilian and military casualties it was feared twentieth century war, especially aerial warfare, would produce (Forder 1971).

Collectively these investigations revealed that there existed serious deficiencies and anomalies in Britain's health service provision. Such shortcomings are worthy of comment because of the influence that they were later to exert upon the foundation of the NHS in 1948. In particular, it was revealed that National Health Insurance did not cover more than half of the population. Local variations existed in the provision of additional benefits; the distribution of medical specialists and general practitioners was uneven throughout the country. Also, variations existed in the adequacy and efficiency of local authority health provision and hospital services were unevenly distributed. All of these findings strengthened the case of those demanding the creation of a National Health Service (Byrne and Padfield 1983).

Both the scrutiny and planning investigations generated a consensus among informed opinion as to the health needs of the nation. This consensus developed around the belief that medical care should be available to all and should not depend upon the ability of an individual to pay for treatment, (Byrne and Padfield 1983). There also developed a majority view among health professionals that the services then provided by local authorities, General Practitioners (GPs) and hospitals must be integrated with hospital services being organised on a regional basis to ensure efficiency of provision (Byrne and Padfield 1983). There was also agreement to recognise both the preventative and curative elements of health provision, (Savage and Robins 1990). The consensus, which emerged by the outbreak of the Second World War, among medical experts was limited and important questions remained unanswered or were the subject of disagreement. Among these were questions of finance, payment of service personnel and the form of service administration. Should the service be

financed from contributions made from local authority rates, direct taxation or some form of insurance scheme? Should staff be paid by salary, capitation fees or by items of service? What contribution should the individual citizen make to the service and for treatment? By what means and by whom, should the service be administered? It was these questions that ensured that when the NHS Act, 1946, created a National Health Service (NHS), it would be a service born in a climate of heated political controversy. Significantly, these same questions have re-emerged as elements of contention in the debate about the NHS in the years since 1979.

Throughout the years leading up to the Second World War, the idea of a fully-fledged state health service was increasingly gaining favour in both medical and political circles. As early as 1920, the Dawson Report (1920) had noted the fragmented nature of the existing arrangements and their inadequate distribution and had recommended a more unified approach based on a series of health authorities and health centres distributed to reflect local community needs and to be available to all. Support for comprehensive health provision came from the Royal Commission on National Insurance (1926) , which advocated an extension to the current National Insurance coverage as a first step toward the separation of health from insurance and the funding of a health service from national taxation (Byrne and Padfield 1983).

By the 1930s the Labour Party, the Fabian Society and a group of radical medical practitioners who had formed themselves into the Socialist Medical Association (SMA) were advocating a fully-fledged health service. It was to be this latter group that conducted an active, national campaign through the media and lobbied MPs to raise the issue in Parliament. In particular, the SMA wanted: medical services to be free of charge; doctors to be employed on a full-time basis by the state; and the introduction of health centres and large district hospitals with administration to be under the control of enlarged local authorities. Before any decisive action could be taken on these proposals, the Second World War intervened and it was not until 1942 that the issue of a national health service again became the subject of debate when planning for the post-war years was commenced. The first statement of policy was contained in the Beveridge report (1942) on Social Insurance and Allied Services (1942). Available to Beveridge was the report of the Medical Planning Commission, which had recommended that medical administration should be separated from social security, and that medical care of an individual should not depend on insurance contributions. Beveridge accepted both of these recommendations and his proposals advocated a comprehensive

health and rehabilitation service for the prevention and cure of disease and restoration of the capacity to work available to all members of the community. Following the report by Beveridge (1942), the Minister of Health published a draft plan for a unified health service and two years later, a revised plan, in the form of a White Paper (1945), which proposed that:

- Free health services would be available to all;
- Administrative areas would be based on joint local authorities;
- These area health authorities would incorporate voluntary hospitals with local health authorities who would also run health services in health centres;
- General practitioner services were to remain independent but GPs would work under contract for the state health service and receive payments on a capitation basis.

Extensive discussions took place on the White Paper as advocates and opponents voiced their preferences. The method of payment to medical personnel was again to prove contentious with the British Medical Association (1929, 1938) arguing that GPs were concerned at the prospect of a salaried service. Those medical specialists were afraid that a state medical service could threaten their private practice upon which they depended to permit them to give free services in many of the public wards of hospitals. In general, the BMA favoured extending National Insurance cover both in terms of eligible persons and improved benefits although supportive of the co-ordination of hospitals on a regional basis.

The inception of the NHS was essentially due to the proposals outlined in the NHS Act 1946. The NHS began life in 1948, under the guidance of Aneurin Bevan, Minister of Health in the incumbent Labour Government, in response to the Beveridge report (1942). Most hospitals in the UK had previously been operated as non-profit making concerns by local authorities. About one third of the hospitals were run independently as Voluntary Hospitals. With the NHS Act, these were compulsorily acquired and subsequently administered by the state. All treatments became universally available at no cost at the point of delivery, the whole being centrally funded by taxation. From then on, hospital doctors, hospital nurses and all other hospital staff became salaried employees of the state. Community staff, such as District Nursing, Midwifery, Ambulance and School Health Services remained the responsibility of local councils under the supervision of the Medical Officer of Health. At the same time, GPs or "Family doctors" managed to remain outside the direct employ of the state and have, since that time, been contracted by the state as private businesses providing Primary Health

Care. This meant that, even though the state was effectively the monopoly employer of GPs, they were classed (and taxed) as self employed, and the state has never had direct control over the activities GPs undertake beyond deciding what services it will and will not buy from them. There are a few GPs in the UK who choose to practise exclusively privately (that is, they do no work at all on contract to the Government) but they are presently very few and far between.

The original ethos behind the NHS was the belief that, through the provision of universal and complete health care, free at the point of provision, the NHS would eliminate significant disease and thereby work itself out of a job (Beveridge 1942). The electorate still believes that there is intrinsic value in a universal and complete NHS, although no one can agree on exactly what constitutes 'complete' healthcare, and none can say what the actual benefit of attempting to provide this, rather than rationed care, might be (Rivett 1998). Politicians have found the NHS a useful political football; any accusation that opposition party policies might damage the basic tenet of a free healthcare at the point of need carries great political value. This allowed an unworkable idea to become a sacred cow, and no politician (until recently) dared question its practicalities.

Another significant problem that the NHS inherited at its inception, and carries forward to today, was its infrastructure. Prior to the NHS Act, hospitals had been constructed generally in places where there was sufficient private custom to make them financially viable as individual going concerns, rather than in response to pure local need. This resulted in a significant excess of hospital service provision, for example in and around London, and a relative dearth in less well off parts of the country. In the less well off provinces, many of today's hospitals are housed in buildings that began life as 'poor houses', often situated geographically in less than ideal sites for their current use.

The basic tenet of the Act was that there was a responsibility vested in government to improve the health of the population and that everybody should be allowed access to any public health provision, on a basis of medical need. The principles of this "health Utopia" were laudable but as modern authors such as Rathwell (1987) note, the idea that provision of adequate health care would result in a falling demand for health services, was a serious misconception. Over the years, demand has exceeded supply and health care is now a major drain on the Treasury coffers. By 1953, it became evident that governments of both persuasions were unable to control the ever-rising costs of the NHS. The Guillebaud

Committee (1955) was formed to investigate current and future costs of the NHS and to make recommendations as to how to make effective and efficient use of Exchequer funds. Since that date there have been five major reorganisations within the NHS: in 1974 when Regional Health Boards and Hospital Management Committees were replaced by Regional and District Health Authorities; in 1985 the restructuring focussed on the internal organisation structures where the hospital administrator became a "unit General Manager"; between 1990/93 General Managers became Chief Executives/General Managers, with an external structure as shown in Figure 3; in 1997 the organisation structure of the NHS looked as shown in Figure 4; and in 1999 General Practitioner Fund Holders (GPFHs) and GPs had been grouped into Primary Care Groups (PCGs), functioning as special committees of the Health Authorities (HAs) to manage their healthcare services.

Policies toward the NHS in the Years of Consensus Politics

The General Election of 1945, which brought into office the first majority Labour Government under the premiership of Clement Attlee with Aneurin Bevan as Minister of Health, published the NHS Bill in March 1946. A Bill much in accordance with the tenets of equality and social justice founded in socialist ideology. After much parliamentary scrutiny, the Bill became the NHS Act, 1946. Its main provisions were that:

- Hospitals were to be taken over and administered by the government through agencies called Regional Hospital Boards and Hospital Management Committees;
- Consultants and hospital doctors were to be salaried but could still undertake some private work;
- Family practitioner services were provided under contract by individual practitioners working together in local authority health centres;
- Local authorities became responsible for health centres and ambulances as well as retaining responsibilities for public health, immunisation, school health and maternity services, all health services were free of charge, freedom of choice was retained in that doctors could choose or refuse patients, and vice versa,
- Private practice was permitted so that not all patients or doctors had to use or join the NHS.

Further debate, between the advocates and the opponents, often acrimonious and always vociferous, took place before the NHS, born out of compromise, came into existence in 1948. Certain principles were behind its foundation and certain objectives were set for it. The principles and objectives, which were stated in the National Health Services Act (1946), were the following:

The provision of optimum standards of service. The social security legislation of the time had made provision for a basic minimum level of service provision but the newly created health services were "to secure improvement in the physical and mental health of the people and the prevention, diagnosis and treatment of illness". The breadth of approach was also to be seen in that the Service was designed "to meet health needs wherever and whenever they arise."

- Services were to be comprehensive in scope and universal population coverage.
- To ensure this last point, services were to be free of charge at the point of delivery.
- Expenditure was to be financed mainly from general taxation with additional although small amounts from insurance charges.
- Services, especially hospitals, were to be integrated and more effectively planned and distributed.

All of these points were to be underpinned by the notion of freedom. No one was to be compelled to join and while patients could change their doctor or dentist, the medical practitioners could also undertake private work.

Following the legislation and its enactment on July 5th 1948, which marked the advent of a major element of the establishment of a Welfare State in Britain, a broad political consensus emerged as to the role that the state was to play in the life of society. This consensus emerged in the late 1940s and lasted through to the late 1970s; although there was some evidence of its decline by the mid-1960s. If there was doubt as to the longevity of the consensus there was also doubt as to its depth and scope. For some it marked the end of ideology and represented that stage in societal development where there was agreement about the collective ends which society was seeking. For others, the consensus was shallower and concealed the fact that profound differences still existed at both practical and ideological levels as to the means that should be used to attain societal goals. For some, the consensus

encompassed not merely the institutional framework within which policy making took place, but also the processes by which policy was formulated, enacted and implemented and the objectives which policy was designed to produce. For others, the consensus was narrower and did not extend beyond the basic tenets necessary for the effective functioning of a democratic policy (Bell 1962). Despite the differing parameters which were used to characterise the consensus, there can be little doubt that those who proclaimed its existence, and those who questioned its extent, arrived at their respective positions after consideration of a common factor; namely the size, scope and operation of the public sector which lay at the heart of the debate about the success of governments in managing the mixed economy and in creating a society free of the tensions which are generated by large and visibly manifested disparities in the health, wealth and general well-being of its members.

The fact remains, however, that the idea of a consensus existing in British political, economic and social life is probably a relative one, which might have been accentuated with the passage of time and now appears more real than it did during the years when it was felt to be at its height. Its origin can be traced to a characterisation of the relationship between the two major political parties in the post war years on matters of policy and style of government which, it was held, exhibited marked areas of cross-party accord on many of the fundamental aspects of British political life. It would be an over statement to maintain that it encompassed the absence of political opposition and inter-party conflict and more realistic to contend that it was denoted by broad agreement on the limits of public policy and the most appropriate role for government to play in economic and social life. According to Savage and Robins (1990) there are three features that are most commonly cited as the framework of public policy underpinning the consensus:

1. The role of the state in economic affairs:

The contention is that, during the majority of the post-war years, both the major political parties in the British political system, Conservative and Labour, were of the opinion that central government had a crucial role to play in the management of the economy and that the economy was perceived to be characterised as a "mixed economy"; incorporating elements which included both public and private sector organisations. Over time, this perception entailed the acceptance of a number of different forms of amalgamation of those two types of enterprise. This partnership role entails the public sector not seeking to do that which the private sector already does but lies in the ability of government to supplement the role of the

private sector by undertaking those necessary functions which, because of commercial and other considerations, the private sector does not seek to perform.

2. The role of the state in welfare provision:

Both the two major political parties were in favour of Welfare provision being made and agreed that government should play an active role in that provision. They were not in accord over the extent of the provision that the government should itself make, although they did agree that such provision should be in excess of a "safety net" for the most unfortunate members of society. The most notable result of this consensus resulted in the acceptance of the NHS. Yet, even here, the role of the state was not that of exclusivity, for other bodies coexisted with, and offered services not incompatible with but parallel to, state provision e.g. private beds in NHS hospitals. Voluntary organisations also played a part in the totality of provision. It was the degree of contribution made by the state and the private sector respectively that afforded the scope for inter-party contention; with Labour traditionally favouring more of the former whilst the Conservatives favoured a larger role for the latter. The debate was never about whether or not it was proper and appropriate for the state to perform and fulfil a welfare function in relation to societal needs for this was accepted by both of the major political parties.

3. Corporatism:

This represented a third strand in the consensus and characterised the way in which the government approached decision making on policy issues. Post-war governments had come to utilise an approach that led to the development of a consultative climate over a broad spectrum of policy areas. This meant that, on any particular policy question, the government sought the views and opinions of interest groups that possessed specialist knowledge of the area and, not infrequently, sought the active involvement of those groups in the implementation of policy. The rationale here was the belief that efficiency and effectiveness could best be achieved through policies which enjoyed the widest possible support from those most closely involved in a particular policy area. This approach demanded that all involved make genuine attempts to reach compromises to which they felt committed. Yet such compromises could often only be achieved at a price, namely, the adoption of policies which fell short of the full attainment of the 3 Es; efficiency, effectiveness and economy.

Such a price was one that was considered to be worth paying as it eradicated the worst effects arising from confrontation.

The NHS fitted comfortably into these elements of the post-war consensus in that it was a key partner in the provision of health services which the private sector could not, or would not, provide. Also the NHS reflected the commitment of successive governments of differing political persuasions to the attainment and provision of a comprehensive health care system in accord with the principles which had led to its creation. Lastly, health policies were the outcomes of consultation between all of the interested actors in the area of healthcare provision.

Demands for improved healthcare on a national basis were evidenced during the inter-war years, yet it was not until the beginning of planning for the post-war period that the provision of a universal health service free to all and funded from taxation began to emerge as reality. During the years of consensus polities in Britain there was acceptance of the mixed economy and the role of the state in the provision of welfare. What was in dispute was the extent to which such provision should be the exclusive preserve of the state and the way in which it should be managed.

From 1979, successive Conservative governments, motivated by the tenets of neo-liberalism and the thinking of the "New Right", introduced into the NHS many managerial practices previously to be found only in the private sector and thought to be inappropriate within a public sector context. All of these changes can be seen to be in accord with the professed aim of successive Conservative governments since 1979 to introduce the tenets of their ideology into the NHS. They stand in marked contrast to the broadly based cross-party agreement on policy during the consensus years and reflect a market orientation and an emphasis upon individualism. This has come to replace the former emphasis upon the mixed economy and a commitment to the Welfare State as it was for so long envisaged. The NHS has been transformed to accord with the Conservative view that the introduction of private sector managerialism provides the best method by which public sector organisations can be made to exhibit the features of efficiency, effectiveness and economy. These have been previously seen as being the exclusive preserve of the private sector. In essence, the health policy of Conservative governments over the 18 years between 1979-1997 has focussed upon the attainment of the 3 Es through legislation, which has removed, or at least lessened, the administrative culture, which typified the NHS from its foundation until 1979. Such a culture

has been replaced with a managerial one more in keeping with the thinking of the New Right. However, this movement from administration to management was characterised as long ago as 1972 by Keeling but typifies recent changes in the NHS.

The NHS since 1979: the ending of consensus

Although the NHS fitted comfortably within the political framework of the consensus years it had its critics. In particular, it was noted that: (i) The achievements of the NHS had been modest and that the rate of improvement in the nation's health had not been greater than that which had been achieved in the 1930s; (ii) Factors other than the presence of the NHS were cited as having led to improvements in healthier higher standards of living and housing; and scientific advances and changes in working patterns (Byrne and Padfield 1983). (iii) Significant deficiencies existed in the NHS such as the number and distribution of doctors, hospitals and health centres and that the nation could not meet the ever escalating costs of the NHS. (iv) As a near monopoly provider of health services the NHS had become impersonal, inflexible and lacking in financial discipline. (v) The structure of the NHS resulted in a fragmented and uncoordinated system not dissimilar to that which had existed prior to its creation. (vi) Its more vociferous critics charged that the NHS had disabled and demoralised people by causing them to rely on cure rather than prevention and to abuse a free service (Byrne and Padfield 1983). These criticisms seem to be interrelated and by the late 1960s it was widely accepted, both in government and medical circles that they could best be addressed through a restructuring of the NHS. The Government contended that only in that way could there be an end to wasteful duplication of service and administrative structures, a closer co-ordination between the administrative and medical arms of the service, the effective exploitation of technological developments in medical science and improved patient care through the more economic use of resources.

The publication of a Consultative Document by the Conservative Government, Green Paper (1970) on the structure of the NHS, proposed a virtual single tier system of 40-50 area health boards. An expansion of this Green Paper proposed an increased number of boards, added the idea of advisory regional health councils to provide co-ordination, and suggested the creation of some 200-district committees to monitor the services of the area boards. This Consultative Document was quickly followed by a White Paper (1972) and the NHS Act (1973), which provided the basis of the structure that came into effect in 1974. This Act brought into being a structure, which unified the three parts of the Service, (hospital services,

family practitioner services, and local health authority services), but had three operating levels; Region, Area and District. The new structure fell some way short of overcoming all of the divisions of the former structure and failed to deliver the promised unity and co-ordination.

The following significant charges were levelled against it: the perceived Lack of unity had several aspects among which were that occupational and environmental health services were excluded from the NHS; family practitioner services were not fully integrated with hospital and community health schemes/District and Area Health Authority boundaries were based on local government boundaries and were not appropriate for medical needs; that health was separated from housing, education and personal social services added to the perception.

Administration and management had several elements merged and were too bureaucratic resulting in slow decision making and ineffective use of resources. This was felt to be because of the multi-tiered structure; the form of management proposed was inappropriate and out of date as it reflected a mechanistic hierarchical "top down" approach rather than an organic, participative "bottom up" approach. The resultant power was left in the hands of the medical professionals who formed a "medical technocracy" with its views dominating what are often social rather than medical needs.

In its response to the public, it was contended that the reorganisation was deliberately aimed to secure effective management with the representative function going from Community Health Councils, which meant that the voice of the public was limited (Byrne and Padfield 1983). Such criticisms resulted in the creation of a Royal Commission on the NHS (1975) to "consider in the interest both of the patients and those who work in the NHS, the best use and management of the financial and manpower resources of the NHS". The Royal Commission reported in 1979 and within twelve months was followed by the Black Report (1980). Both investigations confirmed disparities between differing medical services, between different geographical regions and between different social classes. They both agreed that despite the fact that the cost of the NHS had risen from £500 million in 1951 to £7000 million in 1974, social justice and the effective use of resources could only be achieved through more open access to health provision and a reallocation of resources. The Government's response was to issue a White Paper (1989) to rectify the "well founded" criticisms of the existing arrangements, which were seen to have produced too many tiers of administration, too many administrators and too much money wasted.

For these defects to be corrected, four courses of action were seen to be necessary: (i) Better use of existing resources; since under the new structure too many man-hours were being wasted especially when doctors and nurses had to attend numerous consensus management committees and too many administrators were being maintained. In addition, poor financial control systems and treatment regardless of cost were seen to be unnecessarily consuming resources. (ii) The possibility of more rationally determining priorities between the different arms of the service had to be considered. (iii) Cost reduction through prevention via health boards had to be investigated. (iv) Consideration had to be given to the possibility of expanding the private sector (Stuart Haywood 1986).

In 1979 the incoming Conservative Government embarked upon the above four courses of action which marked a departure from the ideas and values of the "consensus years" supported by both post war Conservative and Labour governments which had hitherto underpinned the NHS. But these ideas and values fitted well alongside the philosophy being espoused by the incoming Government under the leadership of Mrs Thatcher, which showed a marked ideological preference for what was termed neo-liberalism. In place of the three key elements of the consensus years, the new Conservative Government had a belief in the superiority of the market. Successive subsequent Conservative governments have been committed to the neo-liberal view that the market was the best mechanism for producing and distributing resources and is preferable to state run or state regulated processes. The market was seen as being more efficient, more responsive to people's needs and ultimately more productive than any state system. This in turn led to the Government's strategy of rolling back the frontiers of the state and fostered policies of privatisation, liberalisation and deregulation and the encouragement of competitive tendering and contracting out both in the NHS and elsewhere in the public sector.

Unlike the philosophies espoused during the post war consensus years, Individualism was now seen as being closely linked to a belief in the superiority of the market in that the individual was seen as self-reliant and responsible for his/her own actions. Too much state provision was viewed as reducing individual self-reliance and individual responsibility and credited with the creation of a 'dependency culture'. The incoming Conservative Government saw the post-war Welfare State as having damaged individual self-responsibility and "to roll back the welfare state" was held to be the way to rekindle the individualist ethos

through the offer of greater choice. In terms of the NHS, this meant the choice between health-care provided by either the state or private sector.

A belief in strong government: the notion was of firm or resolute government, which would sweep away the corporatist ethos of the consensus years and create in its place a framework for the attainment of the 3Es through leaving the running of enterprises, both public and private, to their respective managements which were held to be best placed to determine and meet customer demands. In the NHS this was to mean the ending of consensus management, the strengthening of the right of managers to manage through the introduction of private sector managerialism; which would itself be aided by a reduction in trade union influence (Savage and Robins 1990) . It was these tenets of neo-liberalism that were to serve as the underpinning rationale of the policy of successive Conservative governments to the NHS in the decade following 1979. This new orientation was evidenced in the early days of the first government under Mrs Thatcher that issued a White Paper (1989) "Working for patients".

The Changes

The "area" tier of organisation was abolished in 1982 and the proportion of the budget spent on administration was reduced. Annual reviews of the performance of Regional Health Authorities (RHA) by Ministers and the Department of Health and Social Security (DHSS) began in 1982 and have been extended to RHA reviews of District Health Authorities (DHA) and DHA reviews of Unit General Managers. From 1983, performance indicators have informed these reviews, which have themselves, reinforced the importance of ministerial and RHA views on policies and priorities and enhanced upward accountability. The NHS Management Inquiry, which reported in 1983 (Circular HC(84)13), led to the introduction of the concept of "general management" in place of corporate, consensus decision-making. The intention here being that this change would increase effectiveness and ensure that expenditure reached its intended target and that management of the health service was geared primarily to the interests of patients.

Value for money initiatives have featured in the NHS since 1979. For example "Health Care and its Costs" HMSO and the National Audit Office Value for Money (1983) The Annual Report for the Health Service in England, (Report 1985) contended that "Getting the best out of resources in terms of maximising the services to patients is a fundamental challenge

for the government". This was to be achieved through improvements in the structure and management of the service, improved accountability of health authorities, better utilisation of manpower and the execution of substantial and sustained cost-improvement programmes. This latter initiative embraced the policy of competitive tendering, which involves contracting with the private sector for the provision of services (HC(83)13). It was advocated by the then Minister for Health, Dr Gerard Vaughan, in 1980 and 1981, and was the subject of a draft circular in 1983 and appeared in the Conservative Party Manifesto for the 1983 general election before definitive guidance followed later that year. (Conservative Party Manifesto 1983) Efficiency was the underlying rationale of competitive tendering, which was itself seen as a way of securing cost reductions.

By the mid-1980s, the above changes brought about in the daily operation of the NHS were the subject of much political debate and controversy. At the general election of June 1987, the NHS was a major issue, as the Service seemed to be plagued by a financial crisis of unprecedented proportions. Ward closures and delays in treatment captured media attention as patients sought legal protection for their rights to treatment. At the Conservative Party Conference in September 1987, the newly appointed Secretary of State, John Moore (1987), attacked the Welfare State as breeding a dependency culture. Whilst the Prime Minister (1987) felt it prudent to assure both supporters and critics of her Government's health policy that "The NHS is safe in our hands", the controversy surrounding the nature and degree of change brought about in the NHS by successive governmental initiatives failed to go away and reached a new peak in early 1988. Under increasing pressure, both within and without Parliament, Mrs Thatcher announced a review of the NHS.

The NHS Review (1989) was seen by the Opposition both as a muddled response to the NHS "crisis of Service" and as a cynical strategy by which the NHS was to be allowed to run into a crisis; thus making the radical alternative of private medical care more attractive. Irrespective of motive, the thrust of the Review was toward improved efficiency in the service rather than toward increased funding of it (Dunlevy, Gamble & Peele 1990).

The NHS Review (1989) worked in secret and the identity of the members of the team was not made public. The findings of the Review were revealed in January 1989 and contained a mixture of radical and consensus measures. The most radical proposals were to enable hospitals to manage their own affairs independently of the Health Authorities (HAs) of which they were a part and to give GPs budgets that they could spend on purchasing care for

their patients. Both of these proposals entailed a distinction being made between financing and provision and seeking to move hospitals away from global budgets toward income, which was related to the services performed. The intention was to create an "Internal Market" in the NHS with HAs being transformed into Purchasers rather than Providers of care, as had been the traditional pattern. Consensus proposals were contained in the recommendation that care should continue to be free at the point of delivery and should still be funded from general taxation.

Conclusions of the NHS Review

The recommendations of the NHS Review, with an emphasis on the provision of better health care and improved services to patients, were enshrined in the Health and Community Care Act (1990) that came into effect in April 1991. Within the changes, services provided by the NHS were still to be available to all; paid for mainly out of taxation and mostly free at the point of delivery. To ensure these objectives, some major changes had been made to the organisation of the NHS with effect from April 1991. In particular, HAs and some GPs became Purchasers of the health services and local hospitals became the Providers of those services. DHAs were streamlined to enable them to focus on their major role of assessing the health needs of their population. All hospitals were now required to provide efficient and effective health services to meet the needs identified by HAs and earn their income from contracts for services and most hospitals had now become NHS Trusts; responsible for managing their own affairs without intervention from District or Regional management.

The Evolving NHS as an Organisation

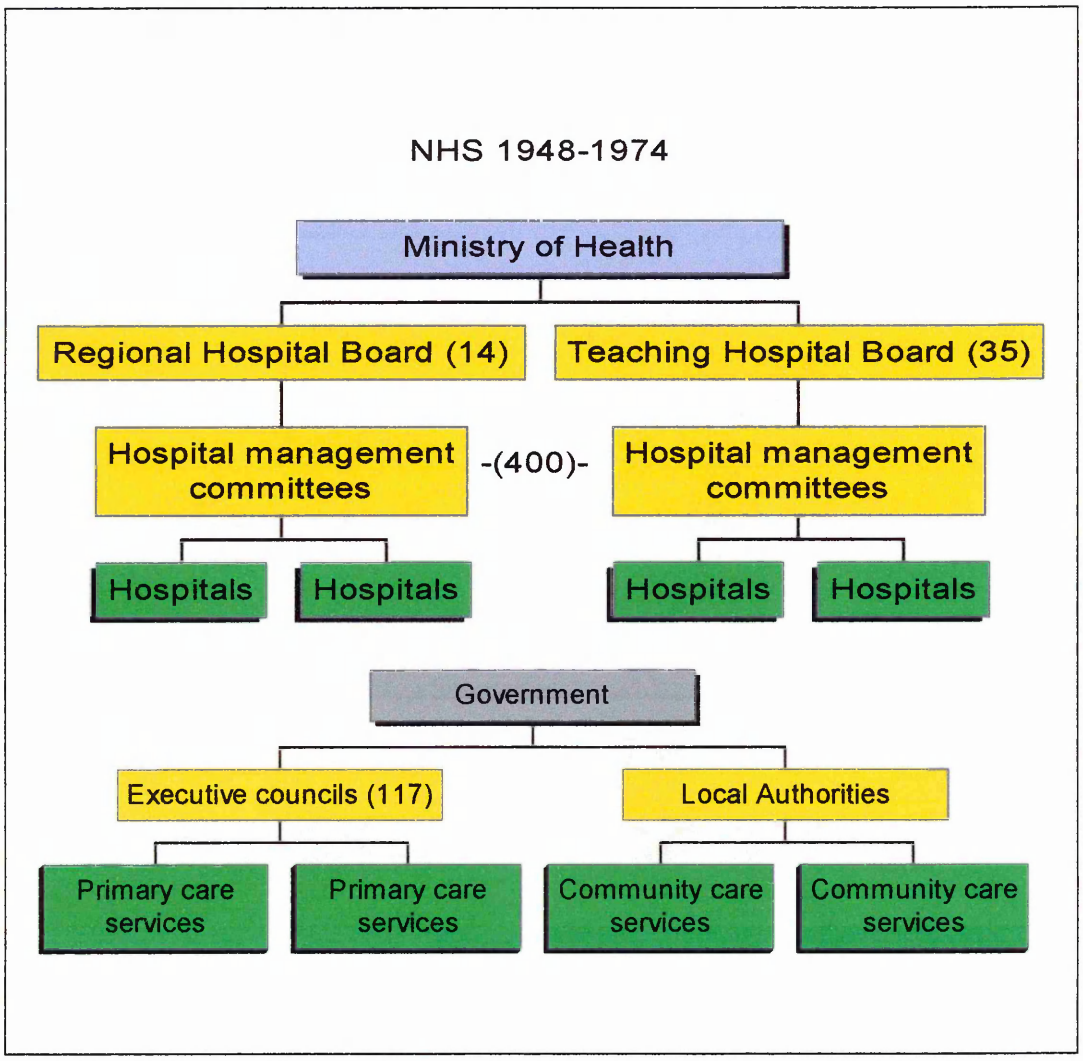
NHS Reorganisations

The original management structure of the NHS, (Figure 1) which persisted from 1948 until 1974, had 14 Regional Hospital Boards and 35 Teaching Hospital Boards reporting directly to the Ministry of Health. Between them, these Hospital Boards supervised about 400 Hospital Management Committees, which in turn supervised the hospitals. Primary Care services were run by 117 Executive Councils, and Community Care by the Local Authorities. In 1974 this structure was reorganised into five tiers of management: DHAs, controlled by Area Health Authorities (AHAs), in turn controlled by Regional Health Boards which were finally accountable to the four Departments of Health and Social Security (DHSS) (one each for England, Wales, Scotland and Northern Ireland) and thereby to parliament. DHAs

administered individual hospitals, with day-to-day running performed by Hospital Management Committees (HMCs). GPs and dentists were employed by FPCs that were answerable directly to the DHSS.

A Hospital's Consultants were employed by the Regional Health Board. Lastly, a small number of highly specialised hospitals became Special Health Authorities, being answerable directly to the Department of Health and Social Security (DHSS). By 1975 the broad structure of the NHS structure was as follows: Departments of Health for England, Wales, Scotland and Northern Ireland, 8 Regional Health Authorities, 177 Family Practitioner Committees, 217 District Health Authorities, 9000 General Practices and 2005 Hospitals. This structure remained essentially the same until 1985 (Figure 2). Since 1948, there have been several reorganisations of the NHS, notably those in 1974 and 1989. Some of the more significant changes have been the abolition of Area Health Authorities, the introduction of general management in 1983 in response to the Griffiths Report (Griffiths 1983) , the GP New Contract of 1987, the introduction of the Nursing 2000 plan, the Health and Community Care Act (1990) and the redistribution of NHS central funding.

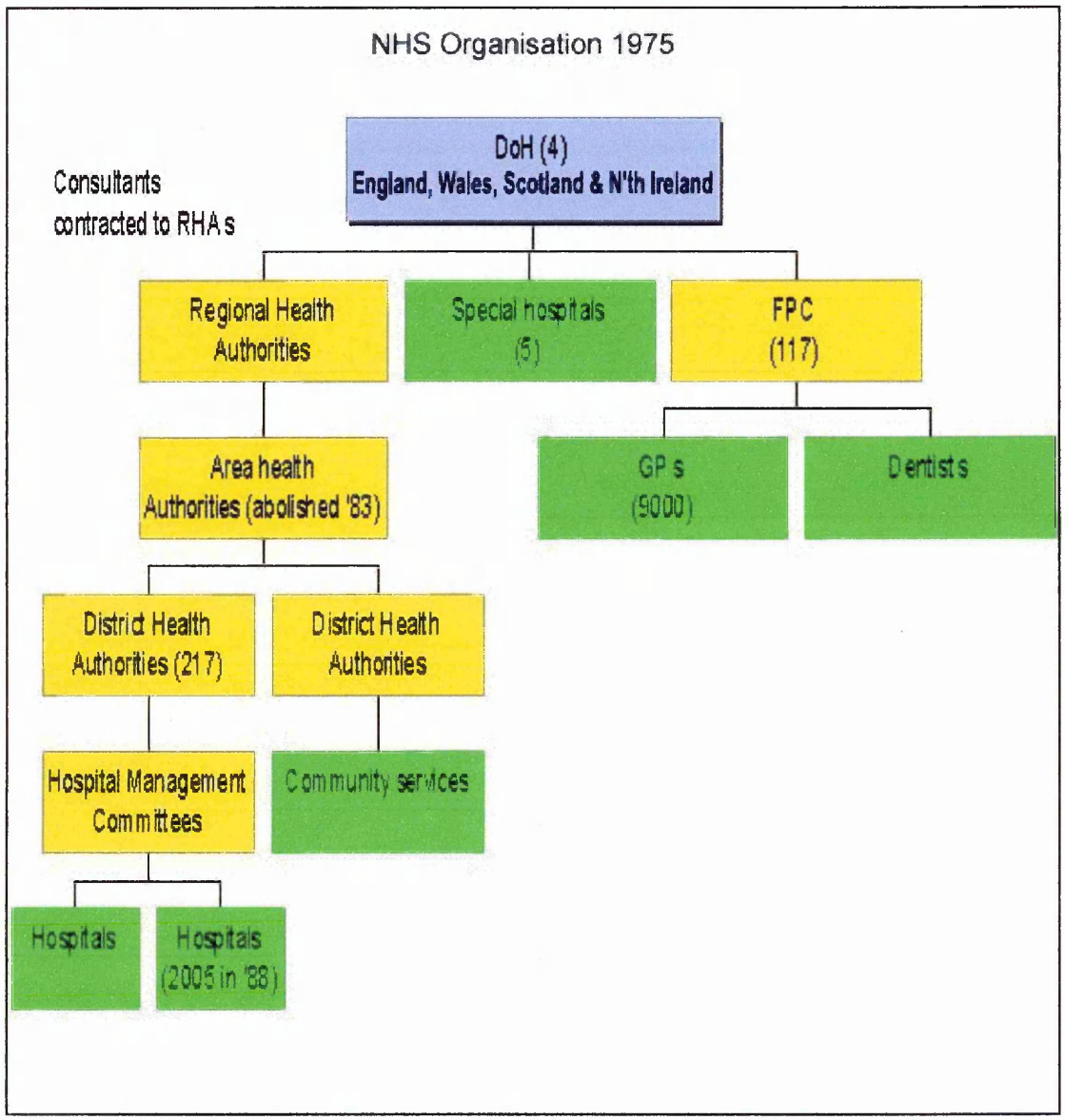
Figure 1: NHS Structure 1948-1974



Until the mid 1970s, the amount of money allocated to individual Regional Health Boards/Authorities each year had been based on the previous year's allocation plus small increase for the coming year thus maintaining the percentage share of the NHS budget for each organisation in the proportions decided upon at the inception of the NHS 30 years earlier. In 1976, a Resource Allocation Working Party (RAWP) (1976) was instituted, charged with the task of deciding how to reallocate the total NHS budget across the country. This resulted in a re-allocation of money away from London to the provinces, based largely on geography rather than assessment of need. This re-allocation of resources continued to be informed when in 1975, a report was commissioned, which reported in 1978, (Royal Commission on the NHS 1978) to study the interplay of social class on health needs. This led

to the publication of the Black Report 'Inequalities in Health' in 1988, and ultimately to social weighting being added to resource allocation calculations.

Figure 2: NHS Organisation 1975



The 1985 Reorganisation

The previous reorganisation was due mainly to the recommendations of the Griffiths (1983) and Korner (1985) Reports. The emphasis of their recommendations was that consensus management should be replaced by power invested in the individual manager and that precise management objectives should be set with a realistic means of assessing health output. Regional, District and Unit General Managers had a clear mandate of authority and accountability with a move towards more business-like budget and resource management.

Nearly four years after the reorganisation, Mamoch (1989), writing in "The Health Care Journal", noted that several of the Griffiths Report's recommendations had not been fulfilled. Due in part to the "centre" of the macro organisation (DoH) still setting many initiatives, such as clinical coding and capital resource management, for which there was a mandatory response from the various Districts and Units. Thus a large element of the new self-governing status of District and Unit General Managers was being eroded by having to respond to requirements from the "centre".

The Griffiths Report

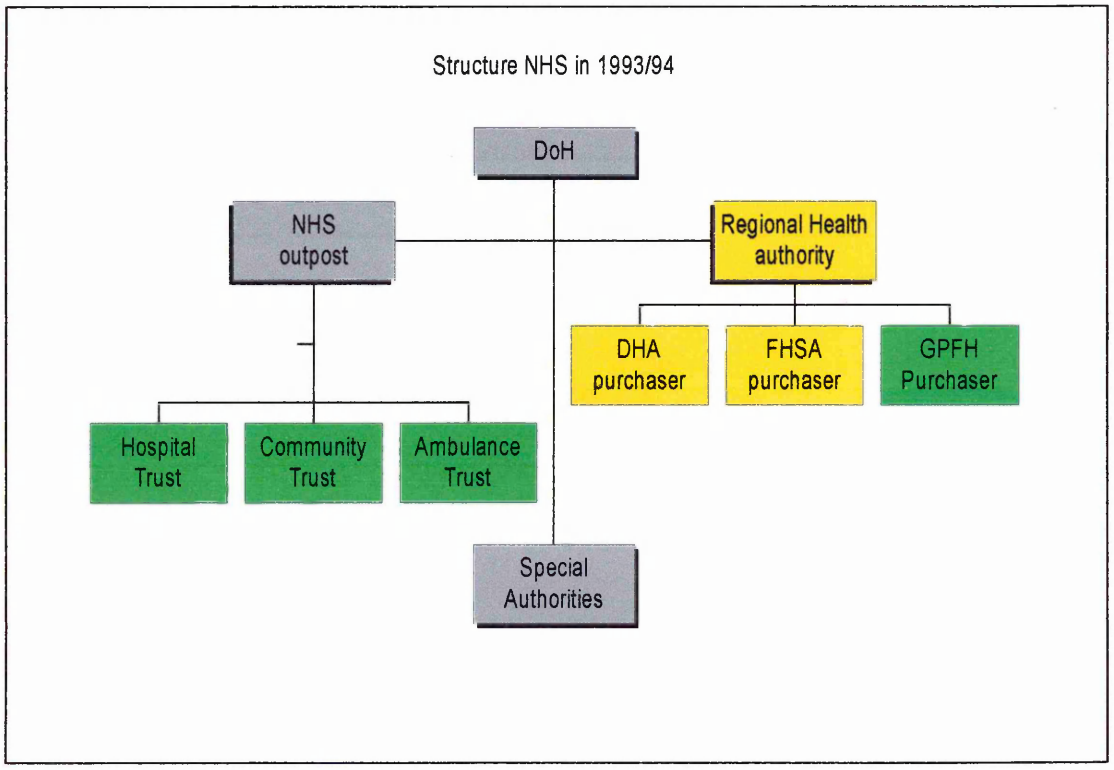
Against all the legislation, restructuring and reports on the NHS, the main thrust of the Griffiths Report was to make the NHS flexible enough to respond to its ever-changing environment. Even though there have been many attempts since 1948, the starting point for the 1995 -1997 (Figure 3 and Figure 4) changes can be argued as being contained in the recommendations within the Griffiths (1983) and Korner (1985) Reports. The main comments in the summary of the Griffiths Report were that "it (NHS) lacked any real continuous evaluation of its performance; rarely were precise management objectives set; there was little measurement of health output; clinical evaluation of particular practices was by no means common and economic evaluation of those practices extremely rare." In 1985-86 General Managers were appointed to take charge of the NHS. However, this was not enough to provoke the evaluation and drive for efficiency that the Government wanted. Korner data was found to be expensive, cumbersome and not business-orientated and thus the "internal market" was introduced in a White Paper (1989) to come into effect by 1st April 1991. Health services were to be forced to become business-like and competitive or disappear. This, in turn, forced the realisation that timely, relevant and reliable information was required, that the existing systems were not up to the task and were crumbling under the strain. The managers were beginning to realise that Provider requirements for information were not the same as the requirements of the Purchasers and the search for appropriate systems to cater for this disparity of need became a priority, (Stanley 1992).

The 1990 Reorganisation

This reorganisation widely publicised in the Government's White Paper (1989) "Working for patients" which came into effect on the 1st April 1991 has completed its cycle. All NHS hospitals have become Trusts, the fourth and fifth wave by 1st April 1994. Both patients and

hospitals have been given a wider range of choice and the State is not supposed to play such a central role in the control of health services. An ongoing programme of denationalisation and increased consumer choice, promoting a more competitive environment, has been central to the economic strategy of successive governments over the last 15 years.

Figure 3: NHS Structure 1993-94

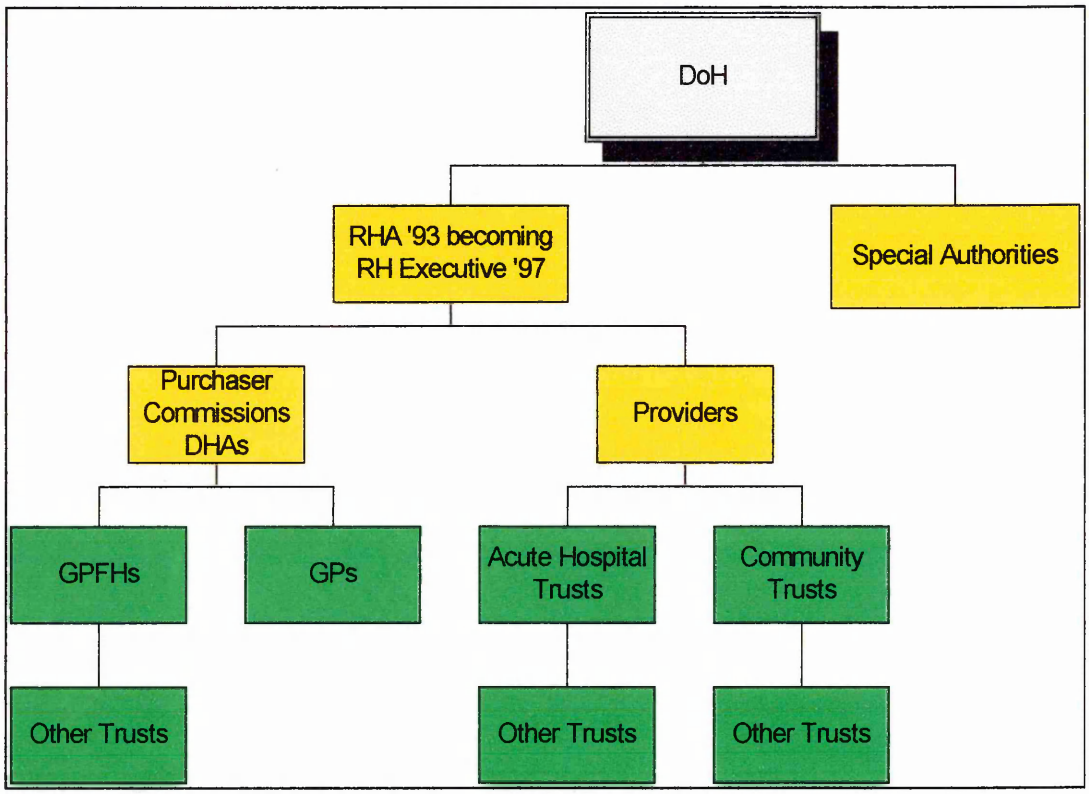


The services that provided health-care were split into "demand services" and "supply services". The former group included the FPCs, GPs and District Purchasing Agencies, whereas the latter is composed of Self-governing, District managed and Private hospitals. Thus the NHS underwent another major reorganisation which reflected a rapidly changing environment. Attempts by the previous Government to control through a range of strategies an organisation whose spending was consuming more and more of the Gross National Product (GNP), was seen to be failing. This rapid reorganisation of the management of the healthcare services which in its initial stages outwardly left the NHS unchanged, has now made unsustainable demands on the old information systems that exist today in the Purchaser and Provider establishments of the NHS 1998 style.

The structure of the Organisation in 1997

The Government White Paper (1989) entitled 'Working for patients', was the precursor to the radical changes that have taken place in the NHS in recent years. It is claimed that the origin of the changes was first hinted at in a one-to-one television interview with Prime Minister Thatcher, a few years previously in 1986. Under some hostile interviewing she announced, apparently unexpectedly, that the Government was going to undertake a fundamental review of the NHS.

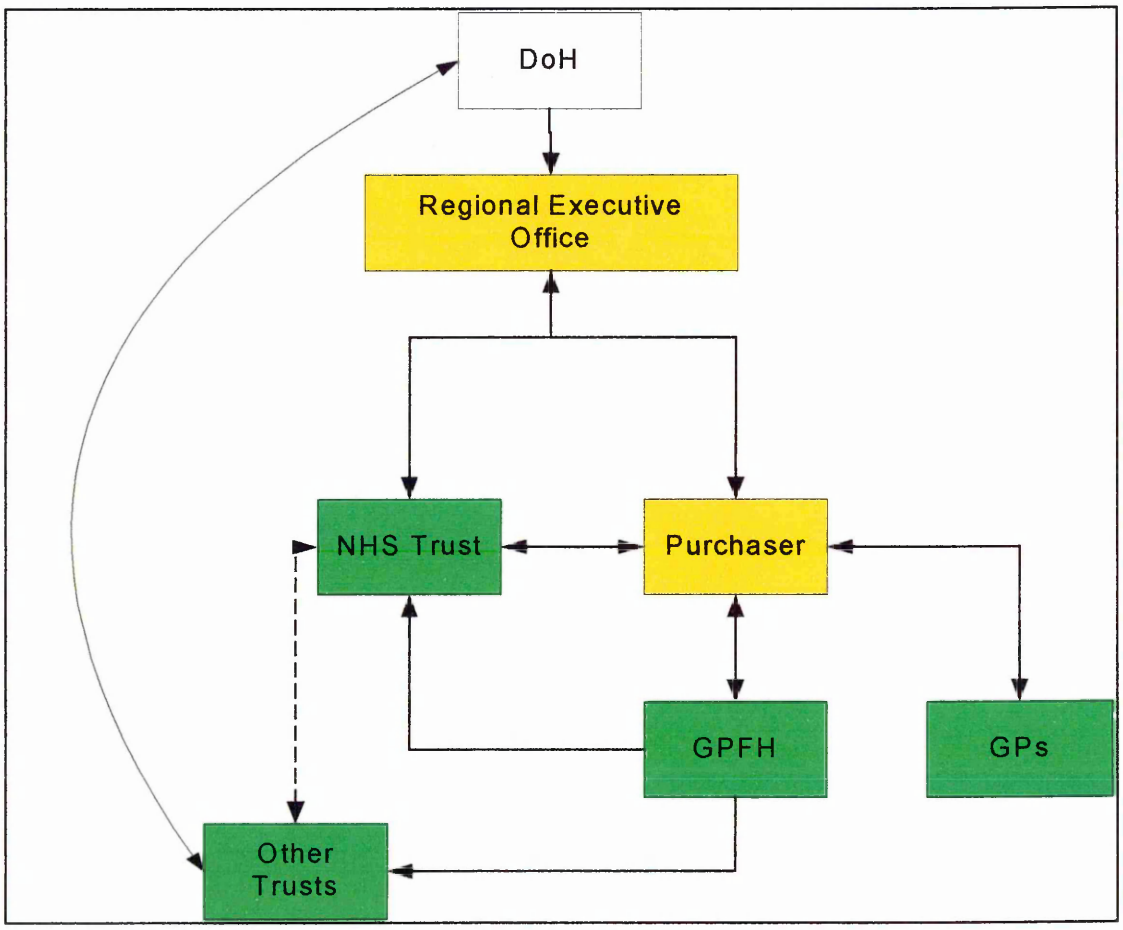
Figure 4: NHS Structure 1995-1997



Having made the announcement, political expediency required that not only the review, but also any implementation of its recommendations, should be completed in a very short timescale before the next general election, then three years away. The review was placed under the stewardship of Kenneth Clarke, Minister for Health who chose to tackle that review phase by assembling a task force comprising a small number of managers and doctors sympathetic to the idea. With the review phase complete, the next step was its implementation. A number of hospitals were approached to see whether they would be prepared to become 'Flagship Trusts'. Amongst these was St. Thomas's Hospital in London. It had originally been stated that no hospital would become a Trust without the vote of the

medical consultant body, a condition that antagonised the other professional interest groups within hospitals whose views were excluded. However, when it became clear that at St. Thomas's the consultant body would not support the move, the rules were changed so that conversion to trust status required only the majority vote of the Hospital Board. The British Medical Association, already incensed that the consultation phase had excluded it, adopted more aggressive tactics. The other professional and trades union bodies also became more militant and vocal. Faced with that growing insurrection, the Prime Minister was apparently forced to move Mr Clarke sideways and replace him with the more conciliatory William Waldegrave. The plans were then pushed through substantially unaltered.

Figure 5: Relationships of the Purchaser/Provider Split



The fundamental changes introduced by the White Paper were embodied in the concept of the split between the Purchasers and Providers of the healthcare services. Individual hospitals, and individual providers of care, were given the option to become self-governing Trusts or fund holding GPs. This meant that such units could decide for themselves what services they would provide or purchase, negotiate the price of those services to their various

customers, and thereby generate income within the constraints of the Health and Medicines Act (1988). In addition to being able to determine their own management structures independent of any HA or DoH control, they were able to hire and fire whatever staff they felt necessary and determine their own levels of pay and conditions of service. This included the right to issue consultants with local contracts, in place of their regionally held contracts. They had also the power to acquire, own and dispose of assets. Similarly, they could also retain operating profits, maintain surpluses and, subject to an annual financing limit, borrow money. Trusts were answerable directly to the Secretary of State for Health (although this was moderated to being directly answerable to Executive outposts).

This freedom strongly contrasted with the situation prior to this wherein the management structure of a hospital and the services it provided were determined by the DHA, which also handed the hospital a fixed sum of money at the start of the financial year with which to provide those services. Any surplus was clawed back (and often led to reduced funding in subsequent years) and borrowing of money was not possible. Any significant capital expenditure (e.g. for a new building) required a competitive bid for the money to be made to the RHA. Whilst the numbers of staff employed were not dictated, the General Whitley Council agreed their levels of pay and terms of service nationally.

Fund-Holding General Practitioners

At the same time as Trusts had been empowered to become independent providers of healthcare, GPs had been given the opportunity to become independent purchasers of healthcare. Prior to this, GPs in any one locale were obliged to refer most of their patients to the local hospital. By giving GPs a budget of their own, they became free to negotiate the provision of certain services wherever they wished, including from the private (Non-NHS) hospitals. Services covered by the Fund included Elective Surgery, Pathology, Outpatients and Community Nursing. Services not covered by the Fund included Accident and Emergency. Fund holders were also given a separate budget with which to pay for drug prescriptions generated by the practice itself. Any savings from either budget at the end of the year could be used to pay for improvements 'for the benefit of patients' within the practice itself. The incumbent Conservative Government wished to extend the principles of Fundholding, and there were (in Oct 95) several pilot sites for "Total Fundholding", where the GPs controlled the budget for all services for their patients.

In practical terms, GP Fund holders never possessed the money from the Fund in terms of it being in their bank accounts. The practice negotiated with hospitals to provide various services, either on:

- A block contract: - a fixed sum for the whole year paid to the hospital, in return for which the hospital will perform operation X on however many patients the practice happens to send, subject to a maximum, or

- Cost per case: - in which the hospital billed the practice each time operation X was carried out on one of the practice's patients.

In either case, the money was actually held by the Family Health Services Authority (FHSA), in essence a renamed and more powerful Family Practitioner Committee, and the money paid out from there. FHSAs were answerable to their Regional Health Authority (RHA).

"Under-spends" from the Fund could be used to employ, for example, a Physiotherapist or a Counsellor within the practice, to redecorate the waiting room or to purchase new equipment. They could not be paid to the GPs running the fund, at least not directly. Some GPs initially contracted themselves to their own practice as providers of a variety of services, which the fund covers, e.g. certain minor surgical procedures. They were then able to 'refer' patients to themselves and receive money out of the Fund. This practice was clearly open to abuse and eventually prohibited. GPs, however, were still free to perform such work for other Fund holding practices and to receive payment for doing so.

Apart from externally contracted work, as outlined above, Fund holding GPs with a surplus of funds could benefit financially, albeit indirectly: without the fund, a practice must maintain, upgrade or replace its equipment out of the total practice income which arises from General Medical Services work. Fund overspends of up to 5% would be deducted from the following year's Fund, and overspends more than 5% may have resulted in withdrawal of Fund holding status.

The Purchaser/Provider Split

The above has already been outlined; in essence it draws a distinction between those who provide healthcare (e.g. Hospitals and Community Care Providers) and those who purchase it

(e.g. DHAs and Fund holding GPs). The most important point is that Providers no longer received monies as of right; rather they had to compete with all the other Providers to sell their services competitively to the Purchasers. GPFHs purchase care on behalf of their patients only, whilst DHAs purchase care on behalf of all non-Fund holding GPs in the district. Services not covered by the Funds, e.g. A&E, are purchased on behalf of all by the DHA. The money would follow the patient. This split had the effect that non-Trust Hospitals found themselves in the invidious position of being obliged to compete for custom, negotiate prices and invoice purchasers for services rendered, but were unable to directly use any profits they might make.

Implicit in the split is the possibility that an uncompetitive Provider might become non-viable (i.e. bankrupt) but it was always unclear whether the Government was prepared to let rationalisation by the market place occur. It appeared to be cautiously in favour of it in general terms, but only one hospital, the Anglian Community Healthcare Trust, has been allowed to close in this way so far. The notable omissions from the 'Changes' was a clear strategy for maintaining a Supra District Public Health Perspective, for maintaining in-service training for doctors and technical staff within an environment where time is money, and a strategy for the provision of Supra Regional Specialist Services such as intensive care beds.

Implementing 'Working for patients'

At the start of the introduction of the NHS Changes as they became known, a small number of large hospitals were granted Trust status and a small number of the larger General Practices became Fund holders. Many of the original bids proposed single trusts, combining secondary care provision (the hospital) with the community side (District Mental Health Nurses, Ambulance services, District Chiropody). In most cases, these bids were invited to resubmit as two separate Trusts. The continuing pattern thereafter was for almost all Trusts to be either just a hospital or hospitals, or a Community Care Trust. All purchasers were obliged to purchase care from the places they had habitually used, so that the competitive market did not, in reality, exist until April 1993 when this requirement was dropped.

By the end of the years of Conservative Governments (1975-1997), approximately 90% of hospitals and community services had Trust Status and at the same time as DHAs merged to form larger organisations, they were no longer responsible for the performance of the hospitals. Their emerging responsibilities reflected the commissioning of healthcare in their

communities, with only non-Fundholding GPs accountable to them. In some DHAs, 40% of the district budget was in the hands of Fund holders by 1995. The marked reduction in the responsibilities of the RHAs that ensued prompted the Government to merge the 17 RHAs into only eight, and to move to abolish RHAs completely from 1997.

Uptake of Fundholding Status by General Practices was always less extensive (40-50% of the total number of practices in England and Wales) for two reasons: firstly, the profession as a whole, and the General Practitioner Body in particular, retained grave reservations of the Purchaser/Provider split (HSJ 1995); secondly, there were a significant number of practices in the UK, which were initially considered too small to make Fund holding a financially viable proposition. The DHSS pursued methods to allow these small practices to hold Funds, for example by grouping them together into super funds, or riding 'piggy back' onto larger, existing Funds.

Difficulties Caused by the Changes

One of the biggest obstacles to the successful management of the NHS, and also to any analysis of its current well being, remains the significant lack of any valid information with regard to what the NHS does; how much it costs; and where the money is spent. Indeed, it is perhaps surprising that 'the changes' were conceived and implemented as quickly or speedily as they were, given the lack of information that was available in 1988. Attempts were made to ensure that hospitals began from a 'level playing field' so that they were in fair competition with one another. However, the sometimes ten fold differences in the early quoted costs for identical services in different hospitals had as much to do with differing costs of maintaining buildings as it had to do with a lack of agreement on accounting methods. There remains considerable discrepancy in pricing. An example of this is 1996 data showing that one major teaching hospital charged more than £1,200 for varicose vein surgery, whilst a nearby local hospital charged less than £250. The waiting time at the teaching hospital for this surgery was given as 3-4 months and for the cheaper local hospital 2-3 weeks.

Furthermore, because the NHS has evolved organically since 1948 as an integrated provider of healthcare, the attempt to fragment it into different units, cross-charging one another, rapidly became beset by boundary disputes and uncertainties. There was much cross-subsidising occurring, for example patients being discharged following Day Case Surgery with instructions to attend the GP for removal of sutures.

It soon became apparent that the NHS continued to suffer from difficulties despite the changes. But it was, and remains, hard to determine which difficulties were the result of the transitional state in which it found itself, and which were due to more persistent factors: under funding of the NHS as a whole, mis-management, or fundamental flaws in the 'Changes' themselves. There were well-documented and anecdotal cases of both Fund Holders and DHAs having spent their entire budget well before the end of the financial year. Equally, and rather more commonly, there were cases where Fund holders had surpluses of over £100,000 in the year 1993/1994. As a result, one DHA was asking its Fund Holders to voluntarily repay £50,000 in order to prop up the District so that it could purchase more care. Some Trust hospitals did require "bailing out" by the centre. Many hospitals and Trusts completed their contracts with District Purchasers before the end of the financial year, and as a consequence suspended elective surgical procedures for all but Fund Holding GP patients. Other Trusts began covertly fast-tracking Fund holder patients for surgery as a means of generating income to subsidise less profitable or loss-making services. It soon appeared that the NHS had become a two-tier service, whereby patients of Fund holding GPs obtained treatment earlier than patients of Non-Fund holding GPs. If all GPs had held funds, this situation could not have arisen. However, many GPs vehemently opposed the philosophy of "Fund Holding", blaming it for the two-tier system, but also mindful of the fact that managing the Fund required increased work for little or no personal reward, and that as budgets became squeezed the work would only increase. Even those Practices that were Fund holders began to be concerned for the future when FHSAs started clawing back fund surpluses at the year end and then, as outlined above, before the year end.

The NHS: The Current Structure

The current structure of the NHS was largely established by legislation in the early 1990s, which introduced a number of radical changes, creating the so-called "internal market" with its "Purchaser/Provider split". The Labour Government elected in 1997 promised to modify what it regarded as the negative aspects of the early reforms.

Key features of the "internal market" include NHS Trusts and GPFHs; the Trusts are Providers of healthcare, and may focus upon acute hospital-based services, or upon community services (typically including domiciliary care, child health and longer-term health care for elderly people). Trusts earn the majority of their income through contracts with Purchasers, including HAs and GPFHs. Contracts, hitherto renegotiated annually, are likely

to become longer term as the Labour Government is proposing 3-5 year "service agreements"; GPFHs are GPs who hold their own budgets for purchasing elective (i.e. non-emergency) healthcare services for their patients, which could, in principle, be spent with any Provider, including the private sector. Of all the recent reforms to the NHS, Fundholding has been the most controversial as GPs have re-directed contracts away from allegedly poorly performing Providers. Under the White Paper (1998) proposals GP Fundholding is to be wound down by 1999 (subject to legislation).

In the summer of 1997 the Government lifted the requirement that all NHS capital projects with a value of £1 million or more must pursue a Private Finance Initiative (PFI) solution, which had applied for the last three years. During this time, a consensus developed around the form of PFI healthcare projects. The essential features of such projects are that, subject to demonstrating value for money and best risk allocation, private sector consortia should finance, build and operate facilities while providing non-clinical support services. The Government selected, through a prioritisation process that ranked submitted projects in terms of improvement of service, 15 hospital projects in England that were to proceed as a priority to achieve PFI project status. At the time of writing the Dartford and Carlisle projects were at the contract completion stage and a review of the PFI process was currently underway. It was anticipated by PFI applicants that future projects might differ from the successful "1st" wave PFI projects.

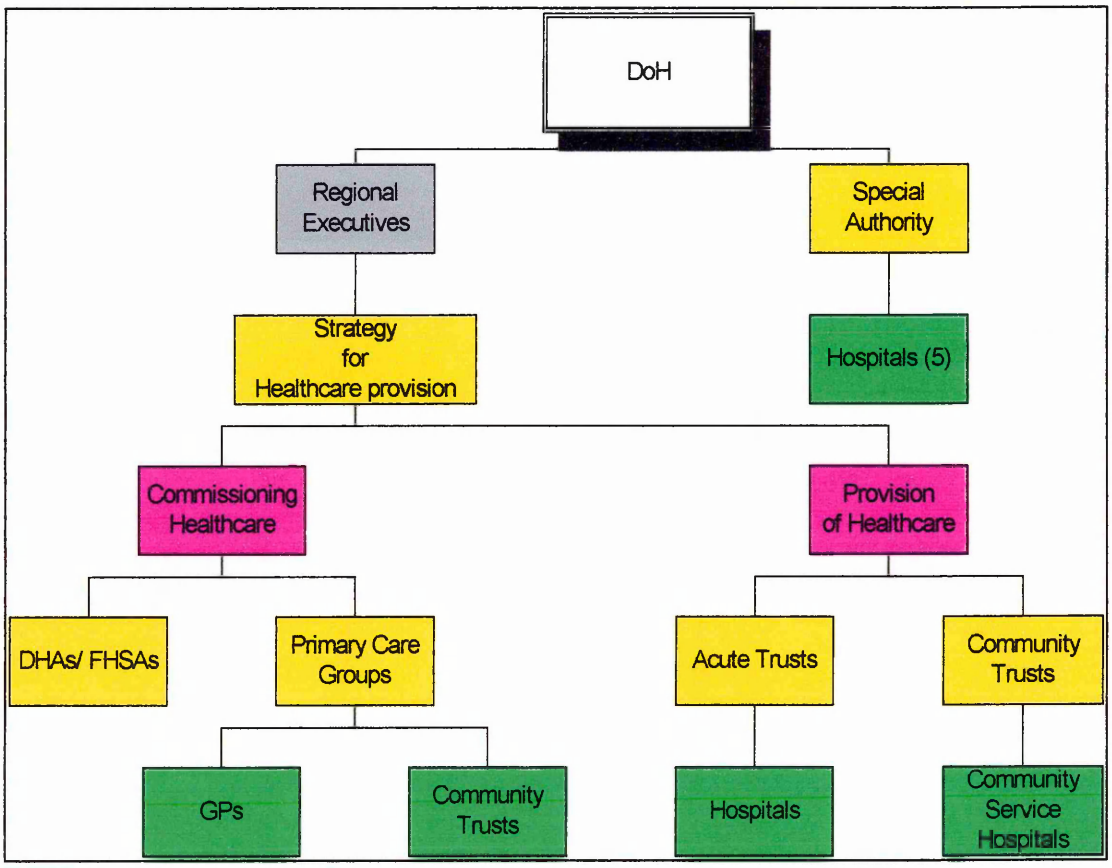
1999 and Beyond

The new Government's Health Service White Paper (1998) produced a blueprint for healthcare into the next century. The plan was to construct a 'sustainable system' delivering better and more responsive healthcare into the next century'. Instead of the internal market there will be 'integrated care' founded on partnership, harnessing new technology, spreading best practice, continuously emphasising quality. It is hoped that it will restore public confidence in the NHS as a universal and comprehensive service.

The White Paper announced that the reforms would take 10 years. That assertion neglected the hard lessons of NHS history since 1974, that no reorganisation survives more than a few years without being swept away or heavily overlaid with further reforms as new policy fads appear; or *force majeure* impinges, or simply enough people become convinced that there must be a better way of doing things.

The White Paper promised that the "new NHS" would chart a 'third way' between the 'command and control' of the 1970s and the 'fragmentation and bureaucracy' of the internal market. But command and control did not disappear 20 years ago; much still exists, and some of Labour's health policy initiatives look set to reinforce it. Neither are fragmentation and bureaucracy the sole preserve of the internal market.

Figure 6: Structure NHS 1997 Onwards



With regard to the bureaucracy, the White Paper forecast that in time the NHS structure would shrink of its own accord, from 3,600 organisations to 500; echoes perhaps, of Aneurin Bevan's prediction that as people's health improved demands on the service would diminish.

Crucial to the vision as espoused in the White Paper (1998) will be the role of GPs as Commissioners of healthcare in Primary Care Groups (PCGs). So the deep-seated antagonism between GPs and consultants will feel another sharp prod, possibly jeopardising the alliance building and ambitions for a seamless service in some places. But how happy will GPs be to have so much influence showered on them? Few have any training in commissioning. Steeped in the culture of the independent contractor, their diverse outlooks make collaboration and effective representation difficult. They will need to be schooled in

how their actions will impact on the service as a whole, which might take time. They will have to come to terms with potential conflicts of interest as both Commissioners and Providers of care and they will have to become accustomed to making difficult decisions, which might threaten their clinical or financial autonomy. The various models outlined will allow the more reluctant a gentle introduction to commissioning - but in practice the Government is making GPs an offer they cannot refuse, just as its predecessors did with Fundholding.

Unlike the earlier reforms, these come without new money to ease their passage other than promises of savings from "red tape" at a time when skilful management will be more in demand than ever. No more internal market, a powerful Commission for Health Improvement (CHI), new PCGs, and strict quality standards. This is the outline for the 10 year modernisation programme in the Government's White Papers on restructuring the NHS in England and Scotland. The White Paper (1998) is part of the "Third way" as espoused by the Government. As yet the third way has to be clearly defined and understood. However, as applied to the "new NHS" it is described below:

A 'third way' which will:

- Keep the separation between planning and provision;
- Keep and build on the important role of primary care;
- Keep decentralised responsibility for operational management.
- There will be new drives on quality and efficiency, which have to go hand in hand.

The Government stated in its White Paper (1998) that it wished to see six principles upheld:

1. Quality and Efficiency.
2. National Service Frameworks – based upon evidence of clinical effectiveness to ensure consistent access and quality of care for particular services (Calman-Hine 1997).
3. National Institute for Clinical Excellence – to disseminate good practice on clinical and cost effectiveness.
4. Commissioning for Health Improvement – to monitor local performance against clinical quality standards, with powers of intervention in cases of under-performance.

5. New Performance framework – replacing the current "Efficiency Index", seeks to promote more rounded performance targets, incorporating national reference costs.
6. Health Improvement Programmes – to be agreed between Health Authorities, Trusts and PCGs will set the local framework for health targets.

The White Paper argues that patients lose out when the NHS is inefficient just as they lose out when standards of care are variable. Every part of the NHS and everybody within it must take responsibility for improving quality, a term which should encompass both quality of experience and quality of outcome, says the document. A major part of the White Paper is given to quality initiatives. A number of new national bodies are proposed, two of which are:

The Commission for Health Improvements (CHI): Government appointed, charged with ensuring that local systems are implemented to 'monitor, assure and improve clinical quality' and;

The National Institute for Clinical Excellence (NICE): a body of patient representatives, managers, economists, academics and health professionals giving 'new coherence and prominence to information about clinical and cost effectiveness'.

As well as the national bodies described above the White Paper describes the process through which improvements will be made; **Health Improvement Programmes**: locally produced strategies for improving health and healthcare, drawn up in consultation with hospital and community trusts, patients, PCGs etc. they must be updated annually, and GPs must ensure that the care they provide as well as the care they purchase fits within the overall local plan.

This improvement in quality of outcome will be achieved in three ways:

1. National standards and guidelines - there will be new evidence-based national service frameworks building on the Calman-Hine (1997) initiative on cancer care to help ensure consistent access to services and equality of care across the country.
2. There will be a National Institute of Clinical Excellence (NICE) that will give a lead on clinical and cost effectiveness. It will draw up new guidelines from the latest scientific evidence and ensure they reach all parts of the NHS. That national drive for quality will be backed up locally in two ways:

a) There will be explicit quality standards in the local long-term agreements that replace contracts

b) There will be a new system of clinical governance in Trusts and Primary Care to ensure clinical standards are being met, backed up by a statutory duty of quality on Trusts.

3. Where there are local shortcomings a Commission for Health Improvement (CHI) will have the power to support clinical improvements or to intervene where a problem has not been properly addressed.

The CHI will be a statutory organisation that will include clinical, academic, patient and service representatives. Its functions will include supporting local developments and, in particular, clinical governance in Primary Care. When there are failures in an organisation, the Commission will have the power to intervene, or it may be directed to intervene by the Health Secretary. There are five proposals to improve efficiency:

1. Clinical and financial responsibility will be united in new PCGs (locality commissions), which will be responsible for a single, unified budget covering most aspects of care.

2. Management costs in PCGs and Trusts will be capped, and the DoH will continue to bear down on bureaucracy. There will be no more extra-contractual referrals, cost-per-case or short-term contracts.

3. There will be a national system of reference costs.

4. There will be clear incentives for all members of the local NHS to improve performance and efficiency. HAs which perform well will be eligible for additional non-recurrent money; Trusts and PCGs will be able to retain savings from long-term agreements to improve services for patients.

5. There will be clear sanctions where performance is not up to standard. HAs are the organisations to which PCGs account.

Structure

PCGs will bring together GPs and Community Nurses in a given area, and will take responsibility for commissioning services for a local community. They will work closely with Social Services. Social Services and Community Nurses will be represented on their boards. The White Paper sets out four models for a PCG, including a new Primary Care Trust (PCT) option, which will be able to run community hospitals and community health services. None of the options will affect the independent contractor status of GPs, but from April 1999, they will replace the range of Fundholding and Commissioning models now in existence, subject to legislation. There will be no further Fundholding schemes in the future. Typically, PCGs will serve populations of around 100,000, but with flexibility according to local circumstances. They will hold a single unified budget, which will be cash-limited although no individual part of the budget will be cash-limited. Within the overall sum, PCGs will be free to decide how much of their money to allocate to the drug budget and how much to spend elsewhere.

The stated aim is to provide commonality between financial streams in order to break down barriers between services. Over time, the number of organisations currently involved in the process as HAs, locality and other commissioners and across the range of Fundholding options will be reduced from around 3,600 to as few as 500. PCGs will have freedom to make decisions about how they use their resources, but they must do so in a manner that is consistent with a local health improvement programme.

The Health Improvement Programme (HImP) will be drawn up once every three years, with the HA taking the lead. It will identify health needs, and decide the range and alignment of services that are needed to meet them. The HImp will be driven by the HA but its formulation will involve Trusts, PCGs, local universities/medical schools and local authorities, both because of their social services role and because of their influence over public transport, housing and economic development issues which affect health more broadly.

HAs will be the accountable bodies under which PCGs operate. They will hold considerable powers to improve the health of their local residents, backed up by a statutory duty of partnership, which will be placed on local health organisations to ensure co-operation. HAs will allocate funds to PCGs on an equitable basis. Links with social services will be

strengthened and, over time, there will be fewer HAs covering larger areas. The White Paper (1998) does not set a target for mergers but anticipates that, as with Trust mergers, they will emerge as a result of local discussion rather than national edicts.

Trusts

Trusts will continue to be responsible for operational management but will be involved as of right in drawing up the local health improvement programme. Trusts will have quality as well as financial duties for the first time, and service agreements concluded with PCGs will contain a clear quality dimension. Trusts will also have to demonstrate how they have improved the involvement of their staff. Frameworks for the organisation and delivery of services, based on the experience of the Calman-Hine cancer initiative, will provide a 'helping hand' to management through which the Government can be clear about its priorities and ensure equity of access throughout the health service. The job of the Regional Executives will be to set and manage standards and frameworks.

Health Action Zones

Health Action Zones (HAZs) form part of the changes, which have been underway in the NHS since 1st May. HAZs are intended to blaze a trail and to find new ways on the ground for health and social services to work together and to commission services together.

Management Costs

The Fundholding management allowance will be redistributed over time to PCGs, allowing them around £3 per head of population. There will be a single 'management cost envelope' for which HAs will have overall responsibility. Management costs should not exceed the current approximate £10 per head of population for HAs plus £3 per head of population for PCGs. As the number of HAs falls over time, it is anticipated that spending on management will also fall.

Timetable

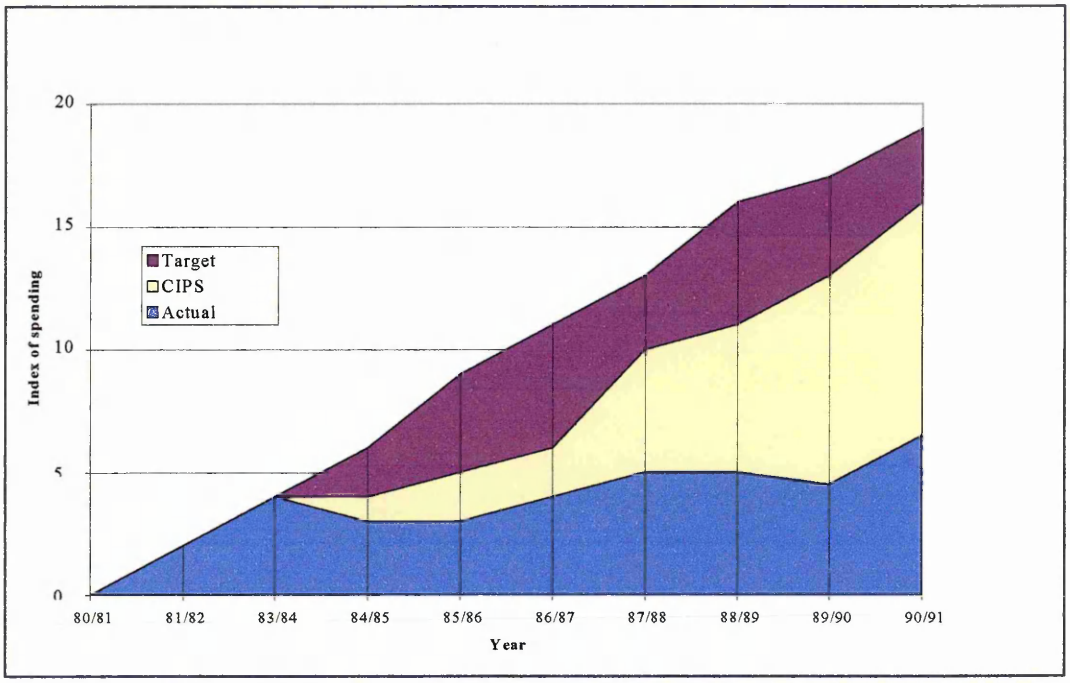
There will be a preparatory year for the new structure in 1998-99, but work began immediately, with HAs and their partner organisations drawing up prototype health improvement programmes for the financial year beginning 1st April 1998. Subject to

legislation, GP Fundholding will end and the new PCGs will begin work in April 1999. Statutory duties of partnership and quality, as well as the promised new statutory bodies; NICE and CHI, will come into effect at the same time.

An Historical Financial Perspective

At the time of the foundation of the NHS in 1948 there was a widespread view that, once whatever backlog of illness there was arising through the effects of war had been cleared up, things would settle down into a steady state. It was even suggested that the cost of the NHS and the demands on it would reduce in time because, people having received medical care and been 'cured', the health of the nation would improve radically, thus reducing the need for the NHS. The experience has been different. The population has grown by 14% since 1948. Nearly half of that growth, about 3.4m, has been in the age group 65+, a group which needs far more healthcare per capita than the rest of the population, and within that group the number aged 75 or over has more than doubled. The need for healthcare clearly increases generally with age (Anderson 1988). New technologies for diagnosis and treatment have been introduced, there has been a political willingness through much of the period to improve the level of service given and, of course, the demand for treatment has grown steadily to take up that service. The building stock within the NHS plays a major role in the financial management of the service. The newly created NHS in 1948 inherited some 2,800 hospitals and in excess of half a million hospital beds (Bown & Ezzamel 1986). By the 1960s there was pressure to expand with a building programme, which was guided by standards of building set by the Government. These standards were set out first in the Hospital Building Notes HBPN (1967-72), followed by a White Paper: (1962) the 'Plan' published in 1962 (The first ten year plan of Hospital Development, and the hospital building procedure notes issued in 1986), (Capricode 1986). These 'notes' were issued as a major effort to financially manage a substantial programme of capital expenditure.

Figure 7: Target & Actual Funding 1980/1-1990/1 England: prices[1]



Note: Target & actual funding 1980/1-1990/91 Hospital & Community Health Services, England: 1990/1 prices

In the early 1970s, it was recognised that the NHS suffered inequalities of provision of service across the country. The first attempt to solve this problem came at the initiative of the then Secretary of State, the late Richard Crossman, with revenue funds being distributed to regions on the basis of such factors as population served, beds provided and cases dealt with. It was intended that the inequalities would be eradicated within a ten-year period. This approach was unsuccessful and, thus, in 1974 the first reorganisation of the NHS came about. With this reorganisation came the Resource Allocation Working Party (RAWP) (1976). This distribution of capital funds from 1977-8 onwards was significant in that it gave each RHA a capital allocation within which it must work, rather than the previous 'bottom-up' approach based on existing capital commitments, priorities, and bids for specific schemes. Also the reorganisation meant that planning was service need led, in that the service needs were identified in the context of the development of the health services, in contrast to the 'capital-led' development of the past.

[1] NAHAT's Survey of the current financial year, quoted in the HSJ News Focus, 13 September 1990

During the 1960s and 1970s a number of papers relating to NHS finance and capital expenditure were produced; these were "The Public Accounts Committee Recommendations (1977)", Royal Commission on the NHS (1978), The Appraisal of Options Procedure Health Notice (81)30(DHSS,1982), and in 1982 another reorganisation in which DHAs were substituted for AHAs and HDs. One of the most far reaching papers of the 1980s to affect the NHS, was the NHS Management Inquiry Griffiths, (1983) which made one of its main recommendations the introduction of 'management budgeting'. Following on from this a fundamental change in philosophy of healthcare provision, from that of 'free to everyone' courtesy of the Exchequer to one of the internal market and revenue generation, occurred as decreed in the White Paper (1989) "Working for patients".

Funding of the NHS

Since its inception in 1948 the NHS has gradually changed from an "existing capital-led resourcing", through to a "service needs-led and population served resourcing", to the present day which has a mixture of resource funding based on the RAWP formula, service outcomes, performance, efficiency savings and purchasing. Since the late 1970s, pay awards have not been fully funded and recently inflation funding has been deficient as well. The revenue consequences of capital developments and the appointment of extra consultants that have not been fully funded, has taken place against a background of bed reductions, vacancy controls dictated by the Government and the need to replenish old building stock, replace equipment and an increasing demand on fewer beds. The effect of increased throughput of patients was handled mainly by an increase in manpower at the bedside. The political philosophy of the previous Government required that less resource from taxation be spent on the NHS. The PFI is now being applied to the public sector and, in particular to NHS capital financing, was designed to reduce the Public Sector Borrowing Requirement (PSBR).

Figure 8: Public Sector Borrowing Requirements[2]

This it has done (Figure 8). In parallel with the introduction of the PFI, the NHS now copes with the increased demands on its services within its resource allocation and at the same time has become more cost effective. Since 1948, funding has gone from bottom up to capital allocation (work within budget) to cash limited and finally to reduced central funding (under funding 1987-88 1.21% of total cash limit), income generation and internal competition.

What must be included in any equation on the state of finances within the NHS is the effect that RAWP has had on the London hospitals. Their funding in the early days was dramatically reduced against a background of increasing workload. This workload was attracted from many parts of the country due to the reputation of the London hospitals.

The Internal Market

The White Paper (1989), "Working for patients", read like a multi-pronged strategy to eliminate gross inefficiencies identifying as the first area of waste in the NHS as bed-days. Of course, there are indeed closed beds in closed wards, a waste of valuable facilities laid fallow by inadequate operating budgets. This is an inefficiency created by the Government and by

[2] Data and graph derived from a seminar on PFI progress by KPMG in London 1998

Parliament. One kind is unused bed-days on nursed wards, a very expensive commodity, and one that hundreds of thousands of waiting patients would love to use. These are beds the Government is fully funding. Some wards have documented occupancy rates as low as 30%, with a two-year list of patients waiting to use the other 70%. To a visitor, this seems unconscionable. Occupancy rates of 50-70% appear to be not uncommon in some hospitals, and the national figure is 75% (Anderson 1988).

The unused bed-days have three causes. Firstly, beds (and bed-days) are assigned to certain specialities and locked into consultants' practice patterns. For many reasons, those practice patterns leave beds empty; but whatever the reasons, they are often not subject to review by someone representing the interests of the waiting patients. Secondly, some senior sisters close beds on an informal and temporary basis when staff are away or highly demanding patients increase the workload. Experienced nurse managers regard this practice as misguided and unnecessary. Thirdly, the NHS actually works on a 250-day year, not a 365-day year. In fact, the ultimate manifestation of British civility is not the good manners shown by its football teams in the heat of the World Cup, nor the subtle discipline of its wondrous gardens, but the restraint shown by most citizens in not getting seriously ill at weekends, Bank Holidays, Christmas or Easter.

Underlying all three causes is the fact that empty beds are free. It costs a nursing establishment nothing to close a couple of beds for a few days, and it costs consultants nothing to under -utilise their beds. In many hospitals (but notably not others), no one keeps close track of unused days or is responsible for them. Charging capital and operating costs for beds and other facilities is potentially one of the healthiest aspects of the current reforms. It will force a serious examination of many long-standing, wasteful practices. It will also lead to awareness that the fixed expenses of empty beds, which make them cost 90% of a filled bed, can be reduced substantially. That had been a major discovery as a result of research conducted by hospital administrators in the US. The other source of waste is overused bed-days. The 1986 study conducted by Anderson (1988), found that in a very crowded, overworked district hospital, 62% of all bed-days did not have medical, nursing or life support reasons for being there. Yet, this little study implies billions of pounds wasted on patients who did not need them. Similar causes produce another source of waste in many NHS hospitals: underused theatre time. Even though there have been studies on the subject, the Government and groups representing patients did not seem to be aware that far more

patients on waiting lists could be treated with current facilities. Instead, this pro-efficiency Government has granted funds to at least one District for several new theatres, even though the present ones are substantially underused.

There is no question, that even though ever increasing resources have been put into the NHS over the last 10-15 years, (increased from 3.92% GNP 1949 to 6.17% GNP 1987 to 5.85% GNP in 1990, see appendix "facts and figures"), there was a financial crisis within it. There were a number of major factors that have contributed to the situation: increased demand and expectation, demographic changes caused by RAWP, more expensive forms of treatment, the need to replace buildings, increased staffing costs (only partially funded), inaccurate inflation proofing, and the increased number of people between the ages of 65 and 90 requiring care. This was compounded by the inability of managers to control costs and manage a cost effective service, the waste and inefficiencies that occurred as a result of day to day operational practices and finally the Government's belief that the problems of the NHS could be reorganised out of the system (an activity with its own contribution to costs). The Government believed that the financial mismanagement of demand led services, and poor management accountability, could be squeezed out of the system by the top down approach i.e.: reducing resource allocation to the DHAs. All these factors brought about the financial crisis of 1992-1993. What had highlighted the problems, was that the White Paper, which, to be implemented on the 1st April 1991, required that all DHAs balance their books by that date, in time for the general implementation of its reforms. No matter what circumstances had brought the financial situation in the NHS to a head, Government policies, service demands and managerial culture in the NHS had joined forces to exacerbate those problems. This confirmed the Conservative Government's resolve to pursue a market led, general management ethos for the NHS as the way forward for health care.

Changes in Working Practices

Industrial discontent within the workforce and problems of delivery of service in the NHS increased until, at the 1995 summer conferences of the Royal College of Midwives and of the Royal College of Nursing, both bodies voted by substantial majorities to revoke their respective vows never to take industrial action. The GPs in particular became locked in dispute with the DoH over the pricing of their Out-Of-Office-Hours duties. Throughout the years of implementation of the NHS Changes, GPs had experienced a steady increase in demand for their time, both from administration and from increasing patient attendances.

The patient's Charter (1991) was widely thought to have been the catalyst in this explosion of patient demand. A particular problem was the rise in the number of requests for GPs to visit patients at home 'after hours'; with the majority of GPs reporting that the reasons for these requests were usually trivial. The dispute culminated in a ballot being taken by the GPs with a view to instigating industrial action if their demands were not met. The outcome of this ballot enabled an agreement to be reached between the DoH and the GPs representatives of the General Medical Services Committee (GMSC). This agreement included:

- £45M to be spent on improving Out-Of-Hours (OOH) Care.
- An immediate reduction in the number of forms GPs have to complete.
- A commitment to undertake a central education campaign to reduce the number of trivial OOH calls made of GPs by their patients.
- An agreement (for the first time) to ask the Pay Review Body to price OOH work separately from the main GP contract.

Less than a month later, the Secretary of State for Health described his vision for GPs, and UK Primary Care generally, which he characterises as the "Jewel in the NHS Crown". This suggested that further changes were being planned for the nature of Primary Care in the UK, and publicly signalled the intention to shift it further towards the provision in the Community of selected Secondary Care services. It remained to be seen whether all GPs would have, want to have, or be able to afford the technical experience, equipment and time to provide this sort of care. In March 1996 the GPs negotiators unilaterally issued an analysis (Beecham 1997) of what they thought GPs should provide as a core service. Pressure grew to seek two separate contracts with the Government: one for the core services so identified, and one for other optional work, including OOH calls. Many GPs believed that this was now a requirement; both to provide for that significant proportion of GPs who wish to provide only the core service and also to separately obtain acceptable pricing of the contracts.

The £45M for OOH care was the catalyst for an extremely rapid and radical change in the way OOH care was provided. In most cities now, care is provided by groups of 10 to 20 practices joining together as a co-operative to finance and manage a single OOH service for all their (100,000+) patients. In addition, the DoH provided clarification of the terms and conditions of service for GPs regarding patients' requests for home visits. This included the revelation that a doctor was not in breach of contract (as previously believed) if he refused to

visit a patient at home on request provided the visit was judged by the Clinician 'to be inappropriate'. A set of guidelines for what was and was not considered appropriate was subsequently drafted locally by one pioneering co-operative, but this has since been published widely and become a de facto national guideline. Most co-operatives now operate by requesting the patients to travel to the night doctor, located at a special night clinic, rather than having the doctor visit the patient at home as was previously the norm. Some co-ops provide free transport to the clinic for patients without their own means. Some also employ an extra doctor specifically to work nights all year round, with only the second-on call being provided by members of the co-operative on a rota basis. The result of all this is that many daytime practising GPs no longer 'work' after 7 or 8 pm, and often for only four hours at weekends, having contracted the remaining hours of on-call work out to the co-operative.

In September 1996, the DoH announced plans to allow hospitals to contract and employ GPs to provide Primary Care. At the present time, there are planning constraints that prevent qualified doctors (and, similarly, pharmacists) simply setting up new practices in an area of their choosing. These constraints exist to prevent competition for a limited number of patients (and thereby associated capitation payments) resulting in list sizes too small to produce viable income for each competing practice. The number of practices and GPs in an area has, until now, been controlled by the FHSAs (as monopoly employers) so as to maintain lists at around 2000 patients per GP.

The winter of 1995-6, saw the high profile seasonal NHS bed crisis. GPs found themselves unable to find free beds in local hospitals into which they could admit urgent patients. The phenomenon of patients lying on trolleys in Casualty for hours until a bed was found seemed to be spreading. Several ill patients were transferred a hundred miles or more to an available bed, only to die shortly after arrival. In particular, the press highlighted the problems associated with the inability to secure Paediatric Intensive Care beds. Several possible factors were advanced to explain the overall problem: e.g.: hospitals were running with higher average bed occupancy, usually 95% or more -which meant there was no slack to take up the predictable seasonal increase in emergencies. There was a nursing shortage, which was partly due to demography (fewer young people). In May 1997 the fourth successive Conservative Government, was defeated and a new Labour Government was elected. The manifesto on which its election success had been achieved included affirmation that its policy on health would include abolition of GP Fund holder status, on the grounds that the two-tier system it

engendered was unfair. However, it also stated that it believed that the Purchaser/Provider split had been useful, especially when combined with a greater input from GPs in a contracting role.

Late in 1997 the Labour Government's policy was crystallised into a new White Paper (1998) for England called 'The New NHS, Modern and Dependable". Scotland, meanwhile, had always had a different system for its NHS but with the imminent arrival of a devolved Scottish Parliament, a separate White Paper (along the same lines) called "Designed to Care (1997)" was published. The White Paper outlines 6 principles, (p39), and goes on to state that the NHS should be a national service providing consistently high quality; prompt and accessible services; driven by local doctors and nurses characterised by partnership, not competition; efficiently focused on excellence and "quality", a public service accountable to patients and shaped by their views. To achieve this, the total NHS budget will be divided among HAs, which in turn will pass the money to PCGs each made up of around 50 GPs. In time, these PCGs will be encouraged to assume complete control of all commissioning/purchasing decisions, and HAs will merge to cover larger populations. Annual contracts between Purchasers and Providers will be replaced by 3-5 year agreements.

The Social and Clinical Services will be encouraged to work together, instead of using the boundary between them to resist referrals and thereby contain costs. Measures including common budgets will be considered, and ideas are to be piloted in a number of HAZs. Fundholding is to be phased out. Hospital and Community Trusts will continue, but they are strongly encouraged to devolve budgetary responsibility to clinical teams and to more involve senior professionals in management. Contract negotiations between purchasing and providing bodies should increasingly take on the form of a dialogue between primary and secondary care clinicians rather than between managers.

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Managing Information within the NHS

A growing number of people are concerned with creating, processing and providing information within the NHS, especially as the quantity of information available to individuals and the organisation continues to increase (Atherton 1977). This increase in itself causes problems because even though the NHS, and its constituent parts, has vast amounts of data, it does not have the tools to use that information, nor in some cases, the expertise. The problem is further compounded since quality of information rarely increases with quantity.

The means that should be available to a health organisation to minimise such problems are, therefore, central to the task of managing information. Particular emphasis needs to be given to exploiting sources of relevant information, such as census data, Health Service Indicators, local population opinion and research data re: health needs of the local population. Furthermore, in-house information services need to be developed where external services prove to be inadequate. High technology needs to be utilised if the goal of timely, economic and efficient management information is to be reached via the utilisation of the large amounts of data being produced in the healthcare environment. This includes improved access to data that is generated from the convergence of computing, word processing and telecommunications; such as view-data, teletext and the Internet. Organisational structures and staff with the appropriate expertise and knowledge are required to ensure that the information services and systems can be properly evaluated, implemented, cope adequately with developments in the light of the White Paper (1989) and the perceived requirements of their health organisation and the DoH.

Information and the Health Organisation

In order to be useful, information has to be communicated in the right quantity and form, and at the right time to those who need it. Communication processes coupled with information flows are, therefore, important elements to be considered in a detailed investigation of information needs and of the ways and means of satisfying them.

Activities and Information Needs

Internal data of the health organisation is generally handled by those manual management information systems (MIS) concerned with the control and monitoring of the Purchaser/ Provider costs and patient activity, i.e.: the contract. A MIS does not have to be computerised and, of course, historically in the health service this has been the case. However, demands for control, quality and performance in health organisations has become of paramount importance, and if the organisations are going to be able to cope with the assimilation of the vast amounts of data and use that data with discerning judgement, then, computerisation is the only way forward. However, those MISs that are designed must be based on sound premises because the failure of a MIS can often be traced back to the use of false assumptions at the design stage.

It is important to consider the need for total information resource management in health organisations, as external information, together with processed internal information, is particularly important for the strategic planning undertaken by senior management and executives. Information for planning and change is largely subjective and qualitative, hence it is less amenable to computerisation than that used for operational control by the units of management.

Information Acquisition and Value

The cost of acquisition of data should always be related to the value of the information sought and acquired (Wiggins 1986). Often in health organisations, information is sought, retrieved and worked upon that is both expensive and not what a manager really wanted, because his needs were poorly defined and lacking in clarity of purpose as a result of the absence of "corporate objectives".

When searching for information there has to be a limit to the time, effort and money which the Purchaser/ Provider is prepared to spend. Once this limit is reached, the information is in effect deemed not to exist and, if still required, the knowledge has to be created by undertaking research or market surveys. The problem that an organisation has with this statement is that it has not defined the level of information it needs and, therefore, the cost it is prepared to expend on provision and, until recently did not really believe that information provided by research and market surveys was necessary. The White Paper (1989) has changed

all that in as much as both research data and consumer survey data have become vitally important to all health organisations if they are to survive in the "internal market" of the NHS. Where the knowledge does exist, but is not "discovered", there is the danger of duplicating work already undertaken or of suffering expensive consequences arising out of ignorance. The latter is of particular relevance with regard to patient data and their health needs.

Sources of Information

The Purchaser and Provider organisations have two basic sources available: other people and recorded data (knowledge) (Wiggins 1986). Direct interpersonal contact is often the quickest and best method of obtaining what is required, having the advantage that the problem can be discussed and misunderstandings resolved. However, the enquirer who is impressed by the personality, standing or experience of the person consulted, may too readily accept, without question, the answer or data provided at face value without checking its validity or accuracy. Resources have not normally allowed for central validation and where they have, it has been discovered that the staff collecting or validating the data have little or no knowledge of the data they were scrutinising. As a consequence of this, the data was often poor in quality. The only solution to this appears to be to have data gathering at source by the staff who generate the information by virtue of the work they carry out, and allow the transmission of the data upwards for collation and presentation to be efficient, timely and accurate. It is also important that the staff that generate the work data and their managers who have ownership of that data, validate it for accuracy, prior to onward transmission.

It is equally important that this information is cross-referenced with comparative data recorded elsewhere and published data that is available from other health organisations. Only then can the information the General Managers receive be assumed to be of valid quality thus enabling it to be used in the corporate processes of the organisation.

Information Needs:

Although the investigation of information needs in relation to health problems and health information services is part of information science in general, numerous researchers in the health disciplines have investigated the subject, publishing in journals in their own specialisms. This makes the field, on the one hand, very productive of ideas and theories but

on the other hand, difficult to review, because of the diversity of sources. At the root of the problem of identifying information needs and information-seeking behaviour is the concept of information need, which has proved intractable for the reason advanced by Wilson (1981). Wilson argues that need is a subjective experience which occurs only in the mind of the person in need and, consequently, is not directly accessible to an observer. The experience of need can only be discovered by deduction from behaviour or through the reports of the person in need. The general concept of need is a psychological concept, since it refers to a mental state and a good deal of attention has been given to the idea, its subjective character and the motivation for the expression of need or the physiological drives that result in the expression of need. The subjective expression of need given above is evident, for example, in a definition by Bumkrant (1976) "a cognitive representation of a future goal that is desired". However, in spite of the subjective nature of need, various types of need have been defined through deduction and report. For example Morgan & King (1971), propose that needs emerge from three kinds of motives:

1. Physiological motives (for example, hunger and thirst).
2. Unlearned motives (including curiosity and sensory stimulation), and
3. Social motives (the desire for affiliation, approval or status, or aggression).

Wilson (1981) argues that the concept of motive may be of general use in the study of information-seeking behaviour since he assumes that, for whatever reason a person experiences an information need, there must be an attendant motive actually to engage in such behaviour. Wilson also argues that the general concept of need is a psychological concept since it refers to a mental state or states. A good deal of attention has been given to the idea, its subjective character and the motivation for the expression of need or the physiological drives that result in the expression of need. Within the general theory of motivation, it is suggested that when a motive is activated, a belief-value matrix within the individual is called on. The matrix is believed to contain images of objects that past experience has proved to be relevant to the satisfaction of the aroused need and that different objects will have different values associated with them relating to the believed level of success they will have in satisfying the person's need (Bumkrant 1976). The notion of motive is implicit in gratification theory which has been developed in mass communications research and which assumes that an audience has complex needs that it seeks to gratify through the use of various media (Fiske 1990). The theory also suggests that people are active

seekers of information to gratify their needs (Rubin 1986). McQuail (1972), suggests that there are a number of categories of gratification, which fall mainly into what are called affective needs, but for which, clearly, information may have a role in gratifying: Diversion, Personal relationships, and Personal identity. That those needs may have a cognitive component, as distinct from, for example, physiological needs such as hunger and thirst, is recognised in the concept of the need for cognition.

Types of Information Need

In spite of the difficulties with the concept, various categorisations of information need have been produced. For example, Weigts et al. (1993) suggest the following categories:

- Need for new information;
- Need to elucidate the information held; and
- Need to confirm information held.

Wilson (1981) noted, however, that the focus of these types is cognitive need and, given the significance of beliefs and values, added:

- Need to elucidate beliefs and values held; and
- Need to confirm beliefs and values held, since information may be needed to achieve these things.

The mode of questioning in carrying out searches also identifies underlying information needs. For example, Carter (reported in Chew 1994) suggests that when an individual is driven to seek information as a result of 'needing to know'; four modes of questioning behaviour are exhibited:

1. Questions to discover what is happening ('orientation');
2. Questions to check that the person is 'on the right track' ('reorientation');
3. Questions to form an opinion or solve a problem ('construction'); and
4. Questions to build one's knowledge of a subject, which could be labelled 'extension'.

Problem of Information Needs:

Part of the problem lies in identifying the information needs of the General Manager, especially when taking into consideration the effects of the rapidly changing environment of

the NHS in which they work. Even though the problem can be concisely stated as above, it only scratches the surface. According to Bird (1991), equally important within the problem is the attitude of the targeted General Manager or executive to information, the continually evolving stakeholders within the organisation, together with the evolving organisation and consequential change in its environment. However, fundamentally more important is the problem that executives have found it difficult to define their own information requirements. This can be for a number of reasons: inability to express their needs; not being sure of what they want; or simply accepting something which is not what they actually want when they are given it.

At the heart of this problem is the task of defining how General Managers and executives actually work in their organisations. How do you design an information package, for example, when the reality for the General Manager is an apparently untidy and confused "desk", where only the General Managers themselves know their systems? Mintzberg (1973), argues that the manager's activities are characterised by brevity, variety and fragmentation and if the systems designer applies present theoretical logic of management organisation and decision making, then, it is highly likely that the implementation will ultimately fail. Bird (1991) and Lee (1991) list this problem under organisational resistance and organisational culture clash. Another problem is that the views coming from the General Managers about their needs can be confused. Some seem to be happy with the information they get, some know that what they get is not enough in terms of speed, accessibility and quality, and others do not get what they want but cannot identify what they actually do need. The problem of providing a traditional solution to the General Managers' needs in their organisational environment may ultimately fail because of an inability to meet their actual needs (Mintzberg 1973). Other problems[3] that must be taken into account are noted.

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Issues of Competence

In discussing issues of competence, perceived attitudes not only to the identification in general of information needs but the potential future views of the General Managers, have to be taken into consideration. People make judgements of their fellow man as a result of first impressions (Lippman 1922) and if the first impression is not favourable, it can take time to reverse the results of that judgement. In the same way, the first impression of the General Manager to the questionnaire will create a reaction, which, depending on the impression may be negative or positive. Related to these "first impressions" is the perception of how the General Managers would react to the style and quality of questions about to be put to them. It was important to create a good impression as by doing this, it was anticipated that they would come to accept the results of the work more readily than if they had been unimpressed by the questions put to them. It was concluded that it was important to establish the credentials of the researcher as a prelude to gaining acceptance for the diagnostic tasks. It seemed that the case for a "system" of information needs had to be put before the establishment of the General Managers' needs. The style and presentation of the questions were, therefore, slightly modified for each interviewee. The other competence, which was present throughout the task of the interviews, was whether or not the right questions were being asked. Were they comprehensible to the General Managers and would a comprehensive understanding of the problems be achieved? It is interesting to note that these questions illustrated in part the same problems that have been identified by Bird (1991), Checkland (1970), Mintzberg (1973) and others.

The purpose of the pilot study was to address these issues and to test the design of the instruments of the research. Having designed a questionnaire of 70 questions, each with a number of sub sections covering information needs, general management needs and opinions, it was appropriate to validate the questionnaire by submitting it to user testing.

Methodology Issues: ways in which the problem may be tackled.

The problem of discussing the issues at the beginning of this project was one of over familiarity with the environment of the organisation, and being overwhelmed with anecdotal solutions to problems as expressed by the users. Instead of examining and analysing the

problem as a new experience, the researcher was faced with the situation of over familiarity with the problem, having been involved with the problem as part of his daily working environment. The challenge was one of finding a methodological analysis that would help to identify the real problems as verbalised by the General Managers. This research was about the identification of information needs, the critical success factors of the organisation, organisation environment, the key performance indicators and providing a workable framework from which the General Managers could make the choice of information needs. The difficulty with any methodology is that it has to be able to cope with the complex, sometimes confusing, and abstract responses from General Managers. Another aspect is that any method that asks for rigid responses, which can be quantified for analytical purposes, will often fail by missing the problem area. Flanagan (1951, 1954) and Kay (1959) have described methods of collecting descriptions of critical incidents and together with the Diary method of collecting data, have formed a useful series of experience. However, the drawback of these methods is that one cannot be sure that important issues have not been left out by being seen as routine or mundane chores, simply because the General Managers perceive them as such. Methods used to analyse the General Managers' activity (and use of information is an activity) range from the ones described above, to Structured Observation as used by Mintzberg (1973). The major disadvantages are that they are inefficient, difficult to utilise to interpret some activities and, in terms of identifying the information needs of the General Managers, may well miss the problem altogether. The activity of observing the General Managers access and use information may well hide the problem that they cannot actually specify their real information needs.

Checkland (1970) argues that a methodology is an explicit, ordered non-random way of carrying out an activity. It represents a model based on particular perspectives and paradigms. A methodology always implies a framework of time dependent sequences of actions or action stages. It appears that there are two paradigms of methodology: the one that subscribes to the science paradigm and the other to a systems paradigm. Under the banner of the science paradigm is such methodology as that advocated within the NHS, that of Soft Systems Analysis Design Methodology (SSADM) and under the other banner Wood-Harper (1990) Multiview. In recognising the arguments put forward by Mintzberg (1973) on the real world activity of the General Managers within an organisation, and accepting that methodologies have to be able to react to different organisational environments

(contingency) Avison & Wood-Harper (1990), then a methodology such as Multiview is the one of choice.

Bryman (1988) discusses the role of theory and concepts within quantitative and qualitative research and notes that theory may be used as a precursor to an investigation, as a means of providing an initial orientation to the situation as in "grounded theory". Caution is advised since it may not reflect the subjects' views as to what is going on and what is important. However, Lipset (1964) argues that quantitative data can be just as exploratory and insightful as qualitative data. Other writers identify the respective link between quantitative and qualitative methodologies and nomothetic and idiographic modes of reasoning (Halfpenny 1979). Nomothetic reasoning attempts to establish findings that are immutable whilst an idiographic approach places its findings in a particular time period and location. It is the inability of the latter to establish generalisations that is one cause of criticism. A survey approach is taken to represent a nomothetic approach.

On the other hand, Bryman (1988) indicates that even quantitative surveys may be criticised for attempting to establish generalisations whilst they are often not based on random sampling. Furthermore, quantitative research has received criticism for being too static whilst qualitative methods are better able to identify linkages between events and activities and to explore peoples' interpretations of those factors that produce events. Perspectives such as phenomenology, symbolic interactionalism, and naturalism led qualitative researchers to suggest that nothing can be taken for granted (Walsh, 1972). Quantitative research tends to view social reality as static and beyond the control of the actor, whereas the image from qualitative research is one of a socially constructed reality. This is demonstrated by Bryman (1988) using a comparative study of organisation structure. The Aston Studies depicted organisational structure as being influenced by such factors as size, and technology (Pugh et al., 1976). In turn, organisational structure was seen as influencing the behaviour of its members. This approach considered organisational structure to be external to, and a constraint upon, the actor. It differs significantly from the qualitative approach adopted by Straus et al (1963) whose work, undertaken in a psychiatric hospital, suggested that organisational structure was a "negotiated order". The behaviour of the hospital members was largely unaffected by formal structures of rules and role prescriptions. Rather, the various sub-groups determined their own structure through a continuous process of negotiation and renegotiations. Data emanating from quantitative studies are often depicted as hard, rigorous

and reliable. This suggests that the data exhibits considerable precision, having been gathered using systematic procedures and can be readily replicated by another investigator. Such attributes often appear to make quantitative data more persuasive, particularly to policy makers. On the other hand, Walker (1985) states "certain research questions cannot be answered by quantitative methods, while others cannot be answered by qualitative ones."

The methodological debate appears, therefore, to comprise two distinct sets of arguments; one, epistemological in nature and the other technical. For those writers who argue that it is legitimate to combine the different methodologies, then the technical argument does not appear to provide many obstacles. However, from an epistemological standpoint, combining the two forms of methodology seems to be more problematic. If one accepts the view that quantitative research and qualitative research represents two divergent paradigms, then, one also accepts that there are incompatible ideas about how social reality should be studied (Gvba, 1985).

Methodology Chosen

I was acutely aware that environment, culture and politics exert great influence on the way in which General Managers work, which in turn influences their information needs in their organisation. Mintzberg (1973), Checkland (1970), Bird (1991), and Wood-Harper (1990) all argue this point. The challenge was one of finding a methodology that would take into account their organisational influencers and help identify a framework of needs, a root definition of the organisations and General Managers' requirements for their business and organisation.

The choice of methodology followed the arguments put forward by Benyon and Skidmore (1987). They maintained that instead of debating endlessly the issues of the correct methodology to use, the toolkit should be available as a set of tools for use by the analyst. It is the analyst who will fit the methodology to the particular set of constraints and circumstances. Also, they suggest that the analyst should be skilled in selecting these approaches. The reality is that the analyst cannot be assumed to be skilled in such a wide selectivity and he may be interpreting the real world circumstances and constraints according to his view of the world. Thus, the methodology selected may be in response to the way he interprets the problem situation. In other words, bias must be recognised and taken account of, if the real world problem is to be clearly identified. Hepworth (1992), argues that research

on the information needs, information perceptions and information use suggest that systems analysis and design methodology should be chosen with regard to the problem situation which the information system will inhabit. Mandatory use of SSADM in the development of Information Systems for the NHS may be promoting a damagingly narrow view of information systems and failing to generate sufficient awareness amongst system managers and users. Such methods do not support a view of total information resources appropriate to an information management approach. Taking into account the above arguments, the Multiview methodology described by Wood-Harper (1990) was the one selected. As previously discussed (Methodology Chosen) the prime objectives were to produce a root definition, identify the General Managers' information needs, taking into account the environmental, political, organisational and personal influencers when identifying their needs.

Multiview: Benefits/ Justification for Use.

A contingency framework, which emphasises contingent approaches within the methodology rather than between methodologies, is apparent in Multiview (Wood-Harper 1990). Multiview is flexible and provides alternative contingencies depending on the organisational culture and environment. A typical research methodology used would consist of three phases (Guimaraes 1991):

Phase I The definition of the executives' problems,

Phase II The definition of solutions and

Phase III Data collection.

Multiview methodology has five stages:

1. Analysis of human activity;
2. Information analysis;
3. Analysis and design of the socio-technical aspects;
4. Design of the human-computer interface and
5. The design of the technical aspects.

They incorporate five different views, which are appropriate to the progressive development of an analysis and design project so as to form a system, which is complete in both technical

and human terms. However, it must be pointed out that not all projects using the Multiview approach progress through all five stages. The methodology can be used flexibly. Davis (1982) advocates the contingency approach to information systems development, where the methodology chosen will depend on the particular circumstances where it is to be applied (the horses for courses approach).

Principal Methodological Approaches

The principal methodological approaches used in this research are qualitative and quantitative, as the aim of the research is to identify and describe specific characteristics whilst determining associations of needs and requirements with behavioural and environmental characteristics. Checkland's methodology can be considered to be an appropriate approach to this methodology of SSM (Checkland 1970). Data has been collected through the questionnaire method by structured, detailed interviews with 20 General Managers from Purchaser, Provider and Regional Executive organisations within the NHS. The research, therefore, employed three research methods, namely, interviews, postal questionnaires, and documentary analysis. The research was concerned with studying the specific characteristics of a population at a particular point in time.

Sample Population.

The size of the sample population was 64 organisational entities within the NHS of England and Wales, consisting of 4 NHS Executives, 22 Purchaser organisations and 38 Provider Trusts. Of this sample population, 3 NHS Executive organisations, 5 Purchaser organisations and 12 Provider Trusts were targeted for detailed questioning and analysis. Each organisation was considered as a detailed study. The focus was on specificity rather than generality.

The selection of the 20 General Managers of the designated organisations was carried out in two stages: Purchaser organisations and Provider Trusts were targeted in different Regional areas. Within those regions the targeted Purchasers (main purchaser of the Trusts selected) and associated Provider Trusts were selected on the basis of comparable size (published size of budget and population served). The selection of each Provider Trust was based on selecting an acute Provider and a Community Services Provider from each of the main Purchasers' "catchment area" of comparable population and revenue size.

To Ensure the Validity and Reliability of the Research:

A small scale pilot study was set up to explore the effects of attitudes to information and the market environment on the identification of the General Managers' needs and to gather thoughts about the best way to design the framework of the questionnaire for the interviews. This ensured construct validity. The same framework would then be used throughout the interview process with all 20 General Managers, thereby maximising the reliability of the data. Each transcript was checked and corrected with each interviewee in order to safeguard the data's quality and validity. All 20 General Managers would be approached and permission obtained before the interviews were undertaken.

The research when completed would provide a better understanding of General Managers' perception of their information requirements; how they used that information; and whether or not it fulfilled a role in achieving the patients' best interest; and the nature of the conflicts the General Managers have to currently face. This was intended to bridge the gap between theory and practice in general management. It would also for the first time add to the body of knowledge on the way forward for information management within the NHS under its market-led strategy. Even though there have been many publications relating to aspects of management and information over the recent years, there has apparently been no research into the wider issues of information management, general management and the business environment of the present day NHS.

Pilot Study of the General Managers: Questionnaire

The purpose of the pilot study was to test the design of instruments of the research. Having designed a questionnaire of 70 questions each with a number of sub-sections covering information needs, general management needs and opinions, it was appropriate to validate the questionnaire by submitting it to user testing. The sample size of General Managers comprised one from a Regional Health Executive organisation, one from a Purchaser organisation and three from Provider Trusts, of which two provided an acute teaching service and the other a provincial service providing acute, Psychiatric and Community services.

Initial Questionnaire Strategy

The pilot was carried out with the draft questionnaire and as a guide for the researcher the outline below was prepared to assist the development, testing, and validation of the questionnaire.

1. Identify key questions that might lead to identification of characteristics that could be associated with the interviewees and any possible groupings of those interviewees.

2. A mail shot was prepared and sent to four interviewees followed up by requests for (post questionnaire completion) evaluation interviews.

3. Secure interviewees' agreement to face-to-face interviews relating to the pilot questionnaire

4. Identify any characteristics of the interviewees by their information needs if possible.

5. Develop questionnaire structure based on observations and evaluation of the results of the test interviews.

Methodology

The questionnaire was sent to each of the selected participants, together with an introduction to the researcher, an introduction to the research project and areas of exploration. Brief explanations of the reasons for the pilot study were offered with a request to complete the questionnaire and to include criticisms, comments and suggestions as appropriate. The prospective participants were advised that I would call to arrange a meeting within a few weeks of their receipt of the document, with a view to discussing any comments/advice that they may have regarding the questionnaire and the wider research programme.

Interviews

Provider Trusts' Views

Of the three General Managers that responded, the following results were obtained. The reasons for the refusal of the remaining recipients to participate were mainly due to pressure

of work and time availability. Comments and suggestions regarding the questionnaire, research and access to General Managers were received. The credibility of the interviewer was an important factor in gaining access to the General Managers as they were inundated with questionnaires to complete. As a result, many NHS General Managers now have a policy of refusing other than NHS Executive inspired questionnaires (Goode and Hatt 1952). Providing a personal CV and explanation of the research was a positive way forward.

- There were drawbacks to the design of the questionnaire in that it lacked ease of use and "complete-ability".
- It was felt that such a large number of questions requiring qualitative responses of a textual nature would deter recipients from responding.
- A "tick box" style encouraging short sharp responses would be preferable.
- The large number of questions tested the stamina of the General Managers to complete the questionnaire successfully.
- Too many verbose responses were present; tick boxes would encourage people to complete the questions.
- An understanding of what information was required was generally reached, despite some ambiguous questions.
- This questionnaire/research was in competition with many other projects, especially from researchers completing first degrees, and it appeared that the researcher's NHS experience was crucial in order to overcome the reticence of the respondent to giving me access to the managers as a source of information.

NHS Regional Executive Views

Access to the Chief Executives of the Regional Executive organisation was more difficult. Outright rejection did not occur, however, and the questionnaire was passed to another Executive Director within the organisation. Initial concerns that the questionnaire would be deflected because of the lack of familiarity with the researcher proved unfounded as the recipients responded in a positive way. The General Managers made the following comments:

1. No outward criticism was made of the style of the questions.

2. In view of the length of the questionnaire and the comment boxes, it was felt that a face-to-face interview would be required to encourage participants to complete the questions.

3. Because of competition from numerous research projects going on within the NHS at the moment, the research required credibility to make it "stand out" and be well received.

4. It was suggested that the following would be helpful especially if a high response rate to the questionnaire was desirable:

    i. Support from a NHS organisation was required such as National Association of Health Authorities and DoH support should be elicited.

    ii. The questionnaire should reflect up-to-date terminology.

    iii. As the questionnaire covered IT bureaucracy, endorsement from the IM&T Executive should be encouraged.

The comments were encouraging but provided mixed views, in that opposing views were expressed as to whether descriptive or tick box answers would produce the most constructive responses. It was felt that the questionnaire was competent, however, highlighting the credentials of the research and researcher as well as providing direct communication with the respondents; and presenting a questionnaire with the majority of the questions provided in the form of "tick boxes, would be advantageous in improving the success of the researcher in gaining access to the interviewees and getting their responses to the questions.

Rejection

The organisations that returned the questionnaire provided comments on why co-operation in piloting the questionnaire was refused. From the comments the following conclusions were drawn:

- The lack of time available to the General Managers to complete the document;
- The competition for available time from other questionnaires;
- The number of questions to complete and whether or not they were tick boxes. (Respondents did not like questions requiring wordy responses.)

- And a lack of credentials of the research, i.e. it is not supported by a recognised NHS organisation.

Action Plans.

The results of the pilot were built into the questionnaire and into the method of approach to achieve a successful completion. The following actions were taken; the questionnaire was rebuilt, with each of the questions requiring quantitative and multi-choice responses being re-engineered using tick boxes in response to specific questions. The target General Managers were sent a detailed profile of the interviewer, a profile of the research and the research proposal. Once an interviewee had been secured, they were sent the questionnaire to complete at their convenience, either prior to the researcher's visit or as part of the face-to-face interview on the day. The interview took the form of explanations, discussions relating to supporting information (qualitative) for the body of the questionnaire, and soft information giving, providing insight into the General Managers' perceptions of their information needs and the effect of the environment on those needs.

Methodology Used

The Questionnaire

Post-pilot questionnaire strategy: As a result of this pilot the questionnaire was developed and used to collect research data. However, as a result of observations made from the evaluation of the pilot study, a number of actions were implemented:

- A Check on the validity of interviewee list was made.
- The questionnaire was circulated with deadlines for return of completed questionnaire attached.
- To keep to the deadlines proposed, first reminders for the recipients were prepared at the same time as the questionnaires were sent out.
- A second reminder was prepared, including a copy of the questionnaire to be sent to the interviewee.
- In-depth interviews were arranged with selected respondents to enrich the picture presented by the completed questionnaire and to illicit any "characteristics" relating to their Information needs.

The questionnaire and covering letter can be seen in the Appendix I and II. The questionnaire was addressed to the Chief Executive of each of the health organisations. Siemiatycki (1979) highlights the usefulness of the telephone in prodding non-respondents to return postal questionnaires. Initially a follow-up 'phone call was made to those health organisations that had not responded to the questionnaire or to a request for an interview four weeks after it had been distributed. Whilst most discussions of survey research refer to work carried out using samples drawn from large populations, discussions by Dexter, (1970) Denition, (1974) Becker and Meyers (1974) indicate that elite, special interest groups such as political figures, lawyers and so forth are more amenable to face-to-face interviews than to postal or telephone surveys. Frey (1986) argues that the ability of the telephone to contact prospective respondents who are members of elite populations warrants further exploration. It would be difficult to argue that NHS General Managers constitute an elite group, and all but two of the questionnaires were completed on a face-to-face basis with the General Managers. Interviews over the phone or by face-to-face methods do not show significant differences in response variation to most items. However, Groves & Kahn (1979) suggest the telephone tended to produce more missing data on sensitive topics than face-to-face interviews. Siemiatycki (1979) reported no difference on missing data on non-sensitive items but on sensitive items, postal questionnaires produced lower item non-response rates than the telephone or face-to-face interviews. On the other hand, O'Toole et al (1986) found the postal survey produced higher non-response rates than telephone or face-to-face interviews. This is contrary to most evidence but may be accounted for by the nature of the research, that is, knowledge versus attitude, rather than perceived threat. Basically, telephone and postal survey method seem to produce the highest rates of non-response. The presence of an interviewer contributes to lower rates in household and intercept interviews.

In the past, telephone interviews have been criticised because of the apparent difficulty in conducting in-depth interviews over the phone (Simon 1978). However, Colombolos (1969) succeeded in engaging a group of specialist doctors in interview over the telephone for an average of 50 minutes. Likewise, Rogers (1976) reported no problems conducting similar length interviews with the general public of a large city. This was significant because, with the rising costs associated with carrying out face-to-face interviews, the ability to elicit large amounts of information over the telephone made the technique very attractive.

The follow-up interviews were used in order to add a further dimension to the research. Posing complex and probing questions is more difficult with postal questionnaires than with telephone or face-to-face interviews. Yet, a study undertaken by Rogers (1976) found no difference in response quality on complex items between telephone and face-to-face interviews.

Response to the Questionnaire

It is appropriate to note that a high proportion of refusals can be caused by a variety of reasons including the sensitive nature of the research, a perceived lack of anonymity or confidentiality, or simply the time involved to complete the questionnaire. Also whether postal, telephone or face-to-face questioning is the medium of the questionnaire. Goode and Hatt (1952) suggest that the extent to which a postal questionnaire represents a valid research method is dependent on:

- The type of information required
- The type of respondent reached
- The accessibility of the respondents
- The precision of the hypothesis

It would be unrealistic to expect General Managers to take more than 25-45 minutes to complete a questionnaire and the questionnaire is only effective if the respondent is both able and willing to express him or herself clearly. In the absence of an interviewer there is less scope to ask detailed questions and no scope to query responses or for General Managers to seek clarification of questions. Goode and Hatt (1952) also point out that not all groups respond equally well to questionnaires. It is clear that a certain level of literacy is required to complete a questionnaire. Filling in a questionnaire is also a time consuming process and not all groups are able or willing to do this. It was for these reasons that a face-to-face interview process was adopted as being the most positive way of getting the General Managers to complete the questionnaires.

This research analysed the responses of the General Managers and compared each in respect of the defining questions of each of the five main objectives, which are:

1. To define the General Managers' conception of management information in the NHS.

2. To identify the General Managers' understanding of their own roles in the manager-patient relationship, their organisation and how that affects their information needs.
3. To explore the problem of identifying the information needs of the General Managers and their difficulties in defining their own information requirements and the nature of those needs.
4. To understand how General Managers work with information within their existing work environment. To analyse their attitudes to information and their needs in a rapidly changing environment.
5. To develop both a theory and recommend practice for change in the area of the General Managers' information needs.

Each question comprised a number of sub-questions requiring choices to be made by the interviewee. These questions required a "✓" as a positive response or a "x" as a negative response. The main questions were grouped into four categories:

1. Managerial ethics, culture and consumerism;
2. Information requirements;
3. The balance of power/influence and
4. The healthcare environment.

There were 70 main questions' each requiring 1-12 responses.

Below is a broad outline of the areas covered by the questionnaire; the detailed questionnaire sent to the targeted General Managers is in Appendix II.

Managerial Ethics, Culture and Consumerism

The questions set out to identify from the General Managers' perspective the work environment in which they work; how they make decisions, what information is needed in the decision making processes, and how they are influenced by the environment in which they work.

England (1967) who carried out a key study of managerial values argued for the significance of the organisation in influencing the operating values of managers. His study showed that a

considerable number of operating values identified by managers was directly related to the goals of the business organisation. His conclusion, drawn from his study, was that organisational activities are influenced by personal values at all levels, from the corporate to the day-to-day operational decision. Values, and the characteristics of their operation, play a considerable part in determining decision behaviour and, therefore, information needs and information seeking behaviour. The questions being posed by the researcher set out to identify those characteristics of the General Managers.

A code of practice assumed the General Managers and their organisations had an ethical stance that they tried to maintain. However, a number of studies have been carried out into the way in which General Managers consider or regard ethical behaviour. The studies indicate that they regard the issue of ethical behaviour as something which is related to their personal feelings, rather than what their organisation expects of them. Newstrom (1975) argued that some General Managers actually have a liking for taking the unethical decision.

Influences

For many General Managers, group situations and managerial style provides much of the context for their decision-making. This context, Cooke & Slack (1984) argue, is the screen and filter that modifies information and is actually the source of information for the General Manager. Power to influence within an organisation often rests with these internal groups, with sanctions being applied depending on the perceived centrality and importance to the group. Tannenbaum (1966) puts forward three propositions summarising the issues, namely that:

1. An attractive group is more likely to see individual views conform to the majority of the group, the norm;
2. If an individual fails to conform, he is likely to be ejected from the group and
3. Rejection is likely to occur the more important the issue is to the group.

The strategy of an organisation, its structure and the people who hold power within that organisation and the way it operates, constitute its culture (Miles and Snow 1978). The cultural strategies of the organisations can be described as conservatives, prospectors and defenders. From the responses to the questions, a cultural web will be developed for each of the organisations illustrating the strategic decision making of the General Managers and their organisations.

The management style of an organisation is expressed in the nature and characteristics of the General Managers, those they manage, the tasks in the organisation and the organisational culture (Handy 1976). Management style is concerned with how the different systems of control within the organisation are put into effect and the fact that they are likely to differ between organisations. The questions set out to identify the General Managers' styles of management and link them with the environment of the organisation and its culture.

Consumerism and Issues of Consumer Participation

The questions seek information relating to the General Managers views of consumerism in the NHS, how it has helped or hindered the organisation to provide an appropriate service for the patient and additionally, whether or not consumerism has helped provide an appropriate service for the GP. Within the context of consumerism, answers are sought as to whether the patient, the GP or Purchaser knows best about healthcare provision and should the Provider actively involve the customer in the type of local service to be provided?

Issues of Social Responsibility of Service Providers

The questions seek to identify what social responsibilities the Provider General Managers and their organisations have if any, and what discretion they have to exercise those responsibilities? Where does the local community fit into the decision-making processes within the healthcare environment? The questions also seek to identify how those organisations business ethics have changed consumer empowerment. To compare how the organisation's past business ethics compare with their business ethics now, and illustrate how they have changed.

Managerial Culture

The questions will seek to identify the managerial culture and its effects on the organisation. In what ways does the managerial culture of the organisations govern professional/ managerial attitudes?

Communications

Information will be sought about how often the General Managers meet with Clinicians within an organisation, GPs and patients and/or their representatives, and the issues that are

debated. Also how sensitive the organisations are to media influence, and whether that sensitivity is reflected in its media policy and behaviour.

Health Policy in the Purchaser/Provider Environment

The manner in which health policy has changed the General Managers' organisations policies and those changes will be examined. Whether or not those changes have been positive and whether or not they have resulted in new norms and values for the General Managers will be examined. The questions will seek to provide an understanding of what drives organisational values now as opposed to in the past and how those values differ. It will also seek to identify whether General Managers are governed by a code of practice.

Information needs

Mintzberg identified ten roles for a manager, four of which are "decisional roles". He saw them as the most crucial and important part of the manager's work, attaching those to justifying the high status and rewards accruing to top management. Those roles were entrepreneur, disturbance handler, resource allocator and negotiator (Mintzberg 1973). The time a manager spends on decision-making depends on one's view of the overall process of decision-making. Choice or the decision may only take a short time. However, choice is only part of the process which includes observing, recognising, interpreting & diagnosing, defining, objective setting, determining options, evaluating, choosing, implementing and monitoring. One of the skills of decision making is deciding which areas of the decision need further information, and in deciding when further information is or is not worth collecting. The increasingly important role of information in decision making; its quality, location and flow patterns is a growing concern to General Managers in NHS organisations. The way in which organisations are structured can often create problems for General Managers in making decisions, in that it restricts or corrupts the information available to them.

The aspects of the questionnaire dealing with the General Managers' information requirements are discussed below.

Information requirements of the managers

The questions under the above heading sought responses that would enable a comparison of the information needs of the General Managers before 1991 and the present. The key

objective of the General Managers was their ability to do their job successfully and to carry out the objectives of their organisations and meet the goals of the NHS. General Managers were asked to define what constituted success both in the past and in the present. An attempt was made to establish an understanding of the effect of decision-making and monitoring activities on information needs. What information was needed for monitoring and making decisions was also sought. Whether or not the information required for making decisions differed from monitoring information was investigated.

Attitudes and Behaviour

The questionnaire sought data that would indicate the General Managers' attitudes to the information received and how they treated the information that they received, especially if the information does not appear to meet their immediate needs. For example: how would you describe your managerial style today; has it changed from the past? General Managers were asked how they would describe and measure success or failure, and their reaction to the latter.

The Effect of Decision Making of the Manager on Empowerment

One of the benefits claimed for the changes in the NHS over the last few years (1991 onwards) was that its patients were becoming empowered in relation to the provision of their healthcare. These questions sought to identify whether decision making by the General Manager directly affected the Purchasers of healthcare and whether or not their decision-making affected other Providers as well. The direct effects of the General Managers' decision-making on the patients either in the hospital, or who may be potential customers of the hospital in the future, were also examined.

Further information with regard to whether decision-making empowered patients in maintaining their health and whether or not the General Managers' decision-making helped improve the health of their organisations' customers were sought. The impact of decision-making on the empowerment of patients past, present and future to determine what healthcare they actually needed was examined. The decisions regarding the nature of healthcare needed and whether or not individuals benefited from any empowerment derived from the healthcare environment were also analysed.

Organisational Environmental (the healthcare environment)

The NHS organisations of today are more than ever "open systems" in that the organisations take resources from and give services back to, a wider environment while adapting and reacting to changing opportunities, threats and challenges in that environment (Cooke & Slack 1984). In the light of the changes in the NHS environment over the last eighteen years, General Managers are only too aware that their organisations cannot remain unresponsive to their environments without attracting adverse criticisms and reaction from the customers they serve. Some of the changes that the NHS organisations have faced include: the increasing rate of technological developments, causing increased demand on scarce resources; the need to develop services to support this technology; an increasingly critical focus on the social responsibilities of the organisation towards its local community; and the increasing political focus on the organisation's performance and the changing role of the Government in the affairs and activities of the organisation.

Cooke & Slack (1984) argue that a manager's perception of his environment is organised into many thousands of different beliefs that do not stay unconnected for very long. When these compatible beliefs are grouped together and become stable, they further suggest that an attitude exists and this pre-disposes a manager to behave in a particular way. For example, if the attitude of the manager to "going to work" or "the local council" is known, then it is possible to predict the way in which the manager will react or behave in the future. The questions relating to the environment attempted to provide a picture of the environmental influences that affected the General Managers' organisations.

There are a number of cultural factors in any organisation's environment that influence the internal situation, especially the values of society and organised groups (Cooke & Slack 1984). The nature of the business, the market situation and development of technology are also important influences. However, even though the most pervasive of those cultural factors is the organisational culture itself, shared expectations of individuals, groups and coalitions can and do transcend the formal structure of an organisation. The questions set out to identify some of the influencers and the General Managers' views on the "balance of power" which they hold. From this the questions seek to identify whether the changes within the organisation have empowered the individual (patient) in their pursuit of good health and/or recovery from ill health.

Changes in Relationships Influence over Healthcare Provision since 1986

Manager, doctor and patient relationships are important elements in any healthcare organisation. The questions sought to identify whether or not these relationships have changed since 1986 and, if they have, how and who has been the beneficiary, the Purchaser, Provider, Government or the patients? Further questions examined the nature of the benefits of the change of influence; i.e. who were the influencers of the organisation and what capacity and capability did they have to influence the organisation? General Managers were asked how the influence was likely to change over time and how had this influence affected their information needs.

Balance of Power between doctors, General Managers & patients

Questions were designed to identify and analyse the balance of power between doctors, General Managers and patients prior to 1986, between 1986-91, and from 1991 to the present; to examine the likely future and consider whether or not the balance of power will change; and to assess who are the present power brokers and whether or not they were likely to alter in the future.

General Managers were asked to define what they regarded as the balance of power, whether that balance of power was important, who controlled it, what were their perceptions of power; that the balance of power influenced; and whether or not the balance of power had changed. Analysis of the General Managers responses sought to understand what effect such changes might have on their information needs; and how have their information needs been influenced and/or changed by changes in the balance of power.

Changes in Healthcare Environment

The questions under the above heading sought to identify the General Managers' understanding of the healthcare environment, describe their beliefs regarding the healthcare environment and their views regarding the market environment.

The questions sought to examine whether or not the managers believed that the healthcare environment had changed over the years and, if so, how their information needs had moved to accommodate those changes; also whether or not the environment would continue to change, to analyse how those needs had moved and how they would continue to adapt as the

changes occurred. The questions were also intended to elucidate whether or not the General Managers believed that they were in a managed market, and to analyse the effect such a market would eventually have on their information needs. Their opinions were sought on whether or not the NHS should be in the market place, or whether better ways of managing healthcare could be found.

The NHS Market

The General Managers were asked a series of questions to elucidate and understand their views and opinions on the NHS environment in which they worked. They were asked:

- How they envisaged the NHS environment changing in the future, how those changes would affect their information needs and how they were preparing to meet those changes.
- Whether or not the NHS environment was a "Managed Market" and if so, was it a mechanism for change.
- Their views on the empowerment of the patient as an individual as well as what they believed the Clinicians' views to be on empowerment of the patients to determine their healthcare needs.
- Their understanding of the apparent conflict of philosophies between a market orientated NHS and the provision of healthcare being provided free at the point of access and how they managed those apparent conflicts.
- And how at the same time as managing those conflicts met the needs of the Purchaser as well as the needs of the local community.

Resources

Cooke and Slack (1984) argue that one of the characteristics of a good manager is their ability to make good decisions and that to judge whether the decision is a good one or not, either the outcome of the decision has to be judged retrospectively or how the decision was made. Using the latter, Cooke and Slack suggest that a good decision is where the decision maker fully understands the background, objectives, alternative courses of action, and range of possible consequences of a decision. The research seeks to augment the process of understanding the General Managers' decision-making by asking them what choices they would make where finite resources had to be taken into account when making decisions within their organisations

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The General Managers' Concept of Management Information in the NHS

It is the researcher's hypothesis that it is not possible to any identify links between market climate, attitudes and behaviour, the working environment, patient empowerment and information need and that a model of information needs cannot be identified that is common across Purchasers/Providers and the NHS Executive

A number of questions needed to be addressed to understand the General Managers' concepts of information in the NHS. What are the individual General Managers' understanding of information; the mechanisms supporting it in the NHS, and the effects of the changing healthcare environment and how is it affecting their information needs? What is their understanding of consumerism in the NHS and does their understanding have an effect on their information needs? What do the General Managers understand of the new healthcare concept such as the market environment?

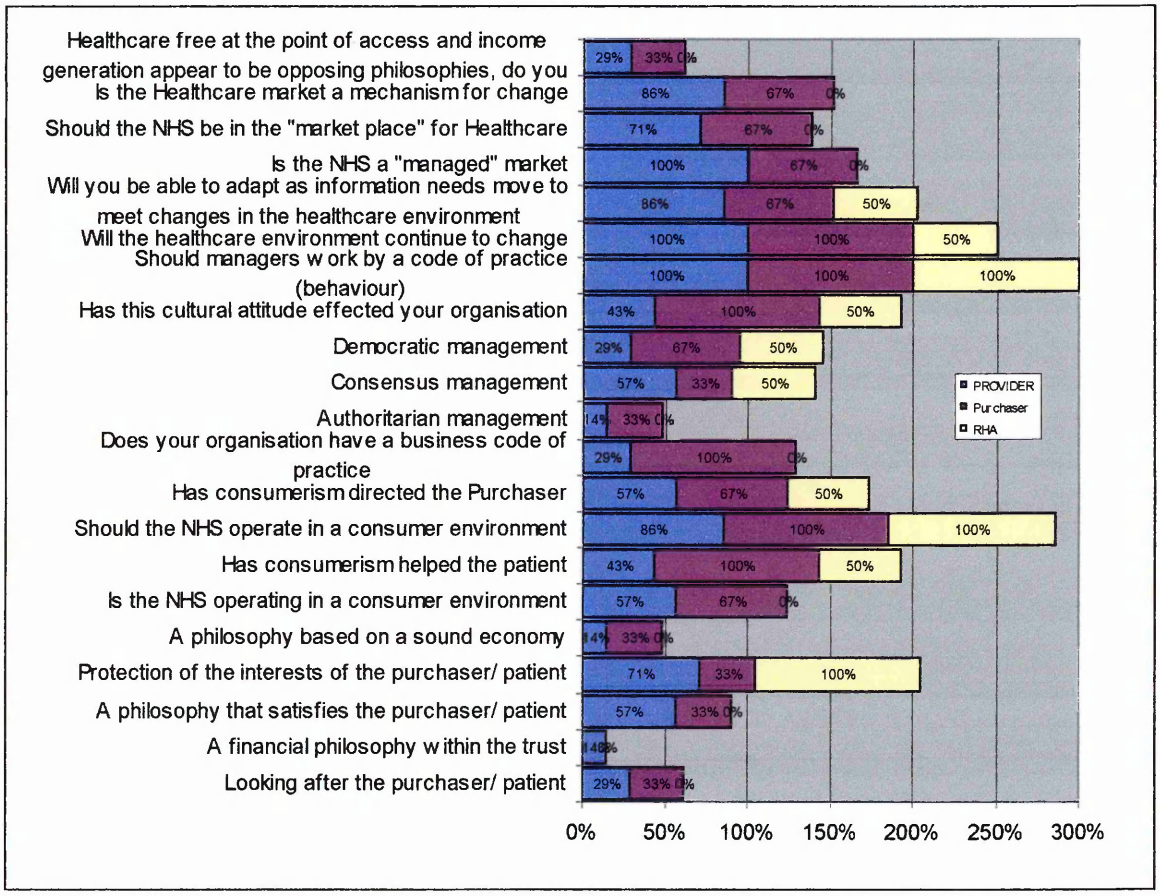
Analytical appraisal indicated (Figure 9) that the General Managers as a homogenous occupational group shared similar views. They appeared to believe in a consumer environment, defining it in terms of service as the protection of the Purchaser and patient. They believed that this consumerism had helped the patient and directed the Purchaser as to what healthcare should be provided. Further analysis indicated that the General Managers supported the view that the consumer environment was a philosophy based on a sound economy, had financial overtones that at the same time looked after the patient and the Purchaser, that the NHS should operate a consumer environment, and should be the marketplace for healthcare, even though the majority believed that this marketplace was actually a managed market

The General Managers expressed a number of views as to the culture of their organisations, the majority believing their organisations' management to be authoritarian in nature. However, a large minority believed that their organisations were democratic in style, operated consensus management and that managers should work by a code of practice. The majority of the General Managers indicated that their organisational environment had been affected by this cultural attitude. The healthcare environment in which the General Managers operated, was a mechanism for change and they recognised that this would cause their

information needs to move in response to changes in the healthcare environment, but that they would be able to adapt as these changes took place.

A small number of the General Managers believed that the existing philosophies within their organisations of "healthcare free at the point of access" and "income generation" were in conflict with each other.

Figure 9: Overview of General Managers' Concept of Management Information in the NHS



Changes in the Healthcare Environment

As part of the General Managers' understanding of their information requirements, they need to have an understanding of their environment (the NHS market environment), and the key changes of the evolving NHS market. The General Managers have to understand how their information needs have moved in response to the environmental changes that have taken place, and how they will adapt as their information needs continue to move to meet those evolving changes. Their understanding is influenced by whether or not they believe their

working environment is in a healthcare market which is managed or not, and whether or not they believe the NHS should be in the healthcare market place at all. Another element to their understanding should include whether or not they are able to use the market environment as a mechanism for change.

The Market Environment

Five out of seven of the General Managers from the Provider organisations indicated that their understanding of the market environment[4] included services which were open to competition, had a requirement for increased efficiency and accuracy, emphasised cost as a major theme of its service principles, had stakeholders who were closely associated with their organisations, who influenced choice of service and who inevitably influenced how the organisation behaved. The General Managers' understanding of their environment has, as its core service, accessibility (in terms of time and distance qualities), quality of its customer service and a primary need to respond to the requirements of the Purchaser. This requirement includes the buying and selling of health services in a fairly restricted environment. However, some of the General Managers expressed a view that the market environment was an ideology unsupported by evidence of success[5].

The General Managers from the Purchaser organisations expressed the converse in that they felt that the market environment did not exist, rather that it was a managed environment that encouraged improved performance at reduced cost. However, where a market environment did exist, it had constraints; allowing the Purchaser to make choices, but only at the margins.

The General Managers were asked whether or not the NHS was a managed market[6] and, if it was, what areas of their information needs were affected? 75% indicated that they thought the market was a managed market. Figure 44 shows that in the areas of information needs most affected the General Managers believed that contract performance, income and expenditure, local Purchaser demands, patient Charter performance, local and national health needs and service planning, were the most affected.

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[4] Question 59 Table of Results

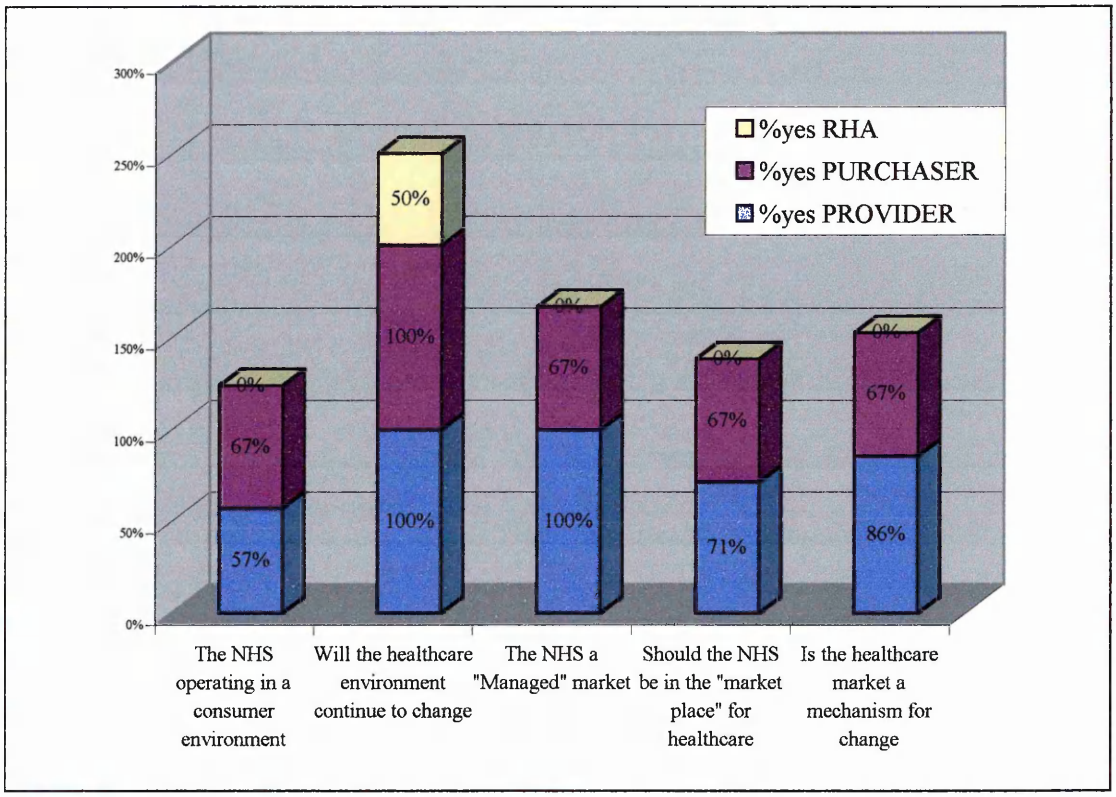
[5] Appendix III

[6] Question 60 Table of Results

A majority of the General Managers indicated [7]that the NHS should be in the "market place" (Figure 10) for healthcare. The General Managers expressed a view that whilst being comfortable with a competitive edge to service provision there was also a need for collaboration where this improved clinical effectiveness, secured cost efficiencies and generated treatment outcomes. However, the sizeable minority of the General Managers who did not believe the NHS should be in the market place suggested that the NHS should be managed locally as a national service; thereby benefiting from some influences of the market place such as clinical and cost effectiveness and outcomes, retaining the Purchaser/Provider split but replacing yearly contracts with long-term agreements in order to provide services. However, within the group of General Managers who did not support the NHS market place, two from the Regional Executive organisations believed that the NHS should maintain the concepts of the NHS as espoused in 1948.

[7] Question 61 Table of Results

Figure 10: The NHS Environment[8]



The Evolving NHS Market

Analysis of the research data indicates that the General Managers' perceptions[9] about a continually evolving healthcare market are characterised by their membership of Purchaser/ Provider groupings. The General Managers from Provider organisations identified the evolving healthcare market as a politically sensitive and a high profile area. They also recognised that clinical developments actually shape services, but reform constraints control the rate of change. In some areas, evolution was quick due to high uptake of GP fund holding, but the market is now maturing and GPFHs are less likely to take short-term decisions and are more interested in longer-term contracts. The speculative responses indicated that "Locality Commissioning" as a strategy would see a resurgence in the form of PCGs and that there would be a greater partnership between the NHS and the private sector as the ability of the NHS to do elective work reduced. Furthermore, there would be fewer and more concentrated Providers. Some of the General Managers felt that there was a need for more integrated contracting to purchase more holistic healthcare rather than simple

[8] Figure 10: The NHS Environment Q2,57,60,61,64 Table of Results

[9] Q63 Table of Results

episodes. There would be more local purchasing, smaller localities, commissioning GPs, GPs leading with patient and community involvement and longer-term contracts. The General Managers from Purchaser organisations felt that the NHS was going round in circles without addressing the "real issues". The General Managers described the "real issues" as being the accountability of the medical profession to the organisation, lack of resources and resources being in the "wrong place". There needed to be a greater control of resources and wider involvement of GPs; especially in the purchasing process and the up-take of the opportunities for meeting needs. The General Managers from the Regional Executive organisations intimated a move to collaboration as opposed to competition, as this conformed to the reality of not being able to make market decisions work.

A Mechanism for Change

The General Managers were asked whether or not the healthcare markets constituted a mechanism for change (Figure 10). A majority of the General Managers from the Purchaser and Provider organisations believed that the market was a mechanism for change, whereas the General Managers from the Regional Executive organisations did not. Those General Managers who agreed that the healthcare market was a mechanism for change, indicated that the market afforded them the opportunity of anticipating locality purchasing, the ability to monitor political developments and policy changes and to adjust priorities for clinical investment. Other benefits included: focusing on local provision and being more responsive to local needs; service reviews being undertaken with local Providers to deliver comprehensive services; and the reconfiguration of low return clinical services if they could be provided elsewhere, thus becoming more cost and/or clinically effective.

The view was also expressed that organisations should be preparing for a new government at the next general election (1997). The General Managers from the Purchaser organisations believed that the market was a mechanism for change and, therefore, developed a strategic framework covering the subsequent five years and signalling annual changes in purchasing plans. In addition to the foregoing, they also are becoming pro-active both internally and externally through innovation.

Areas of Key Changes

The General Managers were asked to indicate the key areas in which changes had occurred in the healthcare environment. The General Managers from the Provider organisations indicated that the following areas had undergone key changes (Table 1).

Adapting as Information Needs Moved to Meet the Changing Healthcare Environment

In Figure 11 it can be seen that 92% of the managers indicated that they thought that the healthcare environment would continue to change and 75% indicated that they would be able to adapt as information needs moved to meet the changes in the environment. One General Manager indicated that the environment would not change, whereas three others believed that they would not be able to adapt as their needs changed.

The General Managers were also asked[10] how they believed their organisations would be able to adapt as information needs moved to meet changes in the healthcare environment. They described their adaptation as developing processes and systems that were flexible and adaptable; learning to use, and increasingly to use, electronic information collection and collation, moving to computer generated enquiry packages; meeting ad hoc requests; the generation of less formal reports; and by tailoring information to the General Managers and their organisations needs. General Managers from the Purchaser organisations described system improvements, re-structuring of the information coupled with the re-organisation and merger of organisations as appropriate. The General Managers from Regional Executive organisations felt that the adaptation would follow the provision of information locally on bespoke systems.

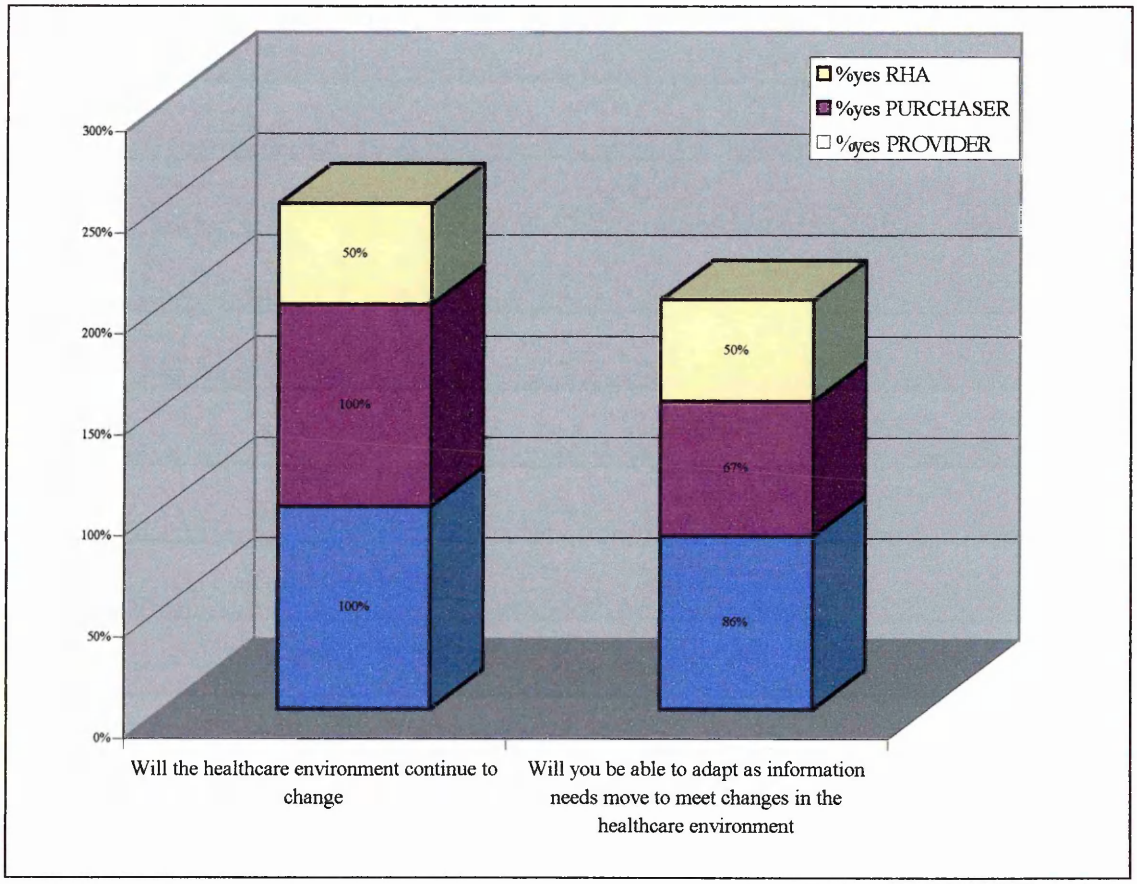
[10] Q58b Table of Results

Table 1: Key Areas of Change

Key Areas of Change	Provider Organisation	Purchaser Organisation	Regional Organisation
Improved purchasing power of GPFHs	✓		
Focus moving towards evidence based medicine.	✓		
Focus on efficiency and outcomes.	✓	✓	
Emphasis on improved effectiveness of provision of services by service rationalisation.	✓		
Drive towards clinical effectiveness.	✓	✓	
Community care legislation	✓		
Emergence of purchasing services for the community.			
Cost effective research & development and education.		✓	
Competition between Provider organisations and Purchaser organisations.	✓	✓	
Market-led service provision.		✓	
Performance monitoring.		✓	
Consolidation of healthcare purchasing strategies.		✓	

Note: Blank boxes in the above table depict that the General Managers from that "organisation" had indicated that no key change had been undergone in that area.

Figure 11: The Healthcare Environment and Information Needs[11]



An Understanding of Consumerism in the NHS

Part of understanding General Managers' information needs is not only understanding the origins and theory of consumerism but whether or not they believed that their work environment was in the "healthcare market place"; what was their understanding of consumerism and did this understanding have an effect on their information needs?

Consumerism

The American Heritage Dictionary defines consumerism as the "theory that a progressively greater consumption of goods is economically beneficial". This theory is at the heart of the economic system based on capitalism and free markets. Brunner (1996) argues that the word forming the root for this theory, "consume", means "to congest, use up, to waste, squander, or to destroy totally". Citing McCracken (1991), Brunner describes a feeling of tension that exists between these two definitions. This tension comes from expecting something

[11] Figure 11: The Healthcare Environment and Information Needs Q57&58 Table of Results

beneficial to result from that which carries an idea of waste, squander, and destruction. This tension describes the unspoken aspect of consumerism. McCracken looked at cultural changes and consumption patterns. He saw consumerism starting with Elizabeth I in the 16th-century and her policy changes and traced its development up to the 20th-Century with changes in marketing, the introduction of the department store, self-created lifestyles and choice of healthcare. McCracken concluded that cultural changes resulted in consumption patterns being changed and, conversely, changes in consumption patterns resulted in changes in culture.

Brunner goes on to cite Bocock (1994) who found that groups of people used consumption patterns as a way of distinguishing themselves from others. Horowitz (1998) provided a primarily American history of ideas about consumerism, concentrating on moralist ideas. Horowitz established that pre-industrial cultures stressed religious, ethical, and communal values and sought to restrain individualism and materialism. The two most relevant topics discussed by "Theorists", in terms of the question of consumerism and the individual, concerned the movement of meaning and the displacement of meaning. The first describes a mechanism for how meaning might be transferred to consumers from something they bought. The second looks at why this purchase might not bring the satisfaction promised, and why the symbolic meaning desired still existed elsewhere. McCracken explained how meaning, which originated in the culturally constituted world, could be transferred first to goods and services and then to consumers by means that utilise the symbolic form of meaning. He further suggested that meaning, as an ideal, might be displaced into another cultural universe with a resulting desire to regain this meaning possibly by purchasing goods. These two insights fit together to describe how a consumer would not necessarily be satisfied by a purchase that promised meaning, when that meaning actually resided elsewhere. McCracken put this forward as an answer to why people consume at the level presently seen in the country, people are trying to regain a displaced meaning.

A review by George Brockway (1995) looked at the economic aspects of consumerism. Those aspects included consumer and individual sovereignty, comfort versus pleasure, the twin ideas of more and progress, and a corporate strategy to privatise cultural aspects of life. Brockway concluded that economics, concerned as it is with the money relationships of human beings to one another, provides two principal insights. With relationships being currently perceived in the language of money: "Is he or she worth the trouble?" or, "I have

too much invested in this relationship to walk away". Brunner citing Alan Durning, who in turn cited Michael Argyle, noted that social relations, work, and leisure were more important than wealth in determining self-rated happiness (Durning 1992). This finding is in opposition to the way people seem to act.

The Concept of Consumerism in the NHS

Consumerism is a largely 20th-Century movement that seeks assurances that what is provided to the public is of good quality. Its objectives are policies and laws that regulate the methods and standards of healthcare Providers and Purchasers alike.

The traditional relationship between buyer and seller is summed up in the Latin *caveat emptor*, meaning, "Let the buyer beware". In other words, the buyer is responsible for protecting his own interests. Without regulations and standards, the lone consumer must accept the decisions and practices of Provider Trusts, GPs and HAs. In a free market economy, competition should guarantee quality; but large Provider Trusts that control most of any healthcare services market are not subject to normal competition and sell many goods and services. Also, the General Managers supported (Figure 15, Figure 21, Figure 24 and Figure 33) the view that in a modern technological society, the consumer is often unable to choose effectively among competing services; as the consumer has insufficient information on which to make a reasonable choice between the different clinical outcomes promised by the clinicians and Provider Organisations.

The history of consumerism shows that there is a relationship between changes in culture and changes in consumption patterns. It shows further that these changes move away from communal values toward individualism and materialism. Social science shows that, whether active or passive, consumers are affected by the symbolic aspects of goods and services. The effects of this are seen or felt in relationship to desire or to need and the pursuit of meaning. Economic strategy stresses the domination of money relationships between people, despite the importance of social relations, work, and leisure. Research has indicated that there is increased level of consumption in the healthcare services, but more importantly general consumption, which began in 16th-Century England, has gradually led to a change in relationships.

The General Managers' Understanding of Consumerism

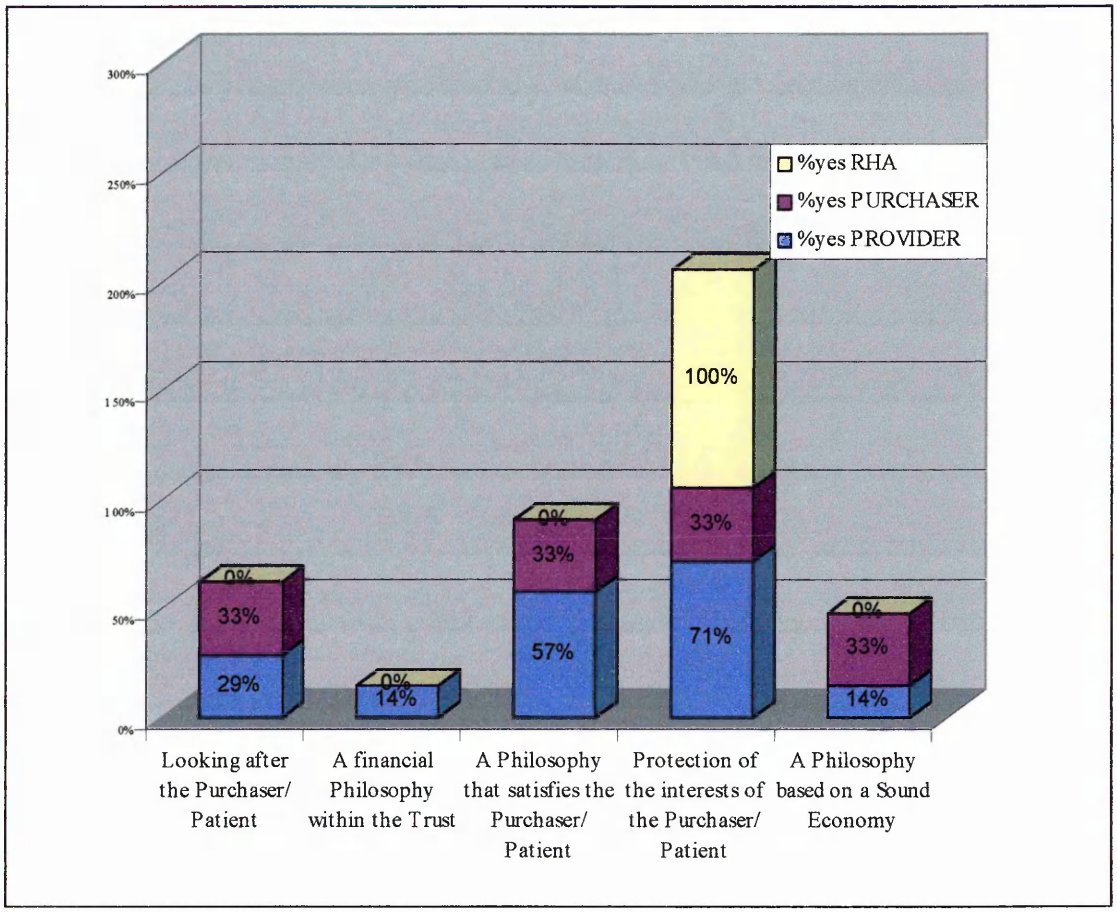
The General Managers' understanding of consumerism is reflected in their choice of phrases as detailed in Figure 12 below. Eight out of twelve of the General Managers believed that "protection of the interests" of the Purchaser and the patient closely matched their understanding of consumerism, with a financial philosophy offering the least close match. Less than half the General Managers agreed that the NHS was operating in a consumer environment, but a majority also felt that the NHS should work in a consumer environment and also felt that consumerism had helped the patient and given direction to the Purchaser in developing the latter's strategies for healthcare.

The General Managers were equally split as to who knew best about healthcare. They indicated that the Purchaser and Provider, but not the patient, were key. However, having recognised this situation, they felt that the Provider must involve the patient (customer) in the type of service provided, and that the Provider had social responsibilities in relation to its service provision as well. This particular view was strongly held by the majority of the General Managers. The role of the local community was believed to be in the areas of the direction of local service provision and in ensuring the survival of the healthcare services in its locality. This was a majority view expressed by the Provider General Managers.

If General Managers are to use information successfully in an environment they believe to be in the healthcare market place, then they need to have an understanding of their customers, any conflicting philosophies, their future information needs and whether the environment empowers. A majority of the General Managers (Figure 10) believed that they should be in the market place, albeit within a "managed market"[12] and that the market environment was continually evolving. The type of organisations from which the General Managers originated, however, differentiated this view. The General Managers' views of consumerism in the NHS, and how it had helped or hindered the provision of an appropriate service for the patient or the healthcare Purchaser, was an important part of their understanding of their information needs.

[12] Question 60 Table of Results

Figure 12: The General Managers' Understanding of Consumerism[13]



Customers in the Healthcare Market

The General Managers were asked who they believed were their customers in the healthcare market: Table 2 indicates their responses. Whereas the General Managers from the NHS Executive organisations did not express a view as to who were their customers, the General Managers from the Provider and Purchaser organisations not only believed that the patients, their carers/relatives and the general populace were their customers, but indicated that the patients' "agents" were also their customers. Their views underlined the complexity of their environment and the task of providing services that satisfied a wide customer base with differing perspectives.

[13] Figure 12: The General Managers' Understanding of Consumerism Q1 Table of Results

Figure 13: The NHS a Consumer Environment[14]

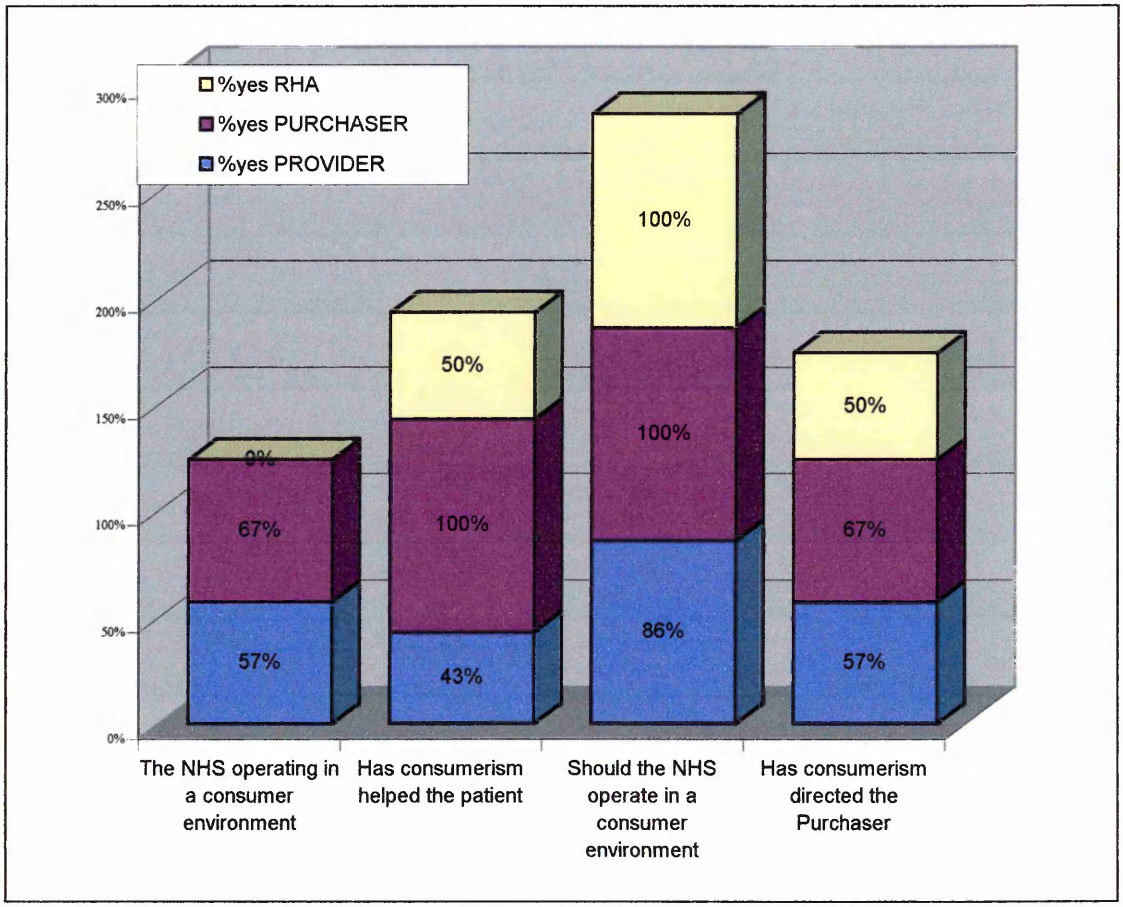


Table 2: The Customers of the Market[15]

Customers	Managers views		
	Provider	Purchaser	NHS executive
❑ patients,	✓	✓	
❑ GPs and GPFHs,	✓	✓	
❑ Government, tax payers	✓	✓	
❑ HAs,	✓		
❑ Clinicians	✓		
❑ Local communities.	✓	✓	
❑ Other Trusts.	✓		
❑ Population in general,		✓	
❑ Potential patients,		✓	
❑ Relatives, carers.	✓	✓	

Note: Blank spaces indicate a nil response from the General Managers of that organisation.

[14] Figure 13: The NHS a Consumer EnvironmentQ2-5 Table of Results

[15] The Customers of the Market Q67 Qualitative Responses to Questions

Empowerment in the Healthcare Market

In 1991 when the White Paper "patients First" was being enacted, many supporters suggested that the changes in the way healthcare would be provided would empower the individual patient. The General Managers were asked for their views on whether or not the healthcare market offered empowerment to the individual, and their views were also sought regarding their understanding of the Clinicians' attitude to empowerment. The General Managers were also asked whether they felt that healthcare free at the point of access and income generation were opposing philosophies and whether such "conflicts" would affect consumer empowerment. A majority of them did not believe that healthcare free at the point of access and income generation were opposing philosophies (Figure 14). The minority who did perceive a conflict of philosophies (less than 50%) indicated that the "conflict" might affect consumer empowerment because the needs of consumers may be in contrast to Purchasers' needs to prioritise services and reduce costs and at the same time generate income; activities which could influence, if not reduce, customer empowerment.

83% of the General Managers indicated that the healthcare environment did not facilitate the empowerment to the individual (Figure 15). Of the 17% who indicated that it did, only one said that it should continue to do so.

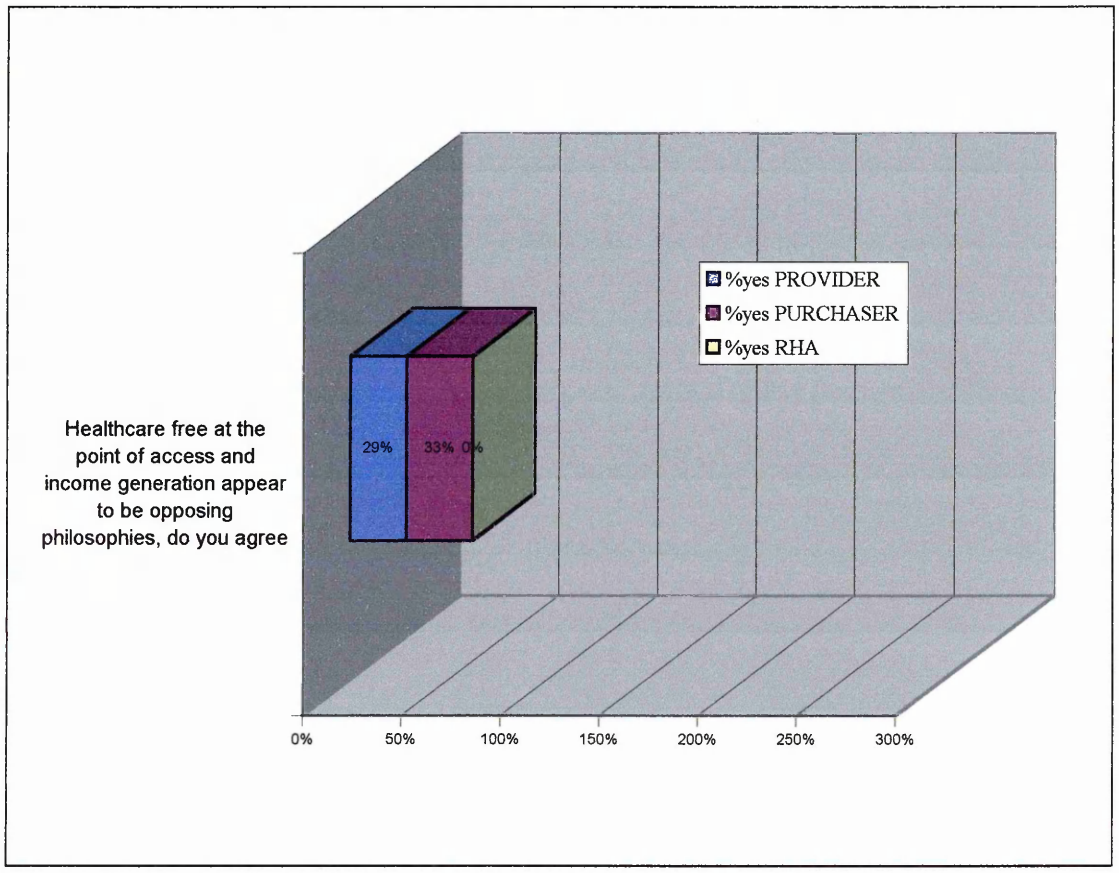
The General Managers did not believe that there were conflicting philosophies (free healthcare at point of access/income generation) that would interfere with the empowerment of the individual. However, neither did they see the environment as empowering the individual. This view was emphasised by their understanding of the Clinicians' support for empowerment as being less than enthusiastic.

The General Managers' Views of the Healthcare Environment

The General Managers' understanding of the healthcare environment included competition amongst Provider organisations, efficiency and cost effectiveness and at its core an environment that focuses the service towards its customers' needs. However, this understanding also included assumptions about the market itself in that it was at best a "managed market" and at its worst an "ideology unsupported by evidence". Up to 75% of the General Managers believed that their environment affected areas of information needs. The areas affected covered organisation performance and local and national demands, all of

which impacted upon service planning. The NHS should be in the "market place" (Figure 10) for healthcare, but a sizeable minority believed that there were better ways of managing healthcare. The picture, therefore, offered a mixed view, from being a managed market, having long-term contracts, to reflecting the NHS as it was viewed in 1948.

Figure 14: Conflicting Philosophies: Healthcare vs Income Generation[16]



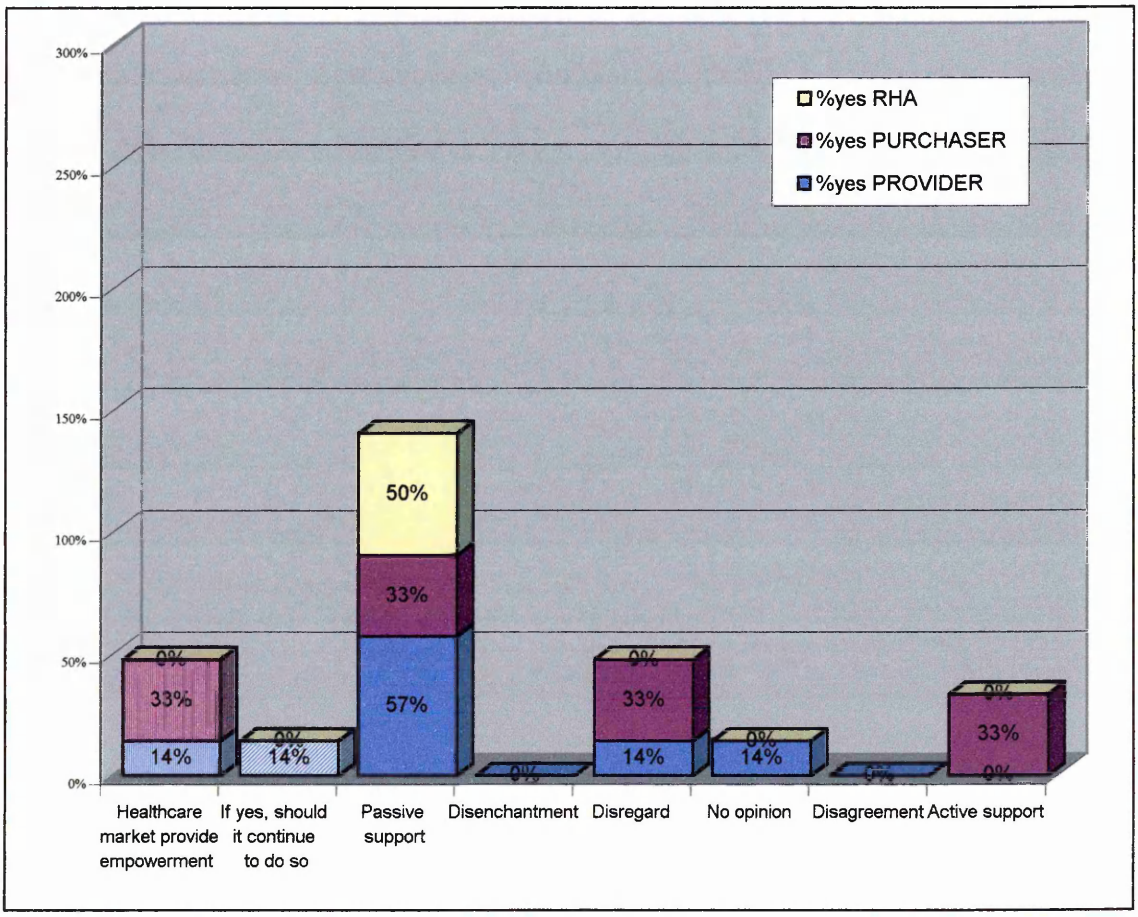
Defining the General Managers' Information Needs

The concept of information needs is a subjective experience that occurs only in the mind of the manager and is not directly accessible to the observer. Wilson (1981) argued the experience of need could only be discovered by deduction from the behaviour of the manager or through reports authored by the manager in need. Therefore, the identification of the General Managers' information needs were deduced from analysis of their responses. The General Managers identified their needs in a number of ways (Figure 39, Figure 40 and Table 10, Table 11). In addition to those needs, the General Managers expressed their views about organisational culture and change, relationships with key stakeholders, and the effects of external/internal influences on their needs. Analysis of the data attempts to draw conclusions

[16] Figure 14: Conflicting Philosophies: Healthcare vs Income Generation Q66 Table of Results

as to whether or not there have been any problems caused which have affected the ability of the General Managers to define their information needs.

Figure 15: Does the Healthcare Market Empower the Individual[17]



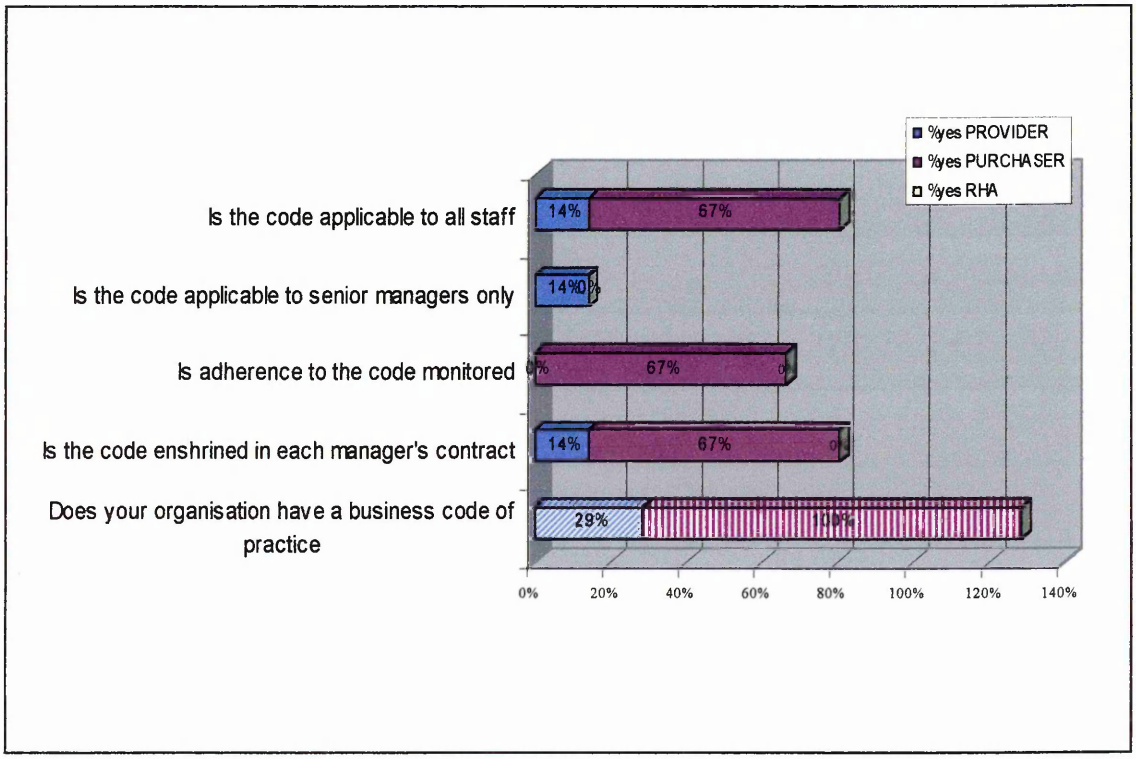
Organisation Culture, Code of Practice, Leadership Style

The General Managers were asked if their organisation possessed a business code of practice. All the Purchaser organisations did, together with a third of the Provider organisations. Of those organisations that possessed a code, 80 % of them applied the code to all staff and the code was enshrined in the General Managers' contracts (Figure 16). However, of those, only a minority of the Provider organisations applied the code of practice to all their staff and managers and did not monitor adherence. The Regional Executive organisations did not have a business code of practice.

[17] Figure 15: Does the Healthcare Market Empower the Individual Q68-69 Table of Results

However, when the General Managers were asked whether they worked by a code of practice, all groups agreed that they did. As Figure 17 shows, the areas covered most frequently by a code of practice were honesty and trustworthiness, confidentiality, conflicts of interest, contracts, rules of the organisation and bribery. It should be noted that since 1991 the DoH most frequently legislates on those areas and that the General Managers from Provider organisations were the most enthusiastic in support of all the areas identified.

Figure 16: Business Code of Practice[18]



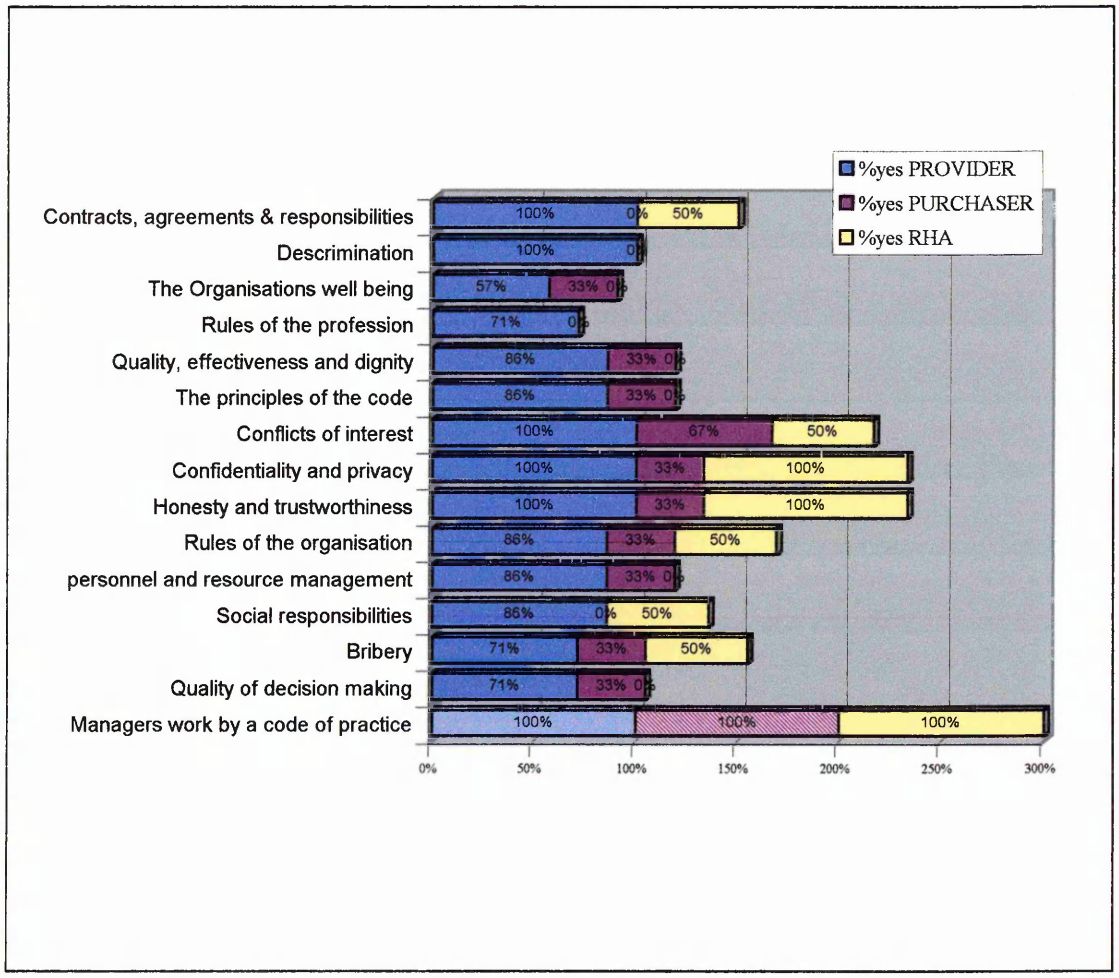
Culture of the Organisation

The views of the General Managers, as a titular group, showed that they believed their organisations to be either democratic or consensual in their style of management. However, as shown in Figure 18, a third of the General Managers from the Purchaser organisations and a minority from the Provider organisations also believed their organisations to be authoritarian in style; whereas the General Managers from the Regional organisations were evenly divided (50:50). Two thirds of the General Managers from the Purchaser organisations believed their organisations to be democratic.

[18] Figure 16: Business Code of Practice Q11&12 Table of Results

Managers and the way they work tended to reflect the culture of their organisation (Miles & Snow 1978). The organisations that were essentially conservative, where low risk strategies secure markets and where well-tried solutions are valued, are Defender organisations. The other type of organisation, in which the dominant beliefs revolve round innovation and breaking new ground, where managers go for high-risk strategies and new opportunities, are called Entrepreneurial or Prospector type organisations. The Defender organisation is typically to do with stability, consensus and decision taking is often rigid, whereas the Entrepreneurial organisation is about growth and change and the use of less formal structures for decision making and planning. Another point made by Miles and Snow was that the two organisation cultures behave in different ways in similar environments.

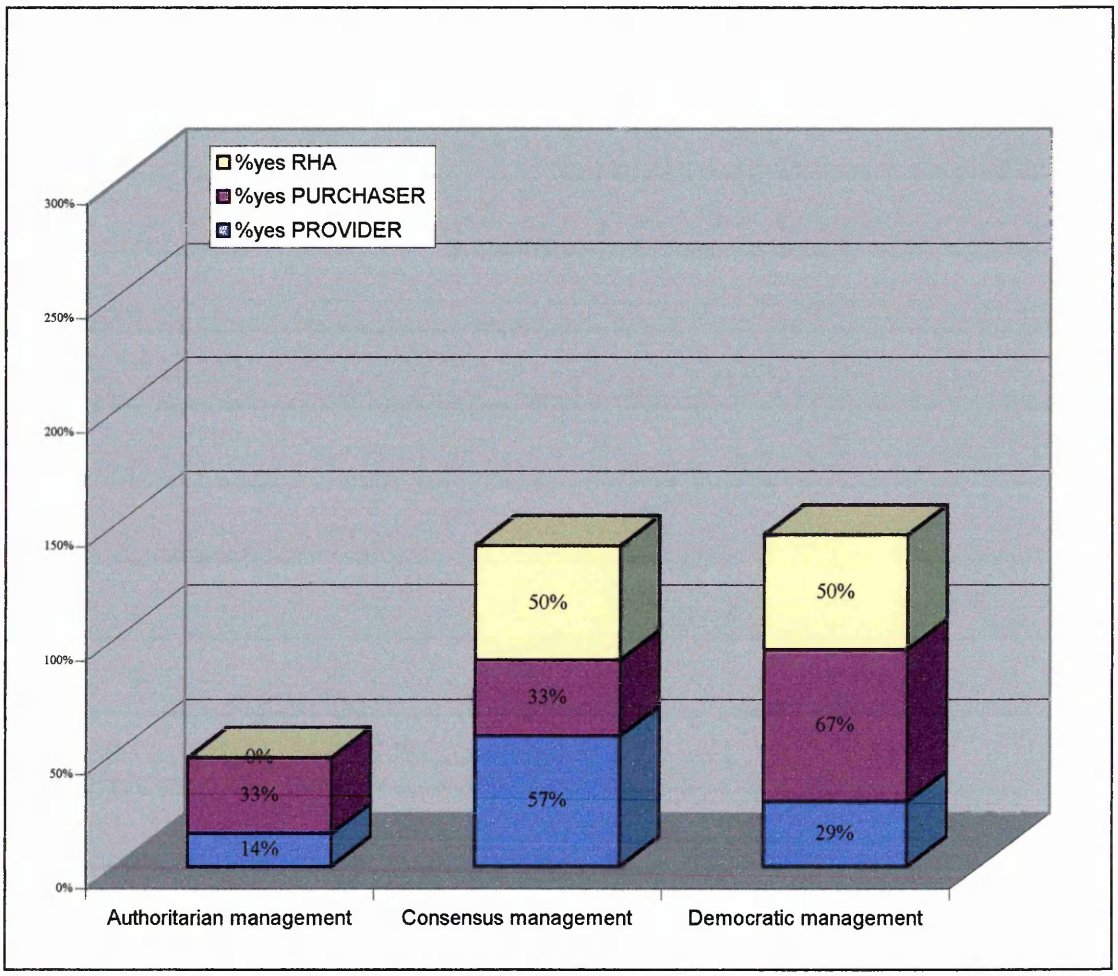
Figure 17: General Managers' Codes of Practice: areas which should be covered.[19]



[19] Figure 17: General Managers' Codes of Practice: areas which should be covered. Q22 Table of Results

The majority of the General Managers believed that their organisational environment reflected the prevailing cultural attitude of their organisation. Further analysis of their views of their organisation is described below in Figure 19. They were asked to describe their organisation in terms of behaviour, leadership style, and attitude to the internal environment and their internal environmental philosophy.

Figure 18: Management Culture of the Organisation[20]

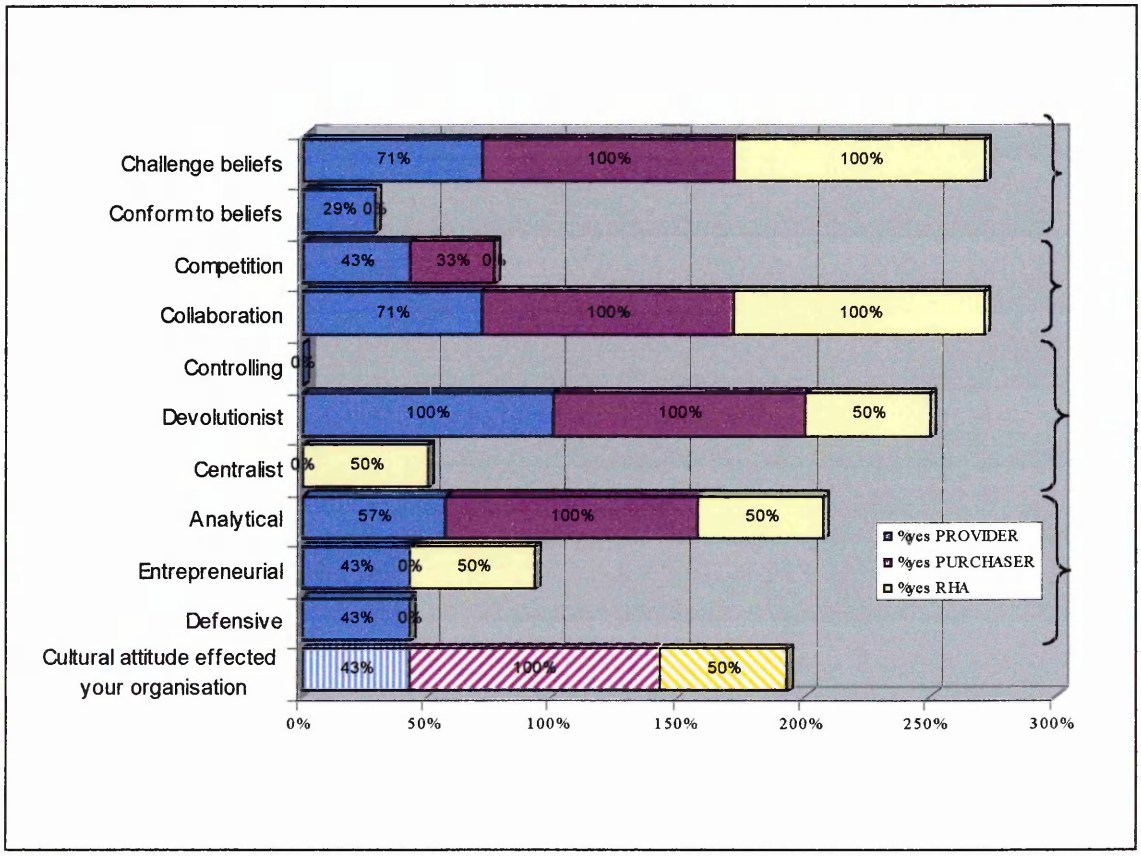


Analysis (Figure 19) indicated a mixed but positive view of the organisations. For example, between 83% and 92% of the General Managers believed their organisation to be devolutionist, and to be a collaborative one that challenged beliefs. However, when asked to decide whether their organisation was Defensive/Analytical, or Entrepreneurial in nature, a mixed view was indicated. The General Managers from the Regional Executive organisations were split between entrepreneurial and analytical. The General Managers from the Purchaser

[20] Figure 18: Management Culture of the Organisation Q13 Table of Results

organisations believed themselves to be analytical in nature, but the Providers believed that they were as a group all three. *(3 were defensive, 3 were entrepreneurial and 4 were analytical.).*

Figure 19: Cultural Attitude of the Organisation[21]



Analysis indicates a consistency in the responses for organisational cultures that are in the main "prospector/entrepreneurial" in nature with devolutionist, analytical and challenging elements. However, it is unlikely that any of the organisations could follow the behaviour patterns as described by Miles & Snow (1978) closely because the NHS infrastructure is so great and unwieldy and the bureaucracy so large that flexibility is limited. This culture of the organisation, which is a reflection of the strategy of enterprise, its structure, the sorts of people who hold power, its control systems and the way it operates as described by Miles & Snow, would have a number characteristics such as objectives that exploit new services and market opportunities, but also a desire to integrate new services into existing ones. This 'cultural web' of the organisation is its political structures, routines, and rituals and symbols (Johnson & Scholes 1989). The organisations' preferred strategies are; growth through service development; constant monitoring of environmental change and multiple

[21] Figure 19 Cultural Attitude of the Organisation Q14 Table of Results

technologies, but mixed with steady growth (due to financial constraints); exploitation of evidence based medicine and to essentially be a follower in the market. The organisations' planning and control systems emphasise flexible decentralised control and the use of ad hoc measurements, with complicated co-ordinating functions such as intensive planning and project management. One of the main criticisms of this in NHS organisations is the emphasis placed on the stewardship of funds as opposed to the quality of service.

Conclusion

The General Managers as a group viewed their organisations as having a cultural attitude that was collaborative, with a leadership style that devolves responsibilities down the chain of command, with an analytical focus that challenges beliefs, whilst encouraging collaboration with other each other. The General Managers expressed the view that this cultural attitude affected their organisation and, as a consequence, their information needs. Only 42% of the General Managers operated a code of conduct and of those, 25% had the code of conduct written into the General Managers' contracts but only 25% indicated that it applied to all staff; even fewer monitored the application of the code.

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The General Managers' Views of their Own Roles

The General Managers' views on the influence of their own roles in the healthcare environment, together with their understanding of their relationships with key stakeholders in their organisations, such as the patient and the doctor, and their responsibilities and accountabilities towards the patients' interests are important factors to take into account when attempting to understand the effects of the views of the General Managers on their information needs.

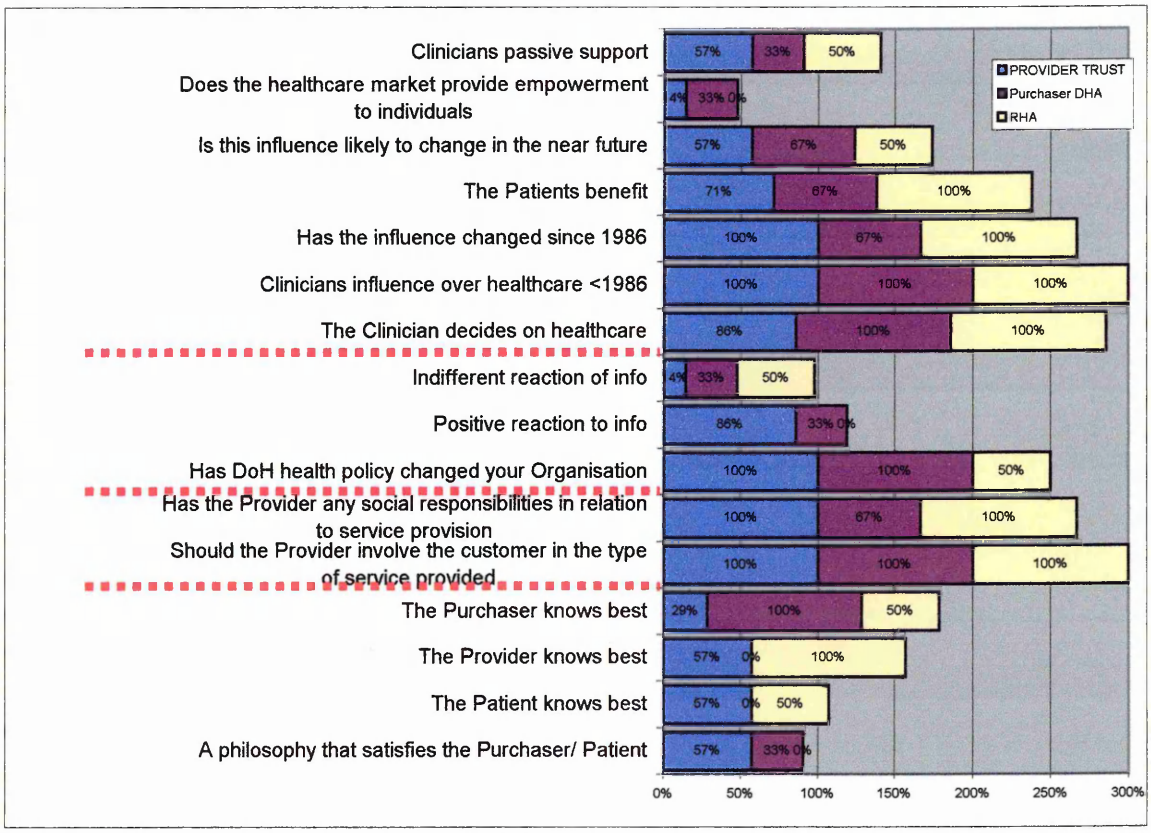
The General Managers' roles and relationships with stakeholders and decision makers within their organisations are analysed as an overview (Figure 20). The General Managers of the Purchaser and Provider organisations viewed their roles as pivotal in deciding the healthcare needs of the patients and that with this pivotal role came responsibilities for involving the customer in the type of service to be provided. This particular responsibility had increased importance for the General Managers of the Provider organisations.

The General Managers believed that policies emanating from the DoH had influenced change in their organisations but the Clinicians continued to be the main influence in healthcare and maintained their prime position in deciding on the type of healthcare that patients should receive. This influence of the Clinicians had existed prior to 1986 but had changed; in that Purchasers had increased their share of influence, with patients being the beneficiary of those changes. The General Managers believed that this change in influence was likely to continue into the near future. Analysis suggests that despite the Purchasers gaining influence in the provision of healthcare for the patients, the existing healthcare environment does not empower the patient in deciding what healthcare they should have. The General Managers expressed a view that the Clinicians were less than enthusiastic towards this "empowerment" of the individual.

Analysis of the research data suggests that the General Managers have a comprehensive understanding of their information needs, demonstrating their ideas and methods of how they satisfy those needs. But their reaction to information received gave a mixed picture; analysis indicates that less than 50% of the General Managers showed a positive reaction to information that they received (a majority of the General Managers in this group were from the Provider organisations); and less than a third of the General Managers showed an

indifferent reaction to the receipt of this information. (This group was made up of the General Managers from the Regional Executive and Purchaser organisations).

Figure 20: Overview of General Managers' Roles



Roles and Relationships

How the General Managers perceived their relationships with the key stakeholders within their organisations was important when identifying their understanding of the influences that affected their organisations, because their perceptions of their roles and relationships affected their view and understanding of the importance of the stakeholders as influencers. The research sought to understand how those changes in relationships, in particular the doctor/ General Manager /patient relationships, had altered the roles of the General Managers.

Healthcare Environment

The healthcare environment was considered in the context of the General Managers' concept of management information in the NHS. However, in this chapter the environment is examined in the context of the General Managers' views of their roles. The questionnaire sought to identify the links between their roles and environment, (relationships), and the

effects of changes in those relationships on the General Managers' information needs. To do this there was a need to know:

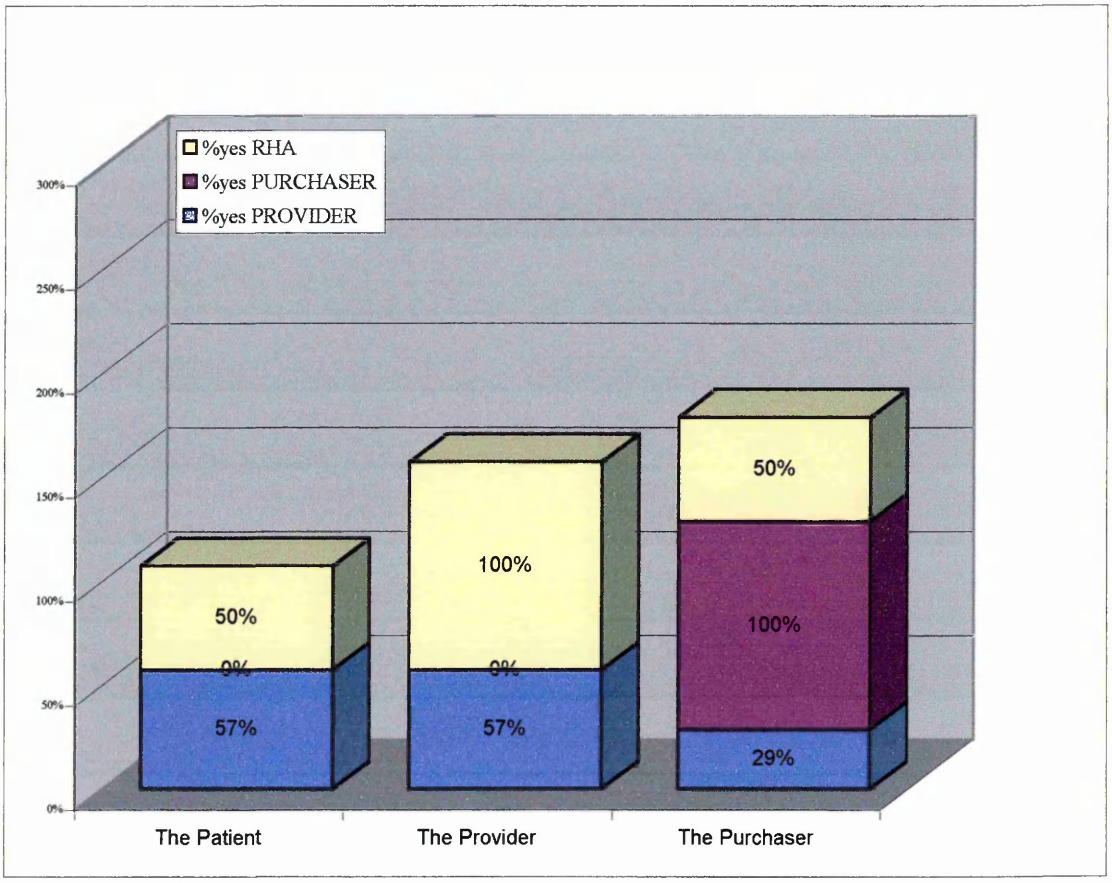
- How the changes in the healthcare environment from a monopolistic one to a market led one had altered the relationships;
- How the changes in the NHS philosophy of healthcare free for all to one of a business philosophy, have affected their information needs;
- How consumer participation and the social responsibilities of the Provider have affected the information needs of the General Managers;
- How the General Managers perceive the health environment to have changed and will change in the future;
- How to understand the areas of conflict where patients' individual interests clash with the "business interests" of the hospital; and
- How the changes in balance of power between consumers/Providers have affected the information needs of the General Managers.

Responsibility and Accountability for the patients' Interests

The questionnaire sought the General Managers' views on which of their organisations they thought knew best when considering the healthcare needs of the patient. Analyses of their responses to the questionnaire are shown in Figure 21, which indicates that they held split views.

Further analysis of the results indicated that the General Managers from the Provider and Regional Executive organisations perceived that the patient and the Provider organisations both knew best about the patients' healthcare needs. However, the General Managers from the Purchaser organisations perceived that they themselves knew best about the healthcare needs of the patient. This mixed result is supported by other views expressed by the General Managers in that 83% believed that the healthcare environment did not empower the individual patient. They also held the view that the Clinicians were less than enthusiastic about empowerment of the patient in determining their healthcare. *(Does the healthcare market empower/ Clinicians attitudes to empowerment[22]).*

Figure 21: Healthcare Needs; who knows best[23]



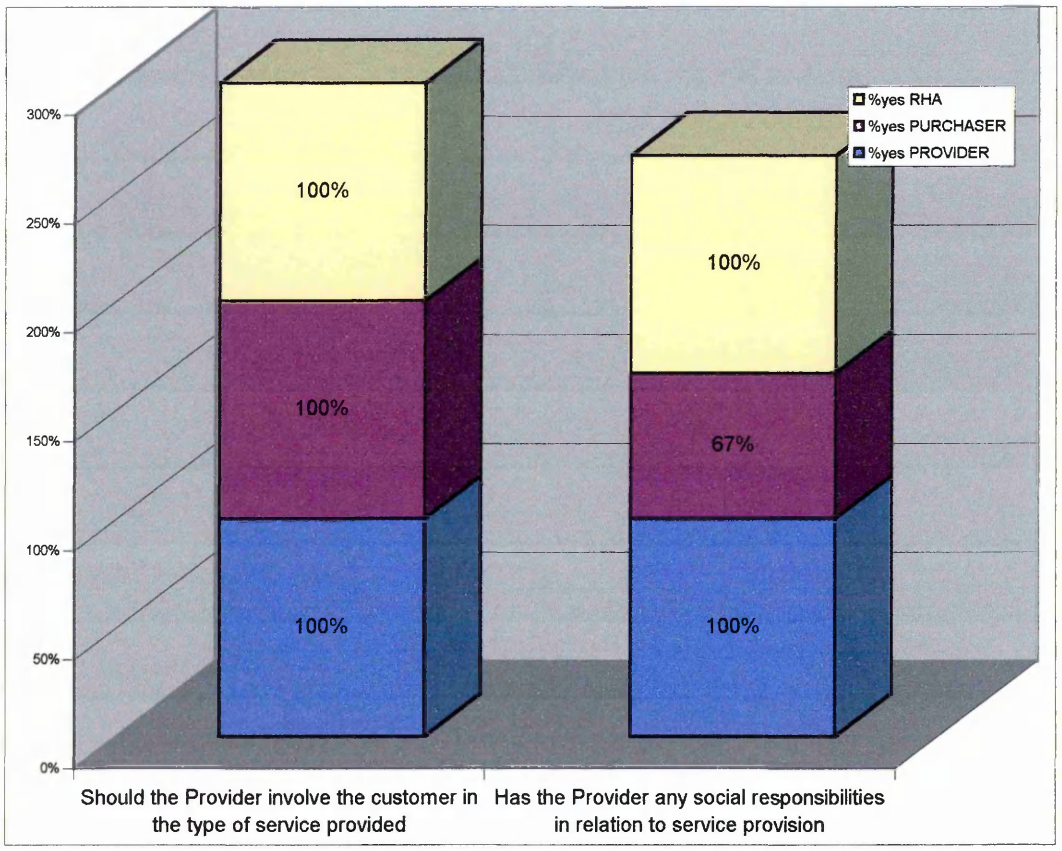
The General Managers were asked for their views on customer involvement in the type of services provided and whether or not the Provider organisations should have any social responsibilities in relation to the provision of services.

Analysis of the General Managers' responses (Figure 22) indicated that they all expressed positive views as to involvement of the patient in the type of service to be provided and also a strong desire to involve the patient in their decision-making. However, the General Managers clearly indicated that they felt they knew best with regard to the healthcare needs of the patient. Further analysis indicated their recognition of the Provider organisations' social responsibilities associated with service provision and at the same time their understanding of the role of the local community in the provision of healthcare (Figure 23).

[22] Q68/69 Table of Results

[23] Figure 21: Healthcare Needs; who knows best Q6 Table of Results

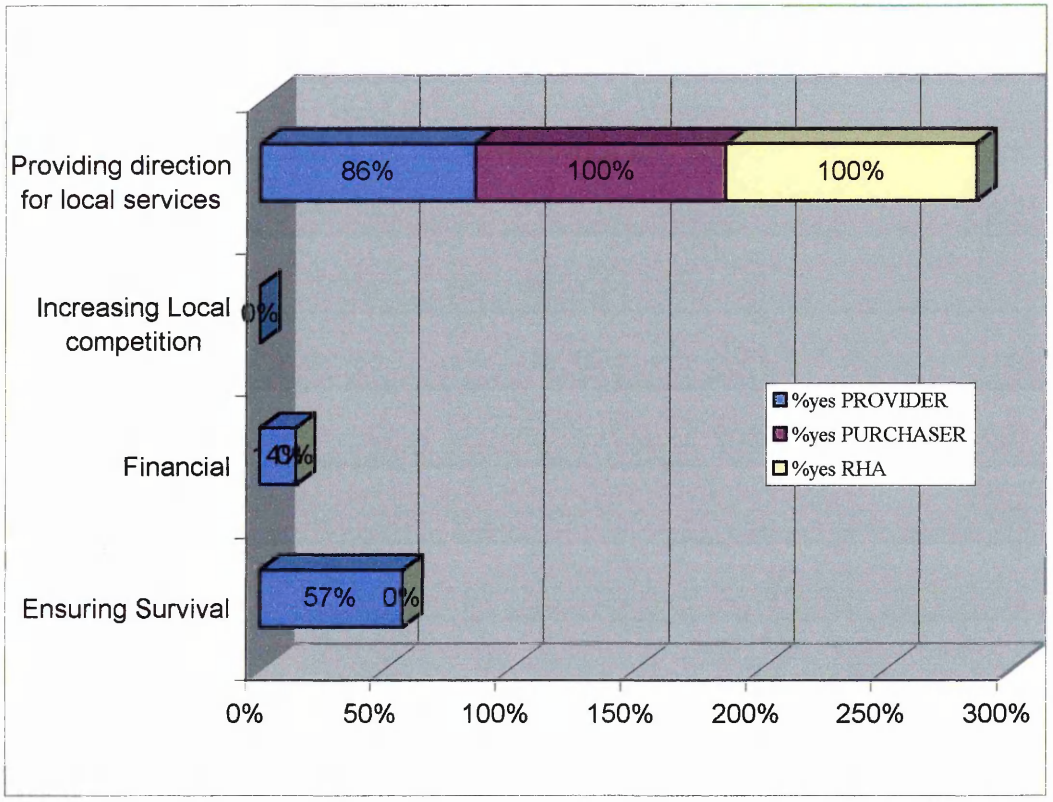
Figure 22: The Provider, its Social Responsibilities & Customer Involvement[24]



Analysing the results of the General Managers' views on the role of the local community in the provision of healthcare, Figure 23 shows that a majority of the General Managers believed that the role of the local community was to provide a sense of direction for "healthcare" for local services. However, a small minority (the majority of the General Managers from the Provider organisations) believed that ensuring survival of the organisations financially was part of the role of the local community. Analysis of this minority view revealed that it represented 57% of the General Managers from the Provider group, whereas the General Managers from the Purchaser and Regional organisations indicated a negative response to "direction of healthcare, survival and financial roles". It could be argued that the General Managers from the Provider organisations may well choose these additional roles as they are more acutely aware that financial stability and survival rests in part on the support of their local communities.

[24] Figure 22: The Provider, its Social Responsibilities & Customer Involvement Q7&8 Table of Results

Figure 23: Role of the Local Community in the Provision of Healthcare[25]



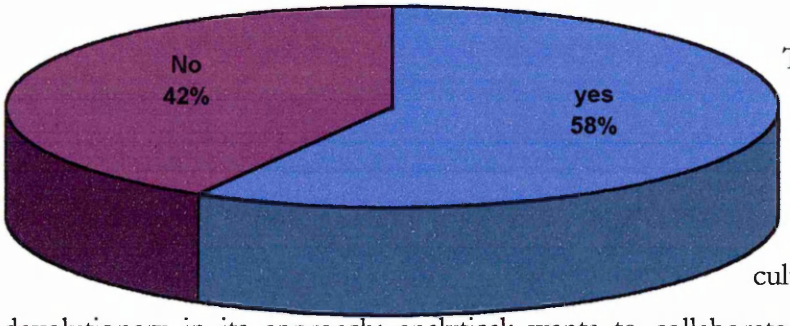
The "patients' Interests" and the "Business interests" of the Organisation

The research sought to identify the General Managers understanding of their roles and how those roles affected their information needs and their views on the areas of conflict where the patients' individual interests clash with the "business interests" of the organisation. Also on consumerism in their organisations, and whether this consumerism enables the patient to be empowered in deciding the healthcare they need, were analysed. The General Managers' views on these questions are influenced by the views of others within their organisation and the organisation culture as shown in Figure 18. Leadership style plays an important part in any organisational culture, the General Managers' views on the styles of their organisations' management are described on p102; whether it was authoritarian, consensus or of a democratic nature and whether that leadership style had affected their organisations.

[25] Figure 23: Role of the Local Community in the Provision of Healthcare Q9 Table of Results

The influences of others that affect the General Managers' views are themselves affected by group influence, balances of power and changes in the roles between General Managers and patients. The most prominent "potential conflict" over the last few years in the healthcare environment has been the philosophies of running the healthcare organisations (Trusts) as businesses and "free healthcare for all". The General Managers, as indicated in Figure 14, suggested that there was no conflict. They believed that the environment did not facilitate empowerment for the patient and they also observed that clinicians were unenthusiastic towards empowerment of the patients. However, a minority of the General Managers who believed that there was a conflict of philosophies also believed that this conflict affected the patients' empowerment in influencing their healthcare needs. At the same time the majority of the General Managers expressed an understanding that consumerism was about protecting the interests of the Purchaser of healthcare and the recipient patient and also that consumerism had helped the patient (Figure 24).

Figure 24: Has Consumerism Helped the patient[26]



The General Managers' views of their organisation's cultural environment showed a culture that seeks consensus; is devolutionary in its approach; analytical; wants to collaborate and yet at the same time challenge beliefs. Those views were similar in nature to the view of the General Managers over conflicts, empowerment, and benefits of consumerism to the patient. They showed organisational thought that attempted to steer a middle course, to maintain the status quo whilst looking to develop the organisations to cope with the future. For example, patients should be empowered but they are not; consumerism benefits the patient, but the Clinicians are unenthusiastic about empowerment; the organisations are for consensus management whilst being collaborative but devolutionist in their approaches; they challenge beliefs but are not entrepreneurial. Overall, these views appear to fall very much in the middle of the culture road.

[26] Figure 24: Has Consumerism Helped the patient Q3 Table of Results

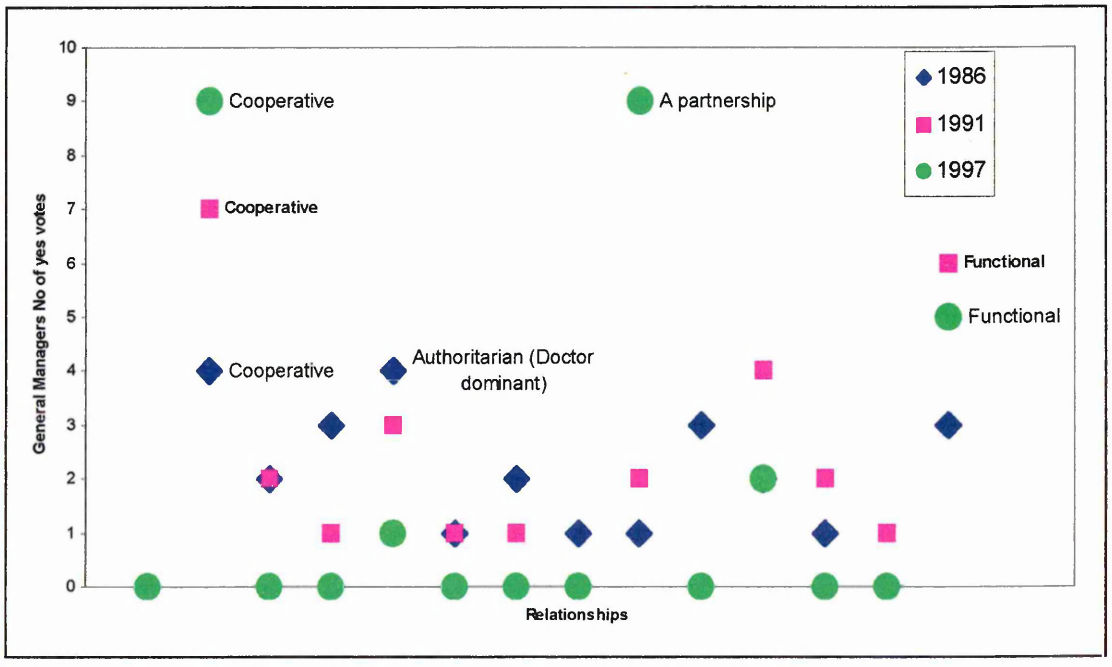
The Perception of the Changing Healthcare Environment

Relationships between doctors, General Managers and patients

doctors and General Managers

Part of understanding the General Managers' perception of how the healthcare environment has altered and continues to alter for the future is to identify the changes that they believe have occurred in their relationships with patients and Clinicians over the years. The General Managers were asked for their views regarding the relationships between General Managers, doctors and patients, and between doctors and patients up to 1986, 1986-1991, and from 1992 onwards. From Figure 25, Figure 26, and Figure 27 the most popular phrases used to describe the relationship were co-operative, functional, partnership, authoritarian and hierarchical. Up to 1986 as shown in Figure 25 the relationship between doctors and General Managers is described as co-operative but authoritarian on the part of the doctor. In 1991 the relationship had become co-operative and functional and by 1997 co-operative and viewed as a partnership. Thus, the relationships have moved from authoritarian on the part of the doctors through a functional relationship to one of a partnership.

Figure 25: Relationships between doctors & General Managers[27]

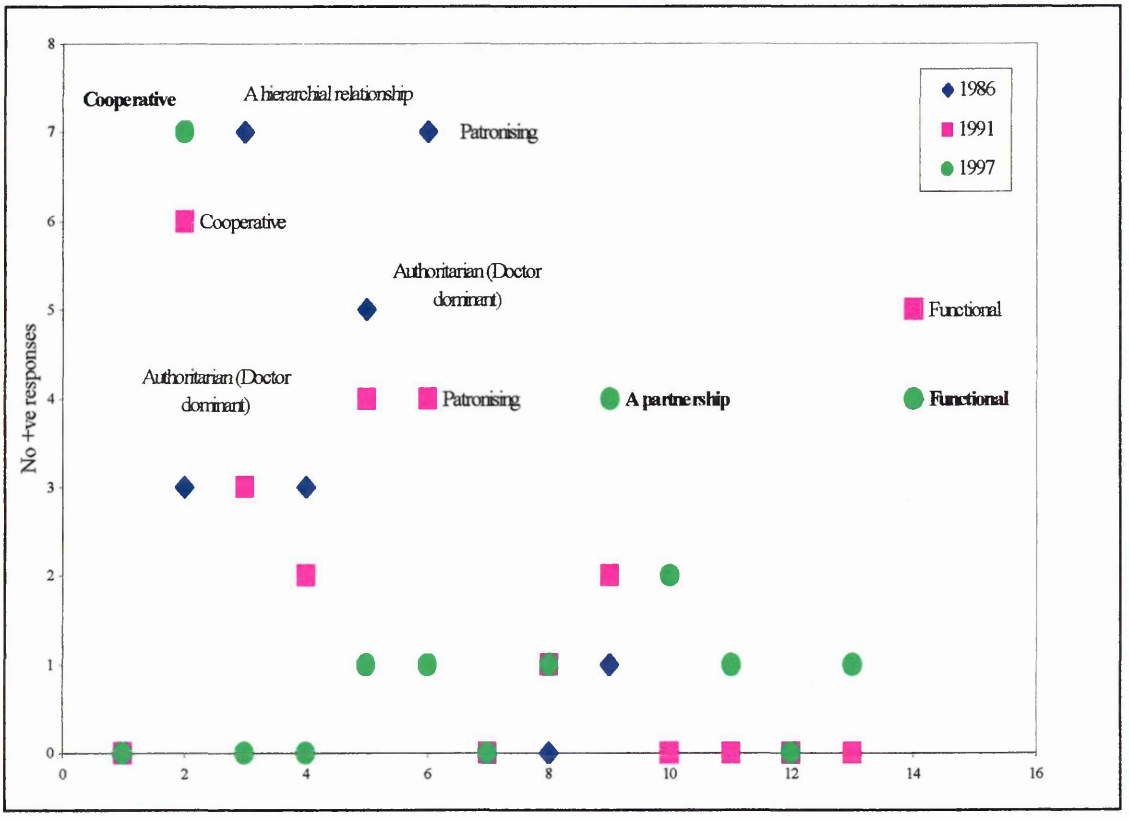


[27] Figure 25: Relationships between doctors & General Managers Q42, 45,48 Table of Results

doctors & patients

In 1986 the relationship (Figure 26) was described as a hierarchical and patronising one, which was influenced by an authoritarian attitude of the doctor. In 1991 the relationship was becoming co-operative and functional but still affected by an authoritarian doctor with a patronising attitude. But in 1997 the situation had changed in that co-operation had improved and the relationships were developing into functional partnerships.

Figure 26: Relationships Between patients & doctors[28]

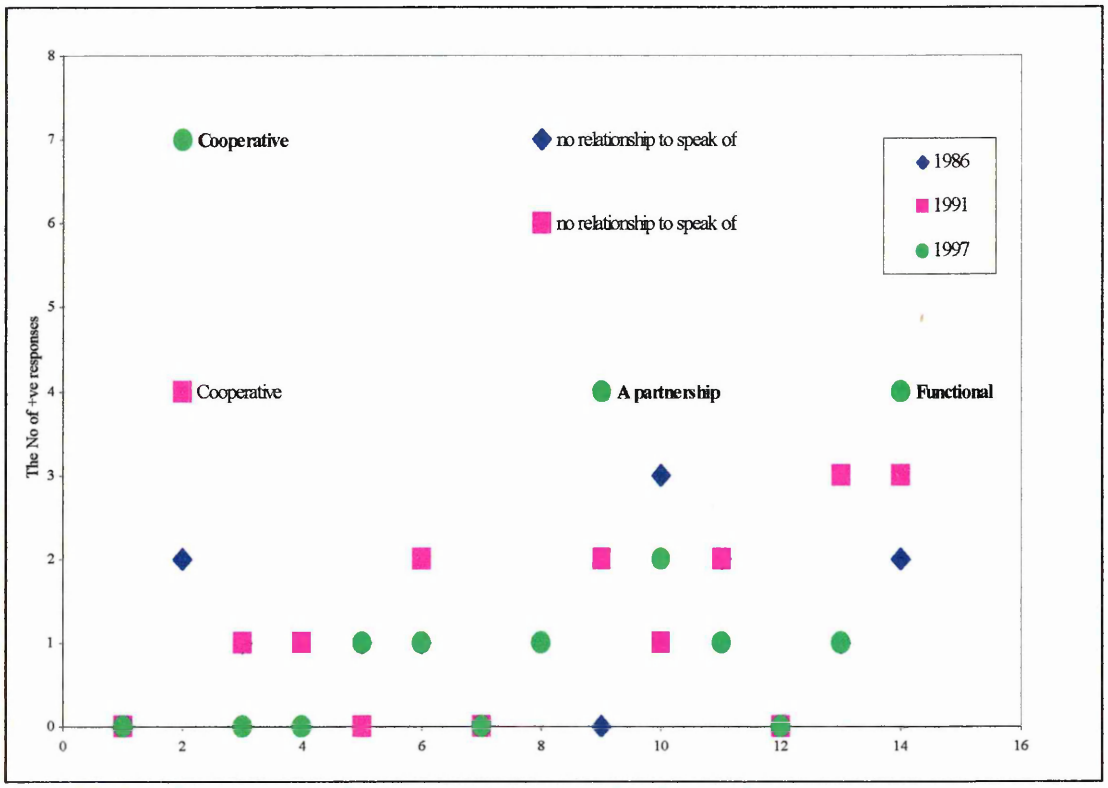


patients and General Managers

Before 1986 the majority of General Managers believed that they had no relationship with patients (Figure 27). By 1991 that view continued to be maintained by the majority, however, a minority of the General Managers believed that a co-operative relationship was developing. In 1997, the majority of the General Managers believed that they had a co-operative relationship that was developing as a functional partnership.

[28] Figure 26: Relationships Between patients & doctors Q44, 47, 50 Table of Results

Figure 27: Relationships between General Managers & patients[29]



How the Changed Relationships Between the doctors and General Managers and the Influences Affecting their Organisations have altered the Roles of the General Managers

The Change in Relationships between the doctor and the General Managers

As well as Clinicians being viewed by the General Managers as the most influential group both at present and in the future, the relationships between General Managers and doctors has altered as well. The General Managers' relationships both with doctors and patients have become more co-operative and in the case of doctors it has become more of a functional partnership. This is mirrored to a lesser degree with the patients. The role of the General Manager has altered as a result of these changes in relationships. The Clinician remains the main healthcare influence, however, the patients' influence is increasing as shown in Figure 31 and pressure is being brought to bear through contracting, performance targets and DoH requirements. The General Managers' roles are becoming more positive in that not only is the business environment strengthening their influence but also, by developing partnerships

[29] Figure 27: Relationships between General Managers & patients Q43,46,49: Table of Results.

with key stakeholders of the healthcare environment, the General Managers are strengthening their roles in their organisations.

Power and Influence within the Organisation

Influence over Healthcare Provision and how this has Changed since 1986

In terms of the General Managers' information needs, for many of them, the group situation may be a major source of influence for the General Managers, providing much of the context for their decision making. That context, Cooke & Slack (1984) argue, is the screen and filters which modifies information and is actually the source of information for the manager. Power to influence within an organisation often rests with these internal groups; with sanctions being applied depending on the perceived centrality and importance to the group. Tannenbaum (1966) puts forward three propositions summarising the issues: an attractive group is more likely to see individual views conform to the majority of the group, the norm; if an individual fails to conform, he is likely to be ejected from the group; and rejection is likely to occur the more important the issue is to the group. The initial strategy of these questions was to identify who was considered to have influence "Power" within the organisation at that moment in time and in the future; to identify the top 10-influencer groups in priority order; then to identify any changes within the priority order of those groups in the future.

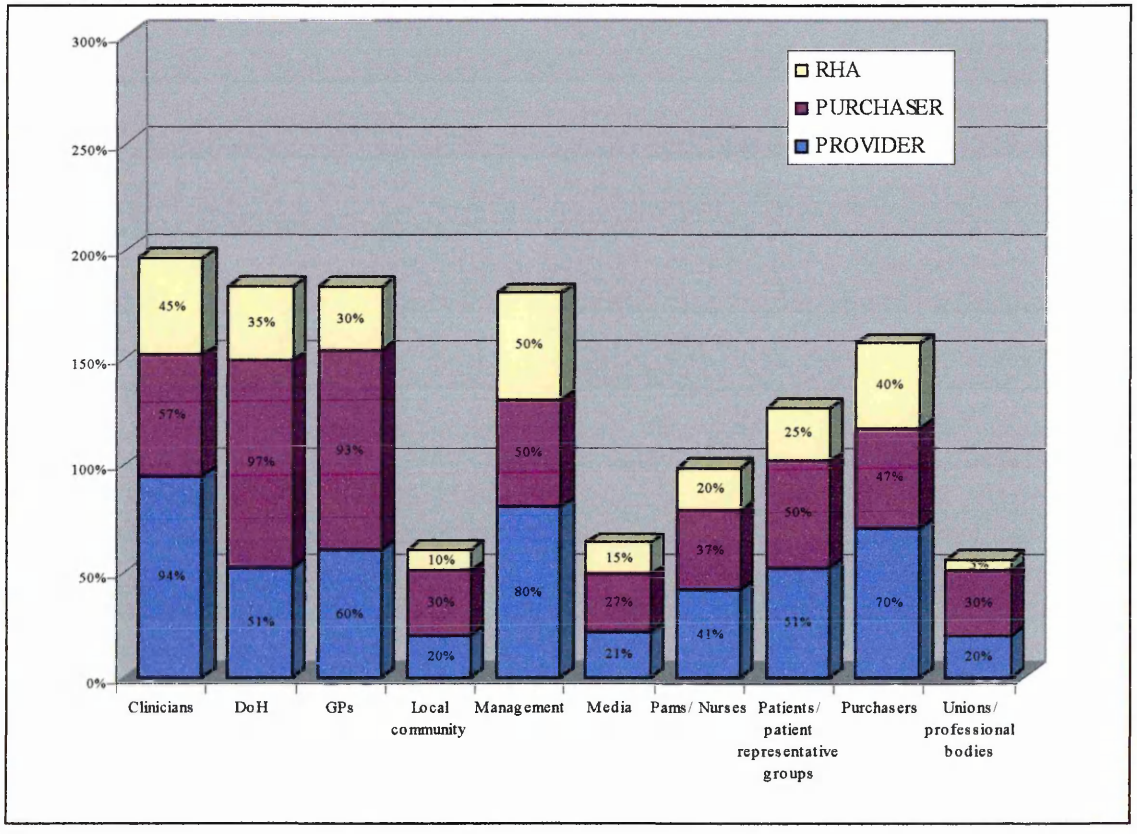
The strategy of the organisation, its structure, the people who hold power within that organisation, and the way it operates reflect the culture of that organisation (Miles and Snow 1978). The General Managers were asked to identify who held sway in their organisations by ranking groups in order of pre-eminence "if power in an organisation is the ability of a group or individual to persuade, induce or coerce others into following certain courses of actions". The groups chosen were as follows: Clinicians, Professions allied to medicine (Pams) and Nurses, Purchasers, the DoH, Unions, Management, patients and their representatives, GPs, the Media and the Local Community. The questions elicited the views of the General Managers as to the influence of the groups, and the rankings illustrated the potential influence that the groups had on the decision making of the General Managers. The initial ranking indicates the order of influence that the General Managers believed the groups held now. Table 3 illustrates the responses expressed. For example, five General Managers ranked Clinicians first for influence amongst the groups.

Table 3: The Influence of Stakeholder Groups (present day)[30]

Group	"1"	"2"	"3"	"4"	"5"	"6"	"7"	"8"	"9"	"10"
Clinicians	5	3	1	1						
Department of Health	2	1	1	2	2	1	1			
GPs	2	1	3	1	2		1			
Local community			1				1	2	2	3
Management	2	4	1	1	1		1			
Media					1	2		1	2	3
Pams/Nurses				1	3	1	3		1	
patients/patient representative groups			2	3		2	1	1	1	
Purchasers	1	3	3			2				
Unions/professional bodies					1			4	2	2

Table 3 presents the data in its basic structure and as a consequence is difficult to analyse and draw any conclusion on how the General Managers ranked the groups collectively in order of influence.

Figure 28: Views of the General Managers as to Who has the Ability to Influence[31]

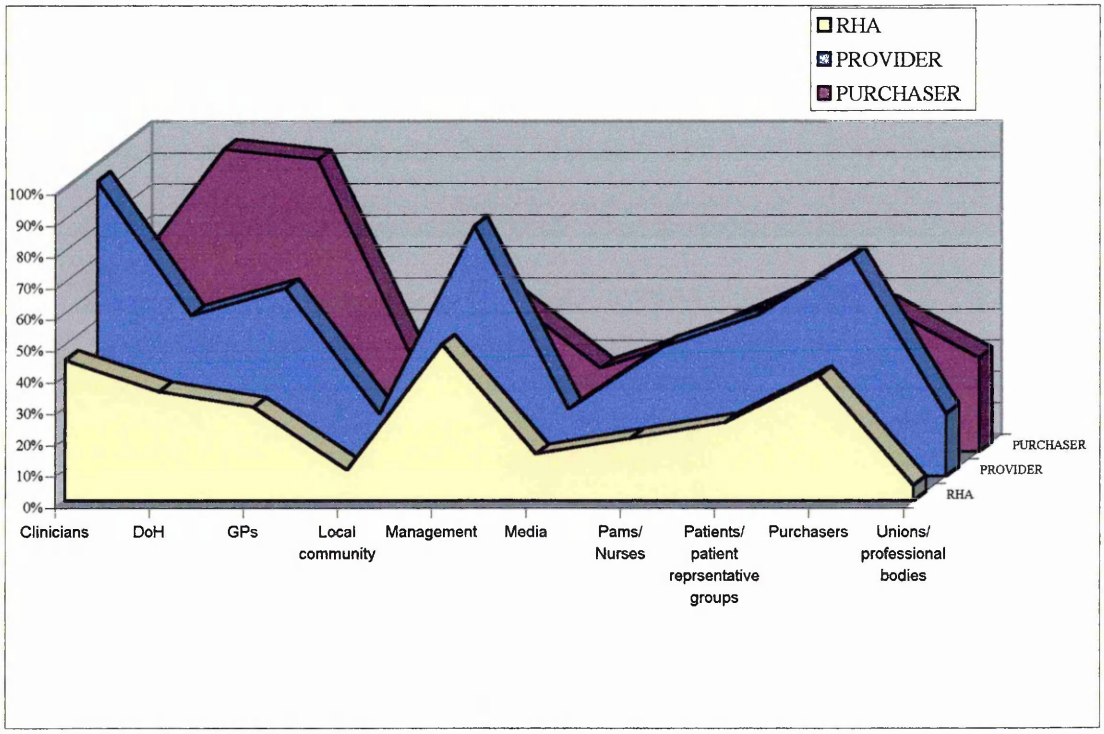


[30] Groups' ability to influence, (now), of General Managers ranking each of the groups Q51: Table of results

[31] Figure 28: Views of the General Managers as to Who has the Ability to Influence Q51:Table of Results

However, Figure 28 indicates the total scores as a percentage of the maximum score possible for each group. This demonstrated how the General Managers viewed their organisation group in comparative terms and as a combined group. Summary results of this ranking can be seen in Table 4 in that it indicates that Clinicians' groups are the most influential with the DoH and GPs as group influencers coming second in the rankings. The local community, union/professional bodies and media groups came bottom of the rankings for group influence.

Figure 29: Views of the General Managers Grouped by Organisation on Who has the Ability to Influence[32]



The General Managers' views when grouped according to whichever organisation they worked in, show that the most influential groups (shown as peaks in Figure 29) are Clinicians, GPs, Management, DoH, and Purchasers.

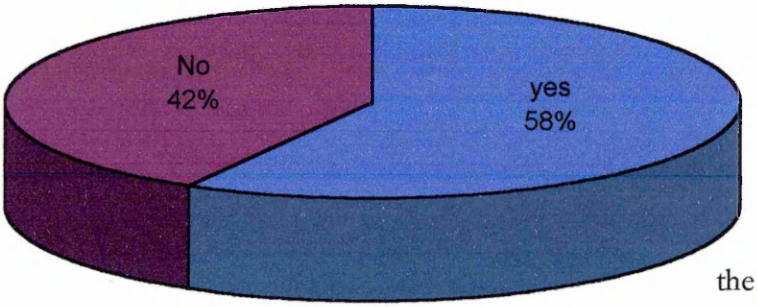
[32] Figure 29: Views of the General Managers Grouped by Organisation on Who has the Ability to Influence Q51: Table of Results

Table 4: Summary of the General Managers' Views of the Most Influential Groups[33]

Group	Ranking order
Clinicians	Most influential
GPs	2nd most influential
DoH	2nd most influential
Management	4th most influential
Purchaser	5th most influential
patients/patient reps	6th most influential
Pams/Nurses	7th most influential
Media	8th most influential
Local community	9th most influential
Unions/Professional bodies	10th most influential

The General Managers were asked to prioritise the same groups as identified above again, if they believed their influence would change in the future; 58% of them (Figure 30) believed that organisational influence would change in the future.

Figure 30: Is this Organisational Influence likely to Change in the Near Future[34]



Analysis of Table 5 overleaf shows a more divided view among General Managers with regard to which will be the most influential groups within their organisations in the future. However, Figure 31 indicates that the General Managers' perception was that Clinicians would remain the most influential, followed by GPs then Management, Pams and Nursing groups who joined the Media, Unions, and Professional bodies at the bottom of the influence table. However, both Table 5 and Figure 31 indicate the low number of General Managers expressing a view on the future compared with the present.

[33] Summary of the General Managers' views of the most influential groups

[34] Is this Organisational Influence likely to Change in the Near Future Q52: Table of Results

Table 5: Groups' Ability to Influence in the Future

Question	"1"	"2"	"3"	"4"	"5"	"6"	"7"	"8"	"9"	"10"
Clinicians	1	3	1	0	0	0	0	0	0	0
DoH	1	0	2	1	0	0	0	1	0	0
GPs	1	1	0	2	1	0	1	0	0	0
Local community	0	0	0	0	0	1	1	1	2	0
Management	2	1	1	0	0	0	0	0	0	1
Media	0	1	0	0	0	0	0	2	2	1
Pams/Nurses	0	0	0	0	0	3	0	0	0	2
patients/patients representative groups	1	0	0	2	3	0	0	0	0	0
Purchasers	1	0	1	0	1	1	1	0	0	0
Unions/Professional bodies	0	0	0	0	0	0	2	1	1	1

Note: Table 5 shows the Number of General Managers Ranking each of the Groups

Figure 31: Who will have the Ability to Influence in the Future[35]

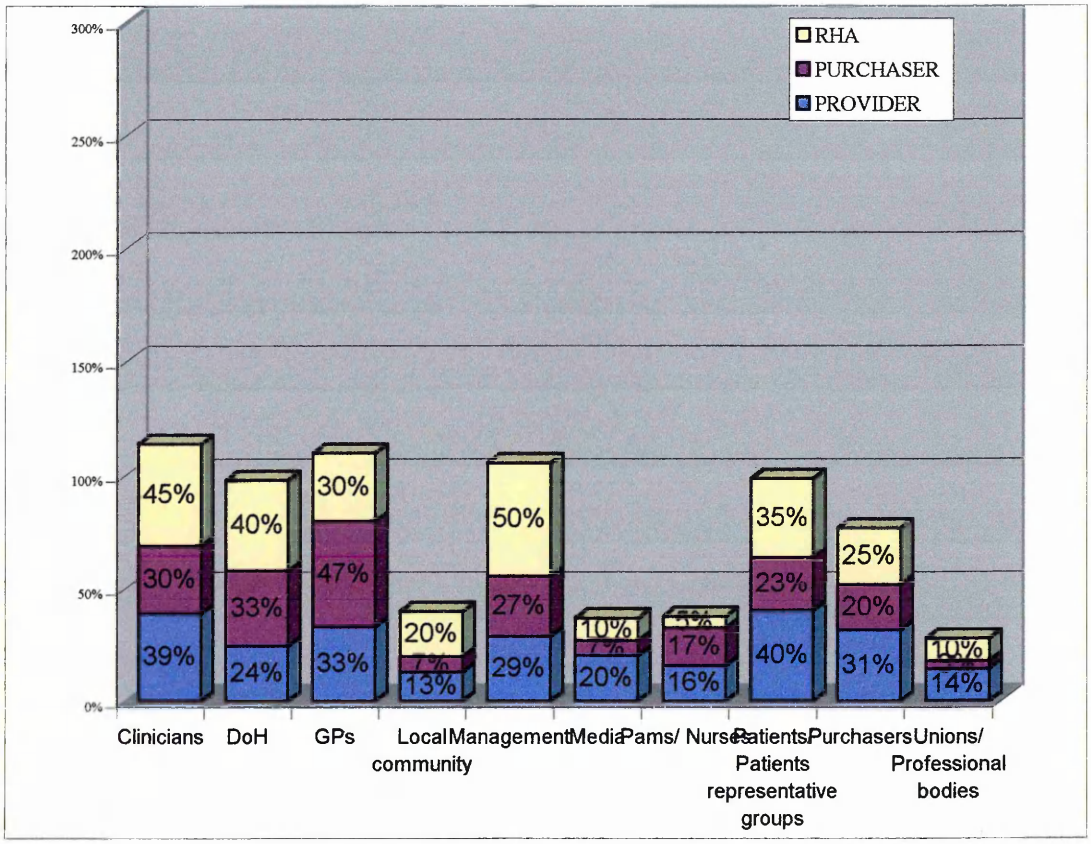


Figure 32 shows the General Managers' views expressed as a homogenous entity but also demarcated into their organisational groupings. Again, as in Figure 29, it is to be noted that

[35] Figure 31: Who will have the Ability to Influence in the Future Q53: Table of Results

Clinicians/GPs/DoH, Management, and Purchasers are shown as peaks, but this now includes patients and their representative groups as having influence.

Figure 32: General Managers' Views Grouped by their Organisation on Who will have Ability to Influence in the Future[36]

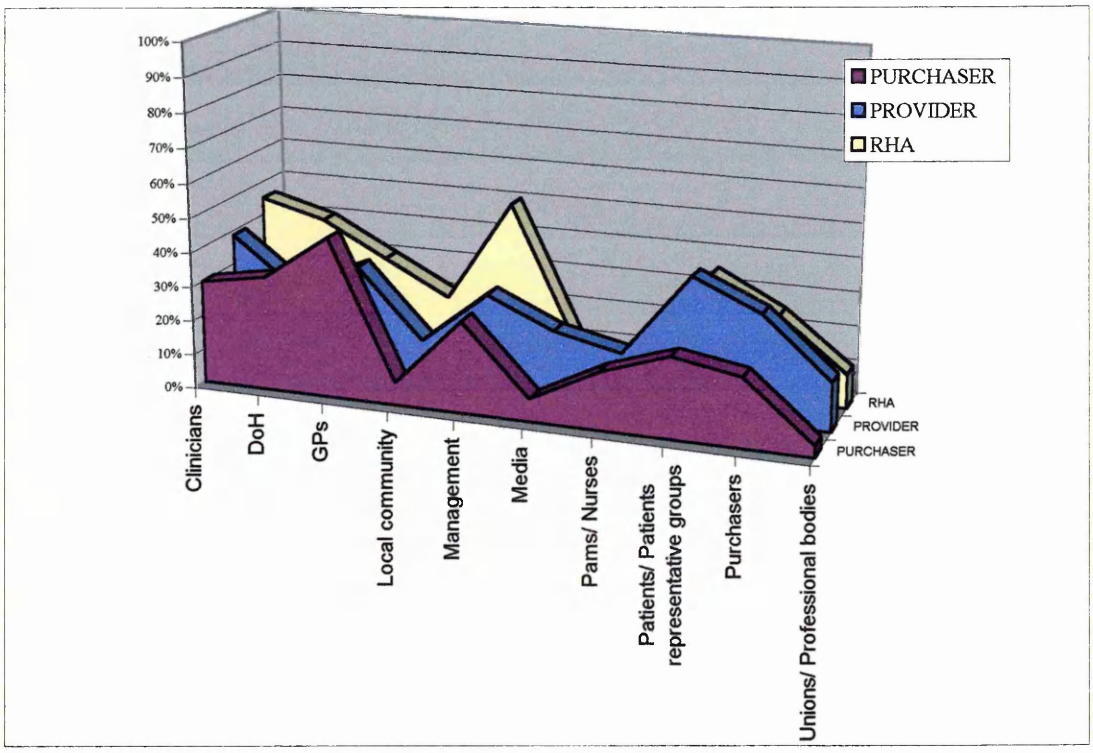


Table 6 summarises the collective view expressed by the General Managers as to which group had the most ability to influence.

Table 6: Summary of Priority Given to Groups' Ability to Influence, in the Future

Group	Ranking order
Clinicians	Most influential
GPs	2nd most influential
Management	3rd most influential
patients/patient reps	4th most influential
DoH	5th most influential
Purchasers	6th most influential
Local community	7th most influential
Pams/Nurses	8th most influential
Media	9th most influential
Unions/Professional bodies	10th most influential

[36] Figure 32: General Managers' Views Grouped by their Organisation on Who will have Ability to Influence in the Future Q53 Table of Results

The comparison of the results (now and the future) of the different priorities indicated by the General Managers is as follows (Table 7):

Table 7: Comparison of Ranking: Groups' Ability to Influence

Group	Ranking (now) & the future	Position
Clinicians	1 (1)	No change
GPs	2 (2)	No change
patients/patient reps	4 (6)	+2
Management	3 (4)	+1
DoH	5 (2)	-3
Purchasers	6 (5)	-1
Media	9 (8)	-1
Pams/Nurses	8 (7)	-1
Local community	7 (9)	+2
Unions/Professional bodies	10 (10)	No change

The Change in Balance of Power Between Consumers/Providers

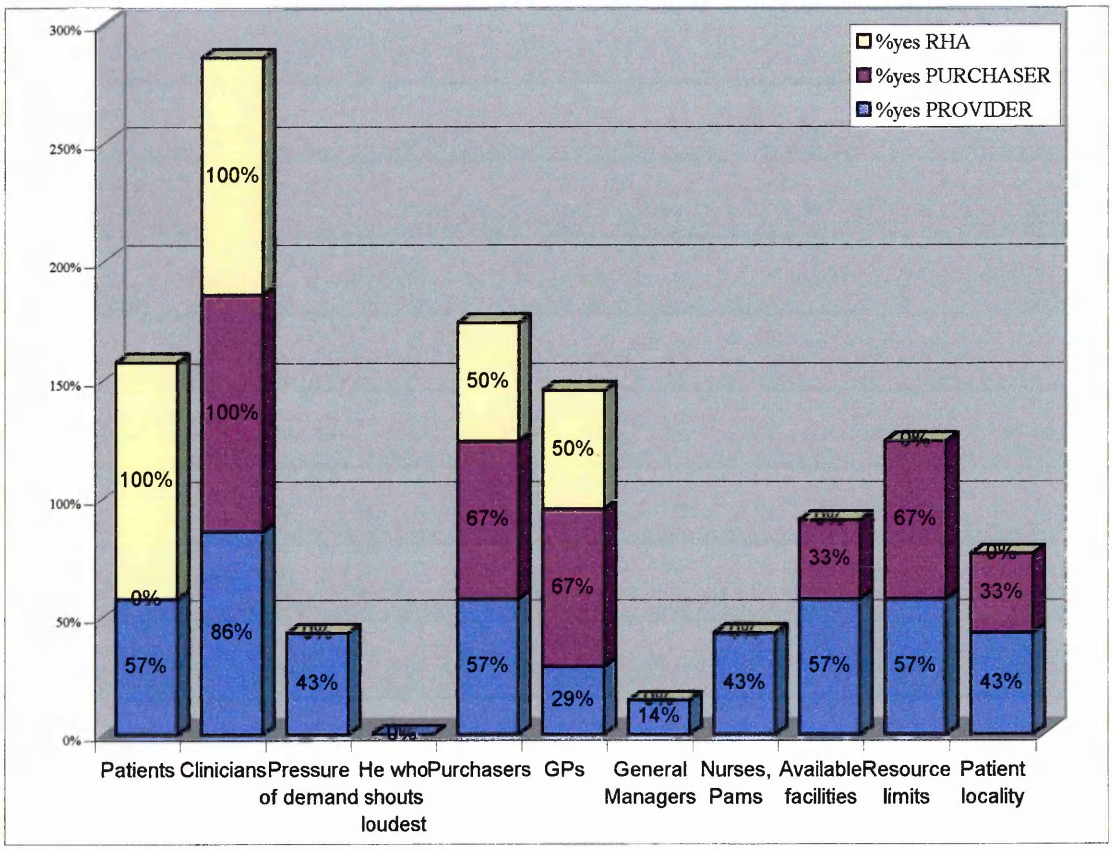
The research sought to understand what the General Managers' views were on who decided what healthcare was needed for the patient. Analysis of the General Managers' responses to the questionnaire indicated that it was the Clinicians who made those decisions. As shown in Figure 33, this was the majority view of the General Managers. However, some of them indicated that the Purchaser organisations, the patient and GPs decided on the patients' healthcare needs. When the General Managers' views are analysed as "votes", the General Managers voted the Clinicians first, with the Purchaser second, the patient and GP third and Pams/Nurses well down the order of influence. Table 8 identifies of the General Managers' perceptions as to who had influence over healthcare provision prior to 1986. The Table indicates that the General Managers believed that it was the Clinicians who have the most influence over healthcare provision.

Table 8: Who has Influence over Healthcare Provision Prior to 1986[37]

Who	Priority	%
Clinicians	1	100
Government	2	75
Local Community	3	25
patients	4	17

[37] Who has Influence over Healthcare Provision Prior to 1986 Q39 Table of Results

Figure 33: Healthcare for the patient: Who or What Decides[38]



The General Managers believed[39] that post 1986 the patient, local Purchaser and the Local Community had all increased their influence. Anecdotal evidence suggests that in the public area, hospital based Clinicians have seen their influence wane. However, this has to be balanced against the continued pivotal role that they play in prescribing and treating patients.

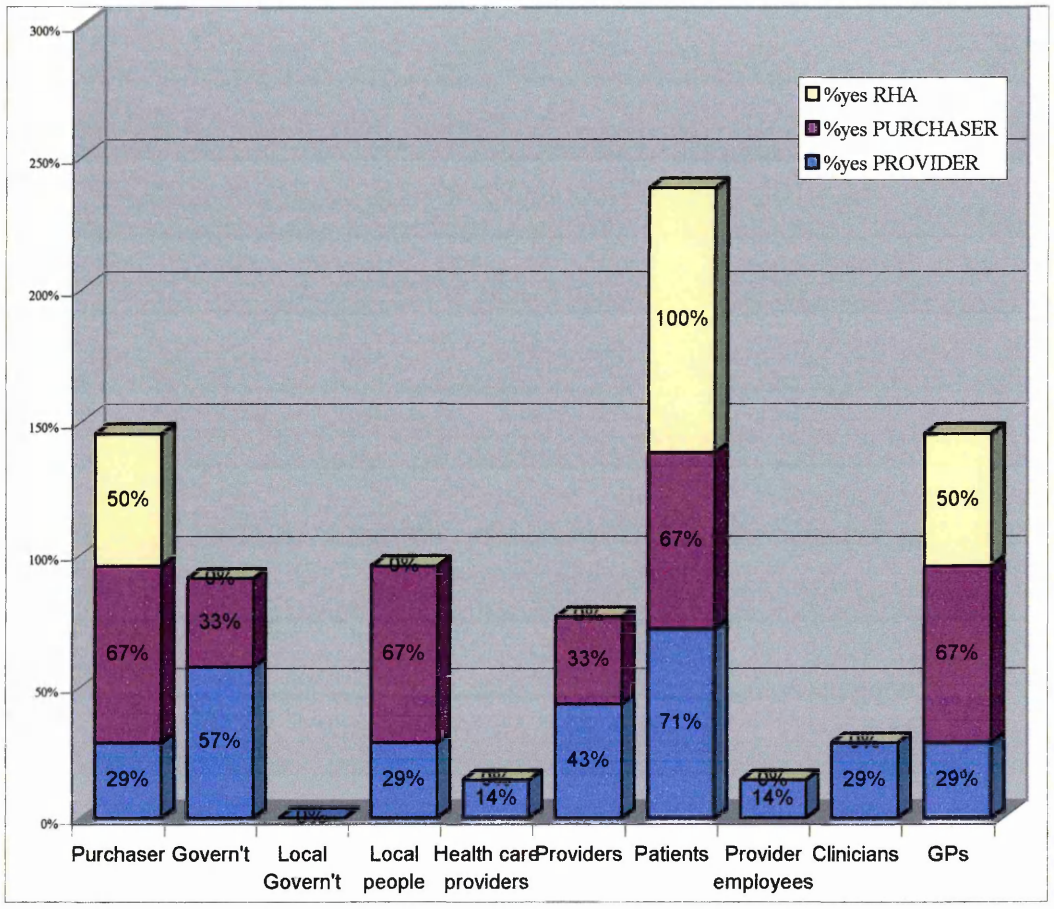
The General Managers also noted the increased relevance of both the Government and local politics in the influence of healthcare provision. This, together with managerial changes, which brought about contracting healthcare and the Purchaser/Provider split, has had an increased influence on the provision of healthcare. This has not, however, usurped the role of the Clinician. This dominance of the Clinician, "the medical model", remains strong.

[38] Figure 33: Healthcare for the patient: Who or What Decides Q38: Table of Results

[39] Q40:Qualitative Responses to Questions

Benefits of the Change of Influence

Figure 34: Who has Benefited from the Changes in Influence[40]



The General Managers surveyed indicated that their patients had benefited from the changes in influence and only 33%-42% believed that the Purchaser, Government, Local community, Providers and GPs had benefited. As indicated in Figure 28 and Figure 31 the General Managers viewed Clinicians as remaining in the forefront of influence. The patients, their representatives and the General Managers would improve their influence, with the GPs seeing no changes in their influence. However, the DoH and the Purchaser would see their influence reduced in the future. (This seems to go against the strategy for health emanating from the DoH at the moment.) The recent White Paper (1998), indicates how crucial GPs will be and their role as commissioners in PCGs. Even though few GPs have ever received any training in commissioning and are steeped in the culture of the independent contractor, their diverse outlooks will make collaboration and effective representation tricky. They will need to be schooled as to how their actions will impact on the Service as a whole. They will

[40] Figure 34: Who has Benefited from the Changes in Influence Q41: Table of Results

need to come to terms with potential conflicts of interest in their twin roles as both commissioners and providers of care. And they will have to get used to making difficult decisions, which might threaten their clinical or financial autonomy. The various models outlined will allow the more reluctant a gentle introduction to commissioning but in practice the Government appears to be making GPs an offer they cannot refuse, just as the previous Government did with Fund holding.

The outline for the 10-year modernisation programme in the Government's White Paper (1998) on restructuring the NHS in England and Scotland indicates a dismantling of the internal market, the creation of a powerful Commission for Health Improvement (CHI), a strategy that replaces the GPFH structure with new PCGs, and strict quality standards. In place of the internal market there will be a system of "integrated care" founded on partnership. The new system will improve care for patients by removing the obstacles of the market and instituting mechanisms for improving quality. It aims to harness new technology and spread best practice, to improve effectiveness and efficiency through a new performance framework to restore public confidence in the NHS as a universal and comprehensive health service; and it removes the internal market.

As part of this strategy the White Paper sets out to:

- Keep the separation between planning and provision;
- Keep and build on the important role of primary care;
- Keep decentralised responsibility for operational management;
- Include new drives on quality and efficiency, which have to go hand in hand.

From a structural point of view PCGs will bring together GPs and Community Nurses in a given area, and will take responsibility for commissioning services for a local community. They will work closely with social services. Social services and community nurses will be represented on their boards. It is intended that PCGs will have freedom to make decisions about how they use their resources, but they must do so in a manner that is consistent with a local health improvement programme.

The Health Improvement Programme (HImP) will be drawn up once every three years, with the HA taking the lead. It will identify health needs and decide the range and alignment of services that are needed to meet them. The HImP will be driven by the HA but its formulation will involve Trusts, PCGs, local universities, medical schools and local

authorities - both because of their social services role and because of their influence over public transport, housing and economic development issues which more broadly affects health. HAs will be the accountable bodies under which PCGs operate. They will hold considerable powers to improve the health of their local residents backed up by a statutory duty of partnership that will be placed on local health organisations to ensure co-operation. HAs will allocate funds to PCGs on an equitable basis.

The Changes in the Healthcare Environment

(And its Effect on the Roles of the General Managers or their Organisations)

Health Policy, the Organisation and Managerial Values

General Managers were asked whether their organisations had changed in response to changes in healthcare policy. Analysis indicated[41] that 92% of the General Managers believed that their organisations had changed. Further analysis, as shown in Figure 35, indicates that the General Managers believed that DoH policies affected organisational changes in the areas of financial control, management, contracting, strategy and primary healthcare. These were closely followed by size of organisation and human resources. However, further analysis of the General Managers' views indicated that the patient care environment, clinical practice and marketing were not affected by DoH policies.

[41] Q18: Table of Results

Figure 35: Organisational Change through Health Policy Changes.[42]

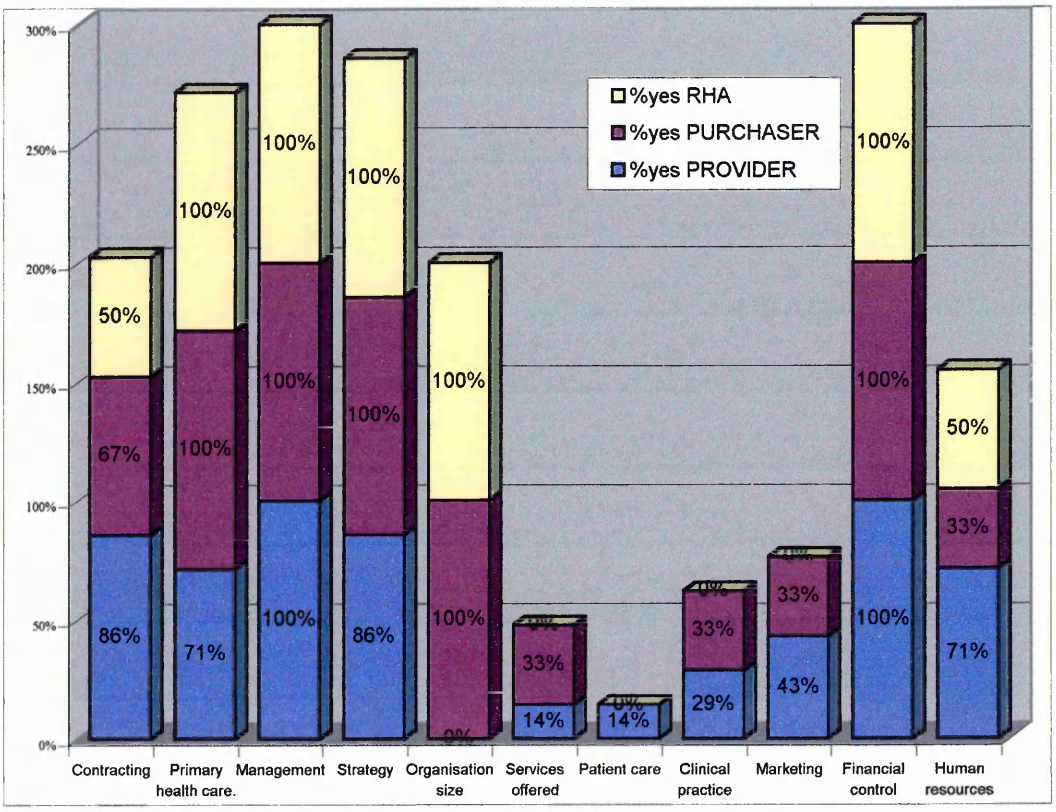
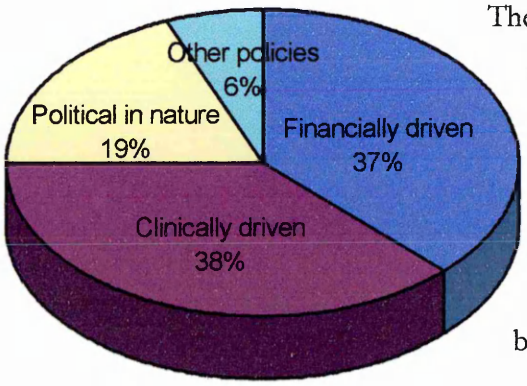


Figure 36: What Drives the External Policies of your Organisation[43]

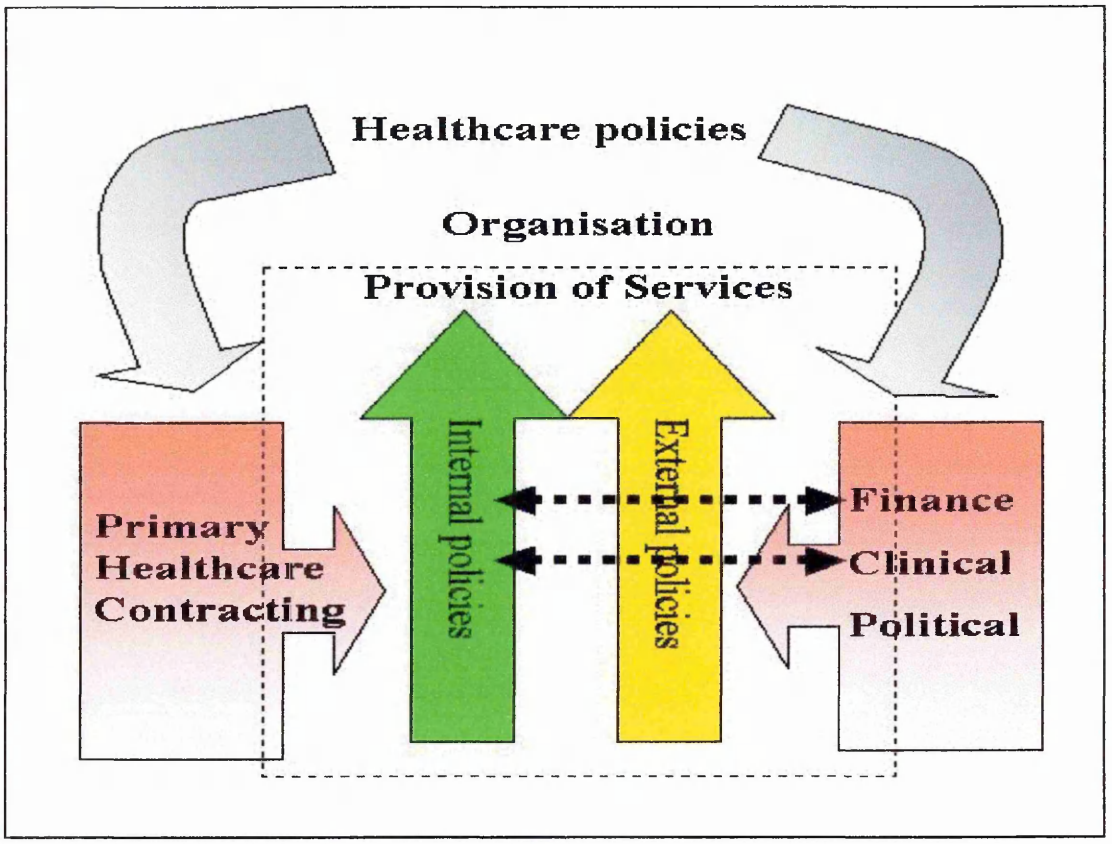


The external policies of an organisation are the policies that affect the provision of the services provided and the interaction of the organisation both with the local community within which it resides and in the wider context of the provision of services in the NHS and geographic boundaries. As shown above in Figure 36, these external policies of the organisations were influenced by financial and clinical factors and to a lesser extent by political influencers.

[42] Figure 35: Organisational Change through Health Policy Changes. Q18: Table of Results

[43] Figure 36: What Drives the External Policies of your Organisation. Q23: Table of Results

Figure 37: The Organisations' External Policies[44]



It can be noted (Figure 61) that the General Managers indicated that their organisations were very sensitive to DoH health policy, and that their organisations had changed in response to healthcare policy externally in the areas of contracting, primary healthcare, and finance. Analysis seems to indicate that healthcare policy changes the organisation both externally and internally and, at the same time, the policies of the organisation are influenced financially and clinically. Figure 37 above shows diagrammatically how these external policies of the organisations were influenced by financial and clinical factors and to a lesser extent by political influencers.

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[44] Figure 37: The Organisations' External Policies Q23: Table of Results

The New NHS: Modern, and Dependable, Department of Health, Dec 1998

The General Managers' Views of their Information Needs.

Information Acquisition and Value

Demands on control, quality and performance of the health organisations have assumed paramount importance. These demands have in turn, required the organisations to define the level of information they need to support such activities and to determine the expenditure they are prepared to commit to its acquisition. Until recently organisations used a wide variety of information sources in their decision making processes. Information received in the course of decision-making had a far greater chance of being used than information that was stored within the organisation. By and large, information stored in files or computers was used mostly for packaging proposals and rarely for learning or initiating and evaluating courses of action. According to Ghosal & Kim (1986), from an organisation's point of view, going from files to user-friendly on-line relational databases eased the problem but did not solve it. Ghosal & Kim also point to the fact that intelligence was usually received too late to be of use in the decision-making process, and at too high a level in the hierarchy, since, by the time a proposal reaches top management, so much had been invested (in terms of psychology and power relationships) at lower levels, that it was difficult to change without major disruption.

Also there was a complex set of interactions between information and its source that influenced the way information was perceived and acted upon by managers. The same piece of information was seen differently when it was received from a favourite and trusted subordinate than when it was received from the General Managers of the information and statistics department.

Other researchers have drawn attention to the essentially social character of information use in decision-making. For example, among the factors listed by O'Reilly (1983) as determining whether the information came from a powerful or credible source is whether the information would cause conflict in the organisation, and whether the information was supplied directly or through a third party. KoopMan (1990) also drew attention to the organisational culture within which the decision-making took place, and suggested four models of the process: the Arena Model, which was dominated by negotiations among parties who form coalitions, which he relates to Mintzberg's (1979) concept of the professional bureaucracy; the Open-end Model, characterised by a limited view of the goals or the means by which to

achieve them, related to Mintzberg's adhocracy; the Bureaucratic Model, in which decision-making was constricted by rules and regulations, a phenomenon of Mintzberg's machine bureaucracy; and the Neo-rational Model, which was characterised by strong centralisation combined with low formalisation and confrontation and which was associated with Mintzberg's simple structure.

The White Paper (1998) has brought focus and change to all that in so much as research data and consumer survey data has become vitally important to all health organisations if they are to survive in the "internal market" of the NHS. Where the knowledge does exist, but is not "discovered", there is the danger of duplicating work already undertaken or of suffering expensive consequences as a result of that ignorance. This assumes particular relevance with regard to patient data and patient health needs.

Sources of Information

The White Paper (1998) brought a new pressure to General Managers in their decision-making and as Payne et al (1988) argue, under severe time pressure, people accelerated their processing, focused on subsets of the information they needed and changed their information processing strategies to cope with the pressures. One element of this was the direct interpersonal contact, which was often the quickest and best method of obtaining what they required. It has the advantage that the problem can be discussed and misunderstandings resolved. However, the enquirer who is impressed by personality, standing or experience of the person consulted, or who is susceptible to group influence, may accept too readily, without question, without checking its validity, the data provided at face value. This has been a problem for health organisations for many years; resources have not allowed for central validation and where they have, it has been found that the staff collecting the data or validating it, have had little or no knowledge of the data that they were scrutinising. As a consequence of this, the data were often poor in quality. One solution to this is to have data gathered at source by the staff that generates the information by the virtue of the work they carry out, and allow the transmission of the data upwards for collation and presentation to be efficient, timely and accurate. It is also important that the staff who generate the work data, and their General Managers, who have ownership of that data, validate it for accuracy, prior to onward transmission.

Information Needs:

At the root of the problem of identifying information needs and information seeking behaviour, which is affected by stakeholders, changing environment, external influences and relationships, is the concept of information need, which has proved intractable for the reason advanced by Wilson (1981). That is, need is a subjective experience that occurs only in the mind of the person in need and, consequently, is not directly accessible to an observer. Types of Information Need (P59) and Problem of Information Needs: (P59) associated with General Managers are discussed earlier (Chapter 3 Managing Information within the NHS). Other problems, which must be taken into account, are noted in brief below:

Identification of information needs: do the General Managers know what they really want, and do they understand what the problem is, as their information needs seem to vary?

What business are the General Managers in: they have difficulty in looking to the future to identify their needs as the turmoil in the NHS is adding problems to the identification of needs.

Do the General Managers understand the limitations of their working environment: it appears that the General Managers want unlimited information that is simple to understand, simple to implement and costs very little.

The NHS is changing continuously: needs identification can be very difficult and also "systems" will never be successful because they can never be developed fast enough. This is the challenge of information today. Can it meet the real world, and can it ever be flexible enough with the minimum of cost to meet the continually changing environment of the NHS?

Is there too much information clogging up the system: i.e.: the decision making tree? Should information be distributed or centralist, are the costs and flexibility the same and, therefore, doing the same thing as before but with another name?

Do General Managers understand the problems of satisfying their needs: Should needs fulfilment be a satisficing solution? (Cooke & Slack 1984). Should the General Managers' needs be met in full, and can the NHS afford them?

Do politics and managerial roles: get in the way of successful decision support systems? Is the success of the General Managers' business reliant on a successful implementation strategy for information?

Information Requirements of the General Managers

Information needs of the General Managers

If Wilson's theory of information needs (Chapter 3 Managing Information within the NHS, sub chapter: Information Needs: pg 57) is acknowledged, in that the information needs of the General Managers can only be deduced through their behaviour, then there is a need to understand how the General Managers' views, attitudes and behaviour influence their need for information (Wilson 1981). What actions do they take towards fulfilling those information needs and how does the information needs of the Provider General Managers and the Purchaser General Managers diverge? More specifically, how has the change in roles and relationships between the General Managers and the patients, doctors and their managerial colleagues affected their information needs?

Identifying the information needs of the General Managers

Identifying the General Managers' information needs is a challenge as much as it is for them to define their own information requirements. As part of this process, their attitude towards information and their needs in a rapidly changing environment are defined. The effects of organisational culture, changes within the relationships of the General Managers with key stakeholders, the impact of external influences on the General Managers, may affect their information needs and, therefore, provide difficulties when identifying/ defining those needs, are also considered.

Part of the problem in identifying the information needs of the General Managers is the quantity of information available to them as their organisations continue to increase in size and complexity. This in itself causes a problem because, even though organisations have vast amounts of data, they do not have the tools to use that information and in some cases do not they have the expertise. The problem is further compounded since quality of information rarely increases with quantity. The means, which should be available to a health organisation, to minimise such problems, are, therefore, central to the task of managing information. To be useful, information has to be communicated in the right quantity and form, and at the

right time, to those who need it. Communication processes and information flows are, therefore, important elements to be considered in a detailed investigation of information needs and of the ways and means of satisfying them. The General Managers were asked to express their views in response to a series of questions[45] seeking to understand their information needs and the way they satisfied them in 1991 and in the present day in order to do their job successfully.

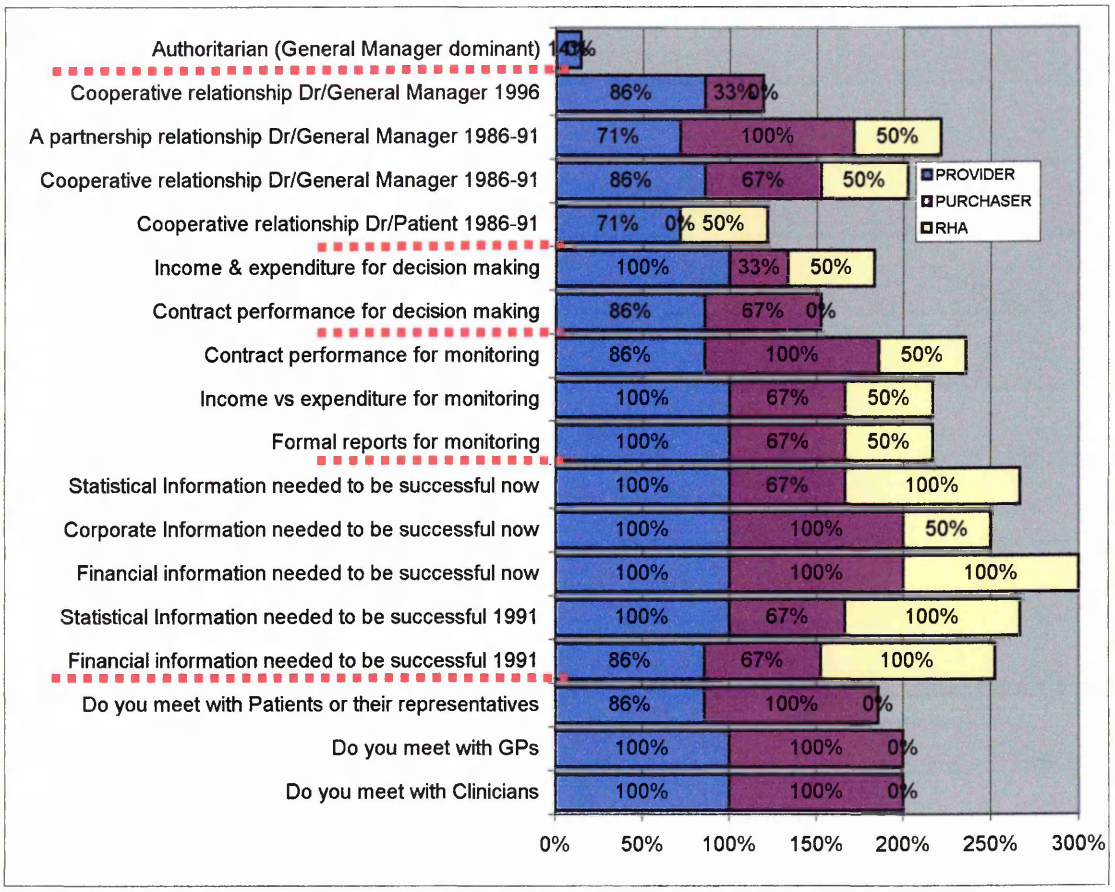
Summary analysis of the research data (Figure 38) from the General Managers indicates that their information needs, and the acquisition of information to meet those needs, has a close relationship between the role of the General Managers and their major stakeholders within their organisations; for example, the patient, the doctor and the General Manager who all have key relationships within that organisation. During the period 1986 to 1991, the General Managers viewed their relationship with the patient and the doctor as becoming a co-operative partnership and the relationship between the doctor and the patient as a co-operative relationship. Analysis also indicated that by 1996 the majority of the General Managers viewed the relationships between themselves and the doctors as being a co-operative one.

Further analysis of the data indicates that the General Managers met with the patients, the patients' representatives, GPs and Clinicians in order to satisfy their information needs and to ascertain what information they needed to carry out their job. The General Managers indicated that during the period 1986 to 1991 they needed statistical and financial information, viewing this data as being key to the success of their job and their organisation. But in their present environment, corporate, financial and statistical information were deemed to be necessary in order to be a successful manager, along with contract performance information, income vs. expenditure information and formal reporting mechanisms, for the purpose of monitoring the progress and function of their organisations.

For decision-making, the General Managers viewed income, expenditure and contract performance information as essential elements of their decision-making processes.

[45] Questionnaire Q27

Figure 38: Overview General Managers' Information Needs



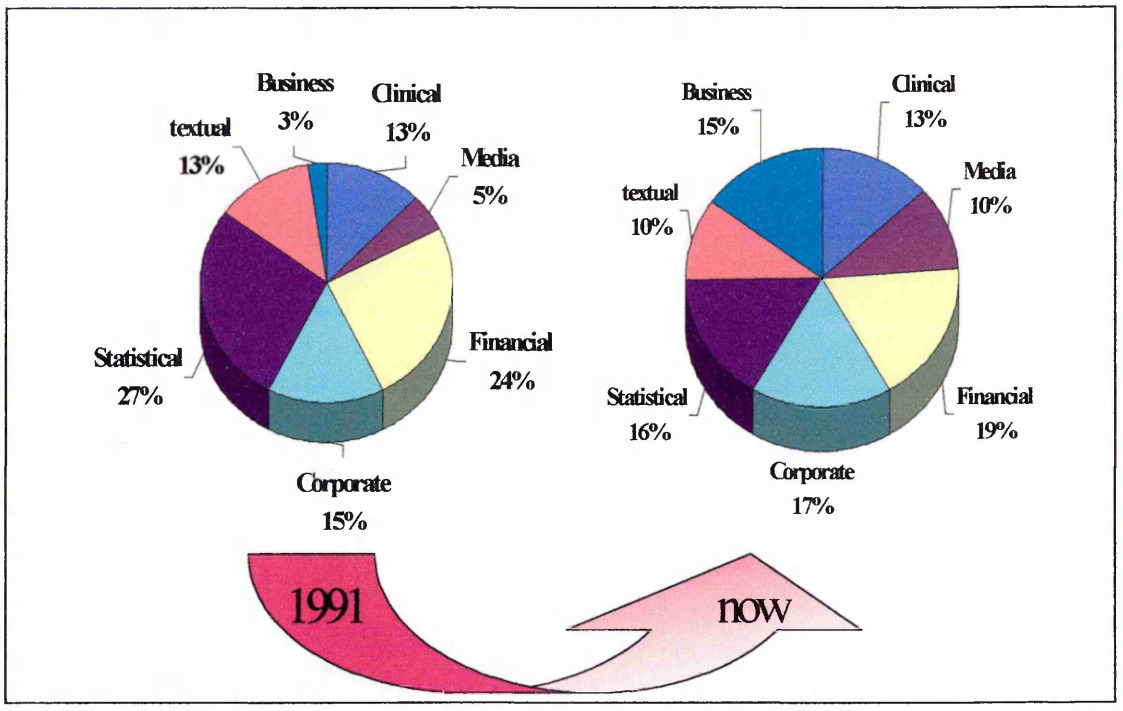
Information Needs in 1991 Compared with the Present Day

Table 9: Categories of Information

Clinical Information	Statistical Information
Media Information.	Textual information.
Financial Information.	Business information.
Corporate Information.	

Figure 39 shows the "needed information" as a percentage of the whole group of General Managers. Comparing 1991 with the "present day" it can be seen that not only has the shape of information needed today become more evenly distributed across the range of information, but the number of General Managers identifying their needs has increased (Figure 40).

Figure 39: Information Needs in 1991 Compared with the Present Day[46]



It would appear that the General Managers in today's environment are more readily able to identify their information needs and that those needs are more equally balanced. Figure 40 identifies the percentage of General Managers and their information needs as a group and as managers differentiated by their organisation type. It can be noted that there is an increase across all the needs identified since 1991 to the present day, indicating an increased awareness of the importance of information in their job success. Figure 40 also shows that whereas in 1991 only Provider General Managers needed clinical and business information, all the General Managers groups needed that type of the information in the present day. Information needs in priority order, present day compared with 1991, are shown in Table 10. Analysis shows that financial information has become the most needed with corporate and statistical information second. Business information has moved up to fourth place in the order of priority.

[46] Figure 39: Information Needs in 1991 Compared with the Present Day Q 27&28:Table of Results.

Figure 40: General Managers' Information Needs as a Group and by Organisation[47]

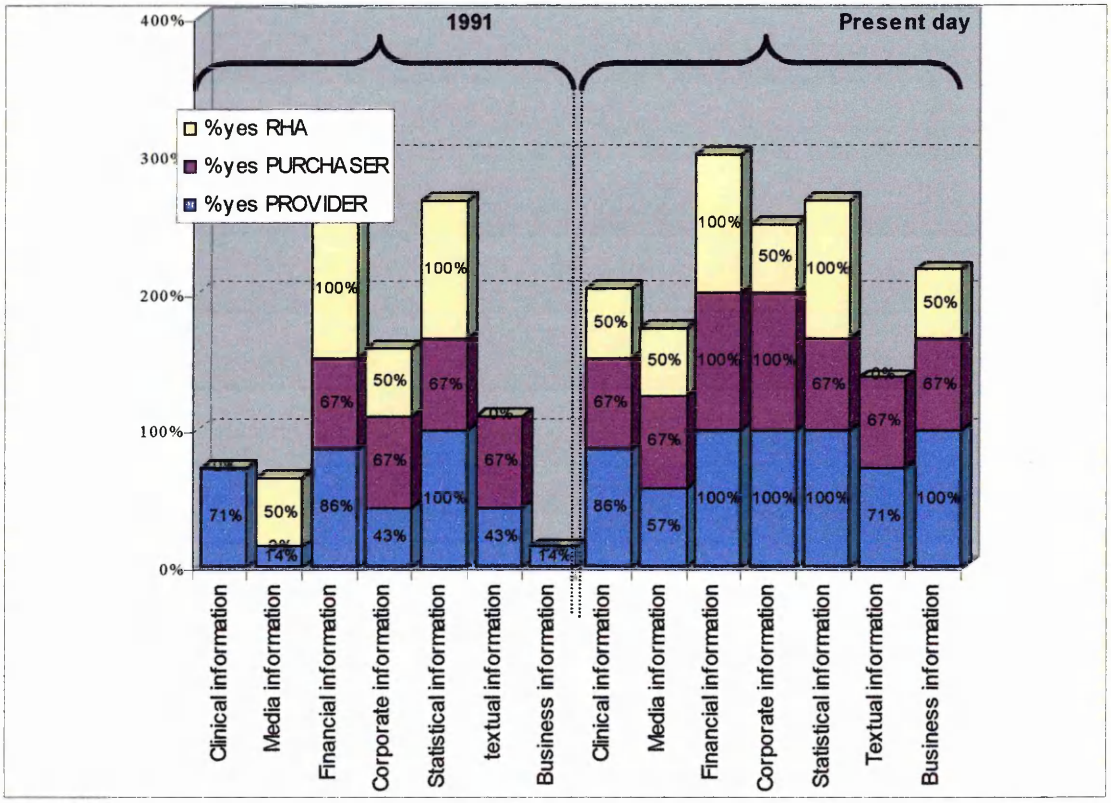


Table 10: Comparison of Priority of Information Needs 1991/Present Day[48]

Priority	1991	"now" present day
1st	Statistical information	Financial information
2nd	Financial information	Corporate information
3rd	Corporate information	Statistical information (2)
4th	Clinical information	Business information
5th	Textual information (4)	Clinical information
6th	Media information	Media information
7th	Business information	Textual information (6)

Diversification of the General Managers' Information Needs

As part of the understanding of the views of the General Managers of their roles and the effects of those roles on their information needs, it is important to look at the diversification of the information needs set against the roles of their organisations i.e. Purchaser/Provider.

[47] Figure 40: General Managers' Information Needs as a Group and by Organisation Q 27&28:Table of Results

[48] Q27 & 28 Table of Results

This diversification is reflected in Figures: 43, 44, 45, 46, & 47. Those questions covered information needed by General Managers to do their jobs, to meet organisational goals and objectives, to monitor progress in their organisation and when making decisions, and the General Managers' views on what achieving success meant to them.

Information Requirements of the General Managers

(from Provider, Purchaser and Regional Executive organisations)

At the beginning of the chapter, the information requirements of the General Managers were identified as a homogeneous group. Here, their requirements are analysed from the aspect of organisation diversification. Figure 39 showed how the General Managers' information needs had changed in "shape" since 1991. In comparing the diversity of those needs between the groups (Figure 40) it can be seen that the requirements of General Managers from the Provider organisation have stayed broadly the same. However, the need for corporate information has increased and overall more of the General Managers have seen their information requirements increase over the time period. The requirements of General Managers from the Purchaser organisation have changed across the information range since 1991, and there has been an increase in the number of General Managers recognising an increase in information requirements. There appears to have been changes in the requirements of the General Managers from the Regional Executive organisations. The data shown in Figure 40 appears to confirm that the change in roles of the organisations since 1991 has affected their information requirements.

Additional Information Required to Meet the Objectives and Goals of the Organisation

Additional information provided by the General Managers about their information requirements to meet the goals and objectives of their organisations indicated that the majority of the General Managers from the Provider organisations identified that data relating to marketing, purchasing requirements, intentions and expectations, knowledge of GP requirements and expectations and the views and opinions of staff were required. Also, political and demographic information both at national and local level was required. All the Purchaser General Managers indicated that information relating to clinical effectiveness outcomes was required together with national trends and feedback from patients. This information needed to be "good" and "auditable". Some "soft information" was suggested as a requirement by the General Managers from the Regional Executive organisations including

intelligence about the strengths and weaknesses of NHS organisations within their particular region. This additional information[49] described by the General Managers, appears to be a sub-set of the information needs as described in Table 10.

Being Successful Today

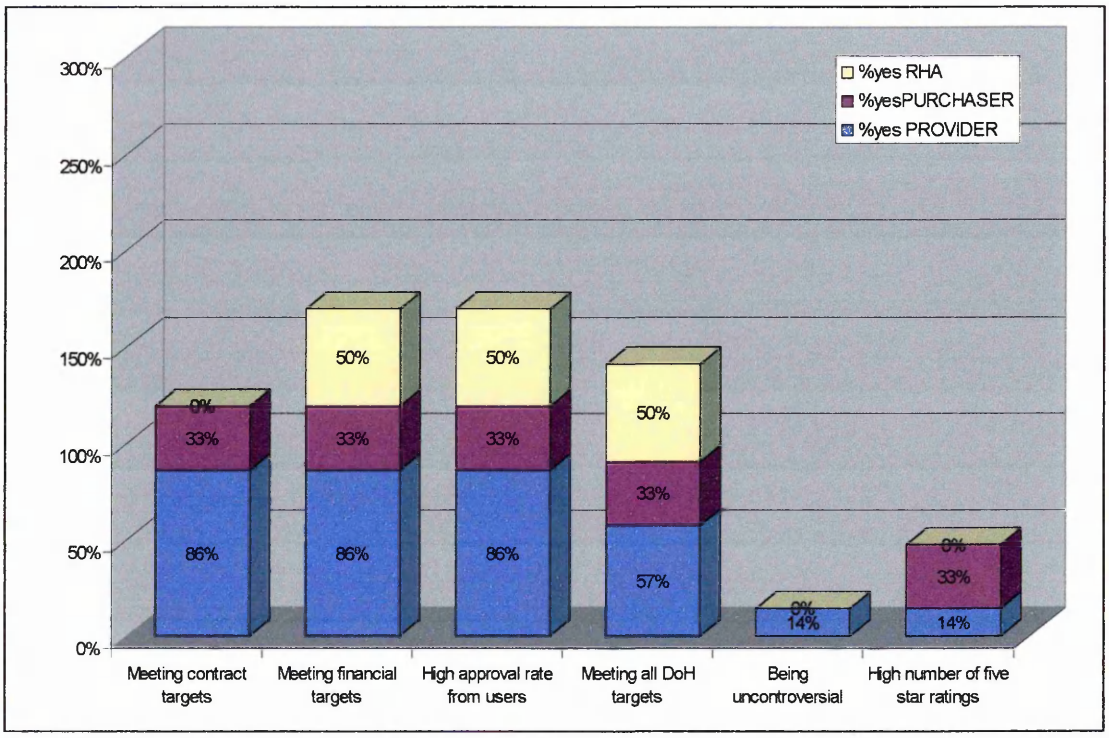
The majority of the General Managers expressed views that indicated that to be successful, meeting financial targets, achieving a high approval rate from users, and meeting contractual and DoH targets, were seen by them as key success factors in doing a successful job (Figure 41).

Peters (1988) argues that the successful organisation listens to its customers and stakeholders as the norm. Peters goes on to argue that the successful organisation is guided by a coherent vision and manned by involved workers with a big stake in the action and improvement. The central theme is that the workers, unions, and customers are all partners in the common endeavour. Being successful entails: the organisation being customer responsive; having an innovative approach that can cope with an ever faster changing environment and flexibility through the empowerment of people; sustaining a management culture that encourages people to 'love' change, when they used to hate it; having a cost effective management structure that can continue to provide the necessary leadership; and finally an information strategy that enables sharing of all information with all employees of the organisation. Peters suggests that a successful organisation has "a flow of power" to the field, and with the need to act quickly, adapts fast and at the same time breaks down traditional functional barriers that resist change. The General Managers' views on being successful are analysed in Figure 41, grouped by their organisations and as a homogeneous entity.

Analysis of the diversification of the General Managers' views on being successful show that all three organisational groups have some common ground in that financial targets, user approval ratings and DoH targets all feature. However, the views of General Managers from the Provider and Purchaser organisations also included meeting contractual targets and "star ratings" from the patient's Charter Standard performance tables. Both Provider and Purchaser management groups are performance orientated but with a different emphasis of support.

[49] Q29 Table of Results

Figure 41: What Does Being Successful Today Entail[50]



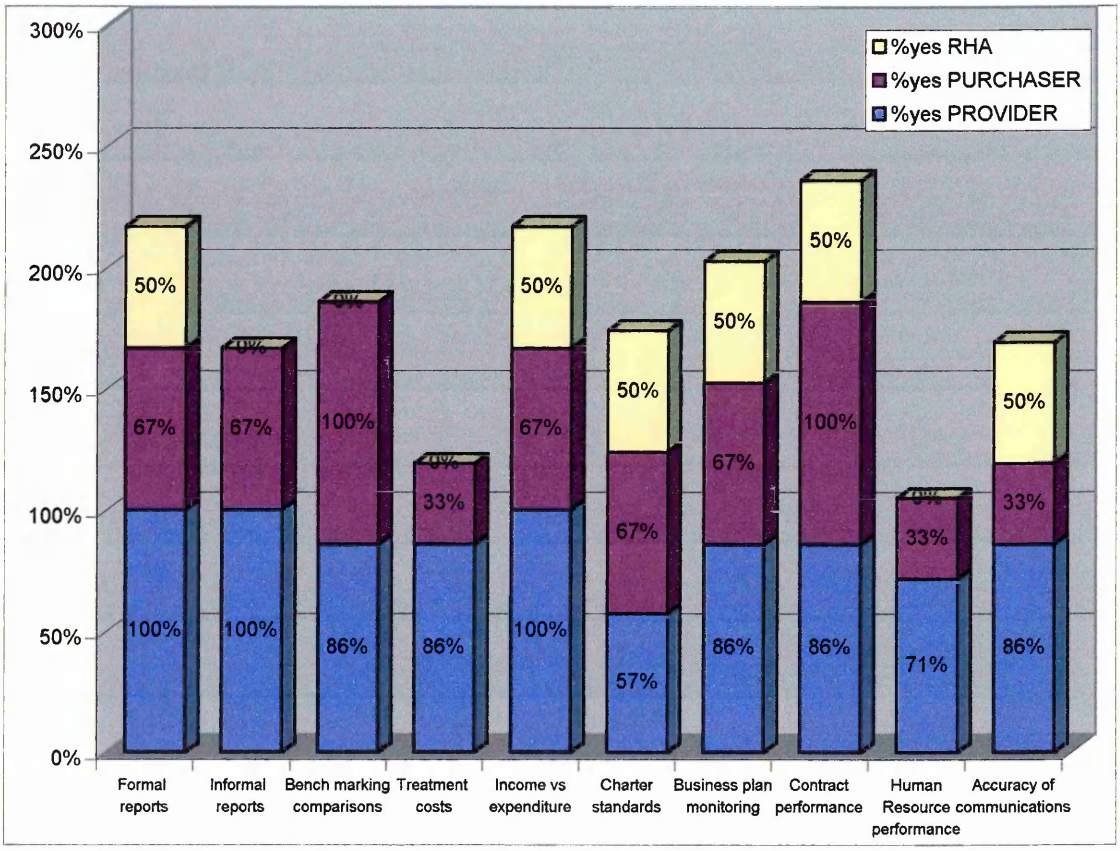
Information Needed for Monitoring Progress in the Organisation

A successful continuous improvement programme is based on effective day to day problem solving which needs useful information which begets information, and this enhances new measures of performance and its monitoring. Progress in an organisation can only be monitored if performance is measured against goals and objectives or benchmarked; for example: Hospital Episode Statistics (1994-95) with other similar organisations. The General Managers were asked what information was required to carry out the objectives of their organisations and meet the goals of the NHS[51]. As indicated in Figure 42, formal reporting, comparison of income and expenditure, and contract performance were the most important sources of information in monitoring the progress of the organisation, whereas business plan monitoring, informal reporting mechanisms and benchmarking closely followed.

[50] Figure 41: What Does Being Successful Today Entail Q30: Table of Results

[51] Q29 Table of Results

Figure 42: Information Needed for Monitoring Progress in the Organisation[52]



Peters (1988) argues that "involved" workers are one of a number of key elements in a successful organisation. However, human resource performance came low on the list of priorities of the General Managers. Cooke & Slack (1984) argue that information is central to decision-making. Whenever a decision is made, the level of information concerning all the elements of the decision shapes the decision process and therefore the choice itself.

In Figure 42 analysis of the General Managers' perceptions of the information needed to monitor the progress of the organisations as a group, followed a business-orientated pattern. When analysed by organisational groups it indicates slight variations in needs, but maintains the business orientation. General Managers from the Provider organisations viewed formal and informal reports and income vs. expenditure as the most important information needed for monitoring, whereas the General Managers from the Purchaser organisations viewed formal reporting, benchmarking and contract performance as the most important. General Managers from the Regional Executive organisations had similar views to those General

[52] Figure 42: Information Needed for Monitoring Progress in the Organisation Q 31: Table of Results

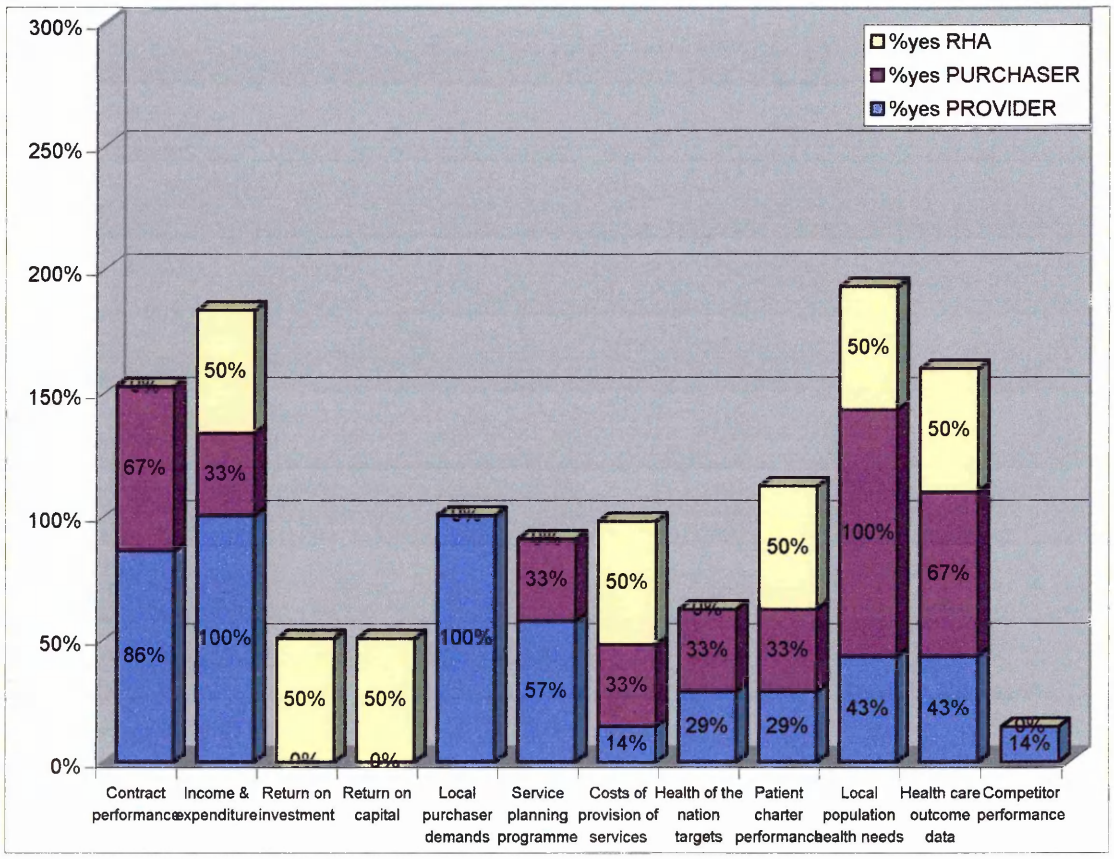
Managers from the Purchaser and Provider organisations but included Charter Standards on the most important list. However, all three groups indicated that human resource performance and accuracy of communications were the least important.

Information for Decision Making

The managers were asked what information they needed to hand when making decisions. Figure 43 shows that the General Managers' considered views were that the local population health needs were the most important closely followed by information relating to income and expenditure, then healthcare outcome data and contract performance. Considered least important were return on investment, return on capital, and competitor performance. Service planning, costs of provision of service and Health of the Nation targets were also well down the list of priorities. It should be noted that contract performance showed well despite no support from the Regional Executive organisation General Managers. The information needed is specified by the subject matter presented by the data, and not the attributes of the information. This does not mean that the key attributes are not relevant. In fact, timeliness, source and detail of the data is important to the General Managers in being able to interpret the data for successful decision making.

Ackoff (1967) identified five assumptions about the way managers use information, which do not generally reflect real decision behaviour. Those assumptions are: lack of relevant information; knowing which information the managers want and really need; effective use of the information given; and better communication, which means better performance. As discussed on P55 General Managers in the NHS are often over-loaded with an abundance of irrelevant information. The General Managers very often do not understand this problem and clutches to as much information as possible in the hope that some of it will be useful to them. Ackoff argues that problem solving is often so complex, that even "perfect information" does not guarantee success. He argues that the notion of "who knows what" can interfere with the hierarchical structure of the organisation and come into conflict with "who has a right to know". This can reduce the effectiveness of the decision-making. However, it appears to contradict Peters (1988) who argues for a well-informed workforce, "including performance data", for a successful organisation.

Figure 43: Information Needed to Hand for Decision Making[53]



Information Needed to Hand for Decision Making

The General Managers as a group indicated (Figure 43) that information relating to local population healthcare needs, income & expenditure, and healthcare outcome data as the most important information needed to hand when making decisions. However, when the General Managers' views are looked at from their organisational groupings, the diversified views of those General Managers demonstrate that the Provider Organisation General Managers view income & expenditure data, local purchaser demands, and contract performance as the most important whereas the Purchaser organisation General Managers view local population healthcare needs, contract performance and healthcare outcome data as being the most important and the General Managers from the Regional Executive organisations have mixed views spread over the range of the information band.

[53] Figure 43: Information Needed to Hand for Decision Making Q 32: Table of Results

Analysis of the data shown in Figure 43 gives a mixed picture of needs. However when analysed as a continuum of need from uniqueness by group-to-group commonality, then a picture emerges. Table 11 shows that the General Managers' common information needs reflect the business orientation of the environment in which they work, and it is only where the needs reflect the individual organisation's unique responsibilities that the General Managers' needs are not shared.

Table 11: Information Needs for Decision Making

Discrete needs		Some commonality of needs		Commonality of needs
Competitor performance	*Provider*	Contract performance	*Purchaser /Provider*	Income & expenditure
Local Purchaser demand	*Provider*	Service planning		Costs of provision of service
Return on capital	*Region*	Health of the nation targets		patient Charter standards
Return on investment	*Region*			Local population health needs
				Healthcare outcome data

Changes in Information Needs

Pre 1991 the NHS environment was not market or business orientated. However, since 1991 the environment has become more so and information needs have changed. Business information together with corporate information is viewed as more important, with Clinical information being considered as less important (Table 10). In terms of being successful, the General Managers identified finance, contracting, and user approval as indicators of success. Monitoring performance, income & expenditure and contracting followed by benchmarking and business planning were now considered the most important information needs together with information needed for decision-making i.e.: income expenditure, and performance, Purchaser demands and local population needs.

Just over half the General Managers believed that they were in a "managed market" and that they identified the following information needs (Figure 44) as being affected by being in a "managed market": contract performance, local purchaser demands and patient charter performance. Income & expenditure, local population healthcare needs and Health of the Nation targets closely followed these areas. This picture supports the other views expressed

by the General Managers that their needs reflect the business and performance orientation of the present healthcare environment. It can be noted (Figure 44) that the views of the General Managers from the Regional Executive organisations are absent. The views expressed by the General Managers from the Provider organisations covered the spectrum of needs listed, whereas those from the Purchaser organisations excluded Return on Investment, Return on Capital, management structures and competitive performance. Otherwise, the views expressed showed threads of commonality for the affected information needs. However, the views when seen by organisational groups tended to reflect the responsibilities of that particular organisation and not those of the General Managers as a homogeneous group.

The General Managers' views on how their information needs have moved in response to changes in the healthcare environment indicated that they had become more complex and more focused, requiring improved accuracy (Figure 45). As noted in Table 10, General Managers indicated that their information needs as expressed as a priority was finance and contract performance data followed by user approval. This appeared to be in response to the demands made on the General Managers to become more business orientated than in the past.

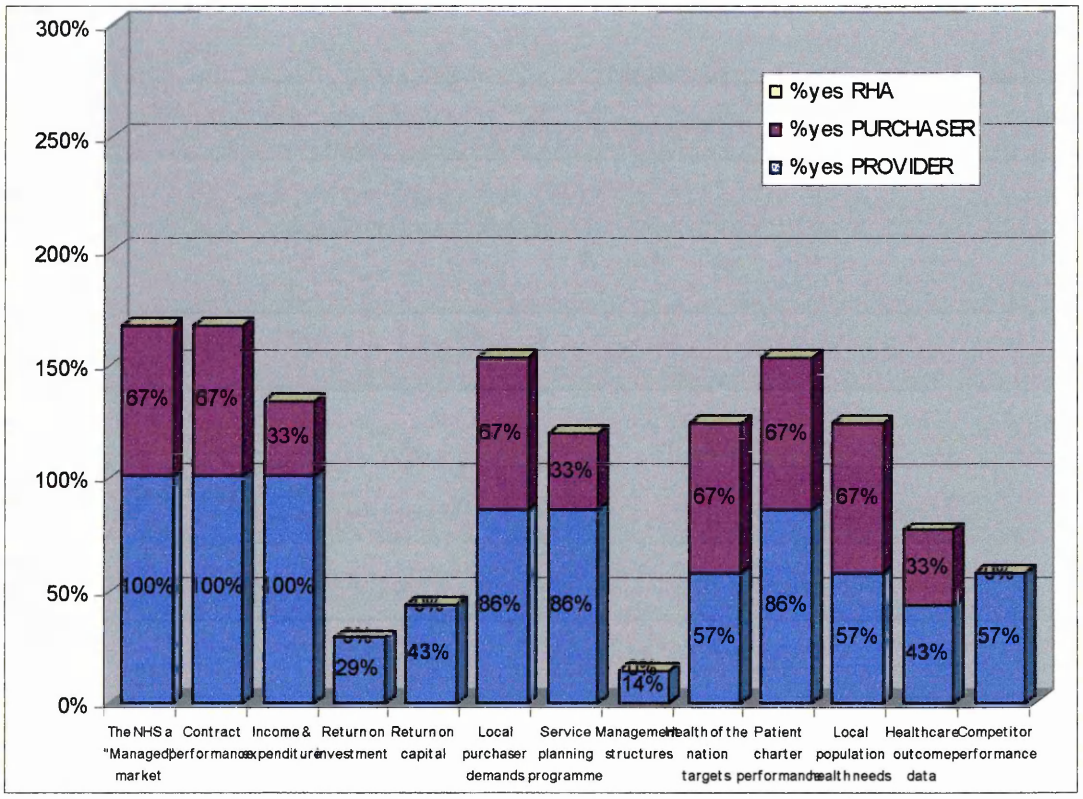
The General Managers indicated that changes to their information needs had increased in complexity, become more focused and with a need for more accuracy (Figure 45). However, this view was concentrated amongst the General Managers from Provider and Purchaser organisations. As well as being more focused and accurate, the General Managers supported a view that their information needs were becoming more sensitive to the aims and objectives of the organisation.

Key Changes in the Environment

As discussed in an earlier chapter the General Managers' views were split into two groups, the Provider organisations, and the Purchaser organisations. The General Managers from the Provider organisations noted the improved purchasing power of the GPs, a focusing on efficiency and effectiveness in the areas of clinical outcomes and a desire to become more efficient by the rationalisation of services. They also noted an increased sense of competition between organisations. The General Managers from the Purchaser organisations viewed the key changes in the form of performance monitoring and consolidating healthcare purchasing

strategies that were market-led. They shared views of key changes that focused on efficiency, clinical outcomes and effectiveness and market competition.

Figure 44: Areas of Information Needs Affected by Being in a "Managed Market"[54]



In Figure 11 the General Managers acknowledged that the environment would continue to change, and that they would be able to adapt as their information needs moved to meet those changes and, also as shown in Figure 45, the information that they needed had become more complex but more focused as a result.

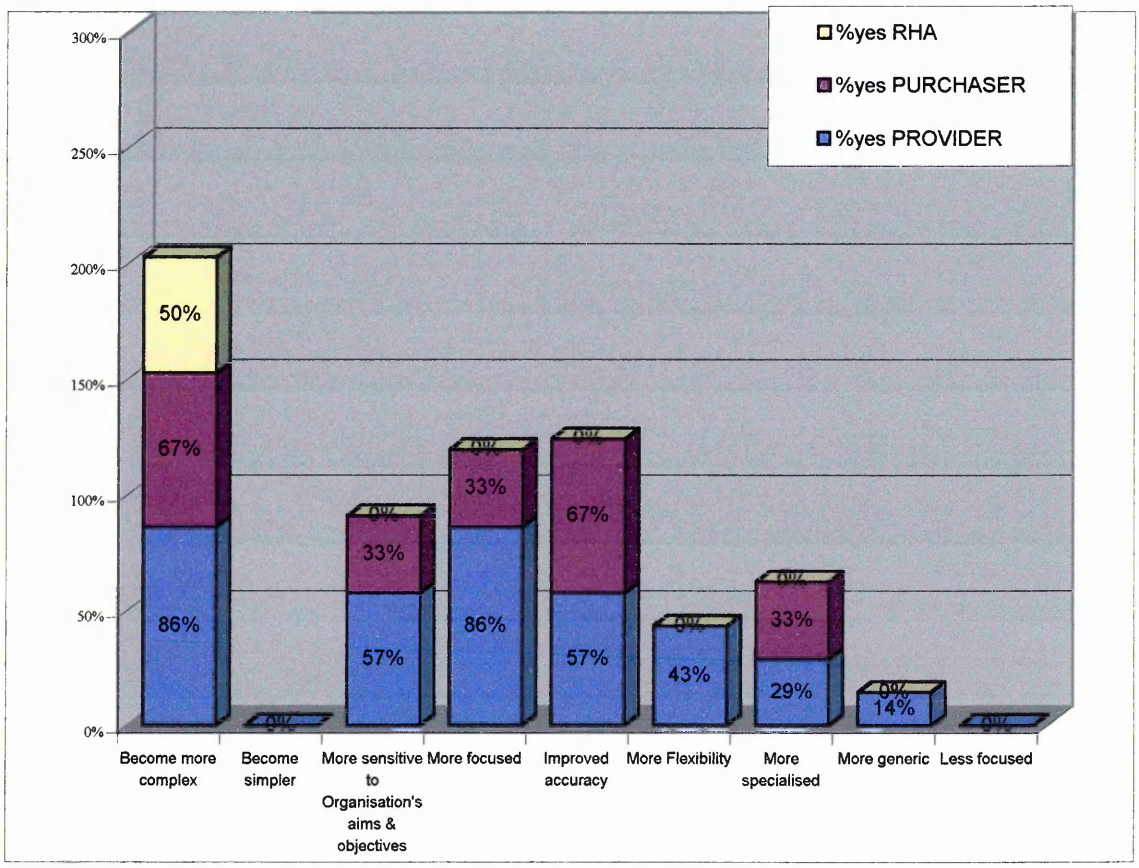
The Shift in NHS Ethics to Business Ethics and the Effect on the Information Needs of the General Managers

The General Managers were split as to whether the NHS was operating in a consumer environment. However, the majority believed that it should. That understanding was reinforced by their views on the need for increased efficiency and accuracy and on an environment that identifies and justifies costs as a major theme of its principles and the choices of service that General Managers have to provide. The majority of the General

[54] Figure 44: Areas of Information Needs Affected by Being in a "Managed Market" Q60: Table of Results

Managers believed that their information needs had been influenced by the changes in the power balance over the last few years (Figure 46).

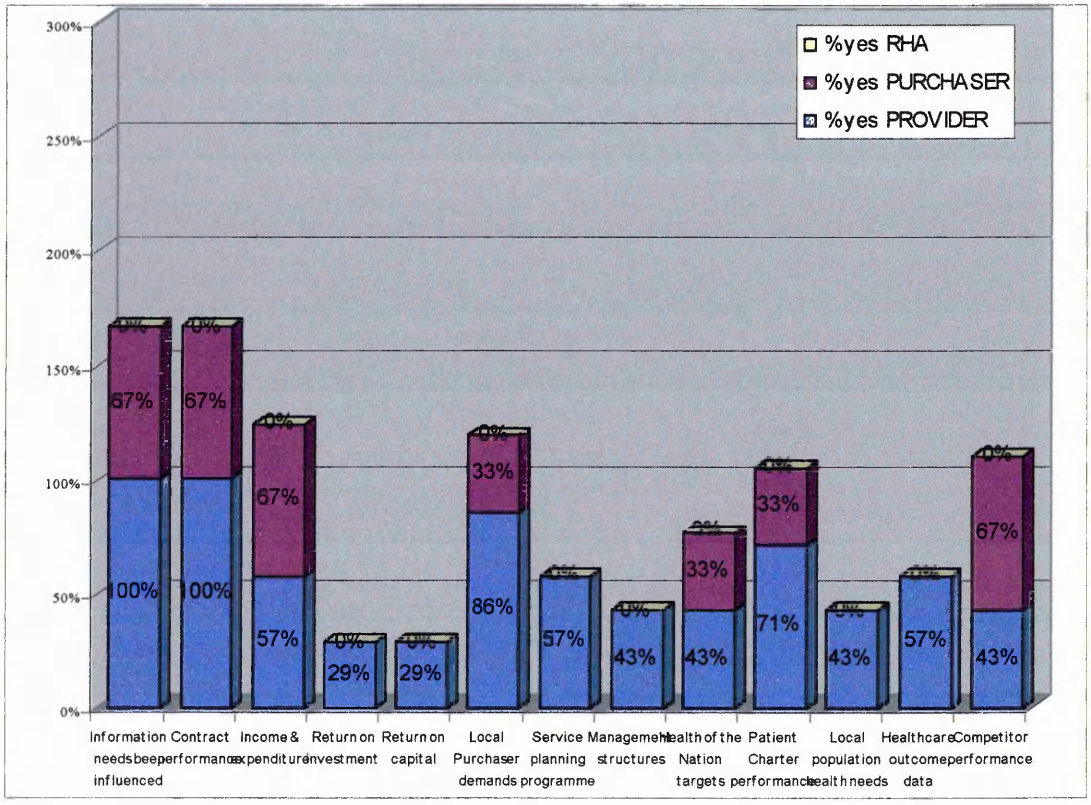
Figure 45: Information Needs in Response to Changes in the Healthcare Environment[55]



They indicated that their information needs had been influenced in the areas of contract performance, local Purchaser demands, patient Charter performance, competitor performance, income and expenditure and to a lesser extent, in the areas of healthcare outcome data, Health of the Nation targets and service planning programmes.

[55] Figure 45: Information Needs in Response to Changes in the Healthcare Environment Q56 Table of Results

Figure 46: Information Needs Influenced by Change in Balance of Power[56]



A majority of the General Managers from the Purchaser and Provider organisations believed that the healthcare market was a mechanism for change (Figure 10). However, the General Managers from the Regional Executive organisations did not support this view. The General Managers needed improved information covering all aspects of the services they managed and that their information needs included links with GPs and the community services. They also indicated that their information should be patient sourced and patient focused whilst providing clinical effectiveness and outcome data. The General Managers noted that the market-orientated environment of the new healthcare system did not conflict with the patients' interests and that those patients and GPs came top in the customer list as viewed by the General Managers (Table 2). However, the General Managers acknowledged that the market does not empower the patients, and they also noted that the Clinicians show little support for the empowerment of the patient.

[56] Figure 46: Information Needs Influenced by Change in Balance of Power Q54:Table of Results

The Impact of Consumer Participation and Social Responsibilities

(The Impact of Consumer Participation and the Social Responsibilities of the Provider on the Information Needs of the General Managers)

It is difficult to come to a conclusion as to whether consumer participation and the General Managers' social responsibilities affected their information needs. Certainly, the General Managers needed to know what the needs of the Purchasers and patients were and that customer satisfaction information has increased in importance since 1991. The General Managers also understand that consumerism and the healthcare market environment should empower the patients, whilst noting in reality that it does not.

Table 12: Information Needs by Stakeholder[57]

Subject matter that the General Managers discussed with their stakeholders	Clinicians	GPs	patients or patients' representative
Communications	✓	✓	✓
Management issues	✓	✓	
Financial performance of the organisation	✓		
Contract performance of the organisation	✓	✓	
Clinical protocols		✓	
patient Care Planning		✓	
Clinical management		✓	
Medical audit	✓		
Support for GPs		✓	
Services for local communities		✓	
Cost of services provided		✓	
Access to beds		✓	
Access to the organisation's facilities		✓	
Access to Clinicians			
Complaints			✓
Availability of facilities			✓
patient Charter standards			✓

However, the views of the General Managers clearly show that they have responded to the "business" aspects as far as their information needs are concerned, but changes brought about by consumer participation and social responsibilities do not appear to have had the same effect. Another aspect of defining the General Managers' information needs is the effect exercised on those needs by the demands of stakeholders. As discussed at the beginning of chapter 3, need is a subjective experience which occurs only in the mind of the

[57] Data from figures 47, 48 & 49

person in need and, consequently, is not directly accessible to an observer. The Stakeholders' assessments of their information needs are summarised in Table 12

General Managers Fulfilling their Information Needs

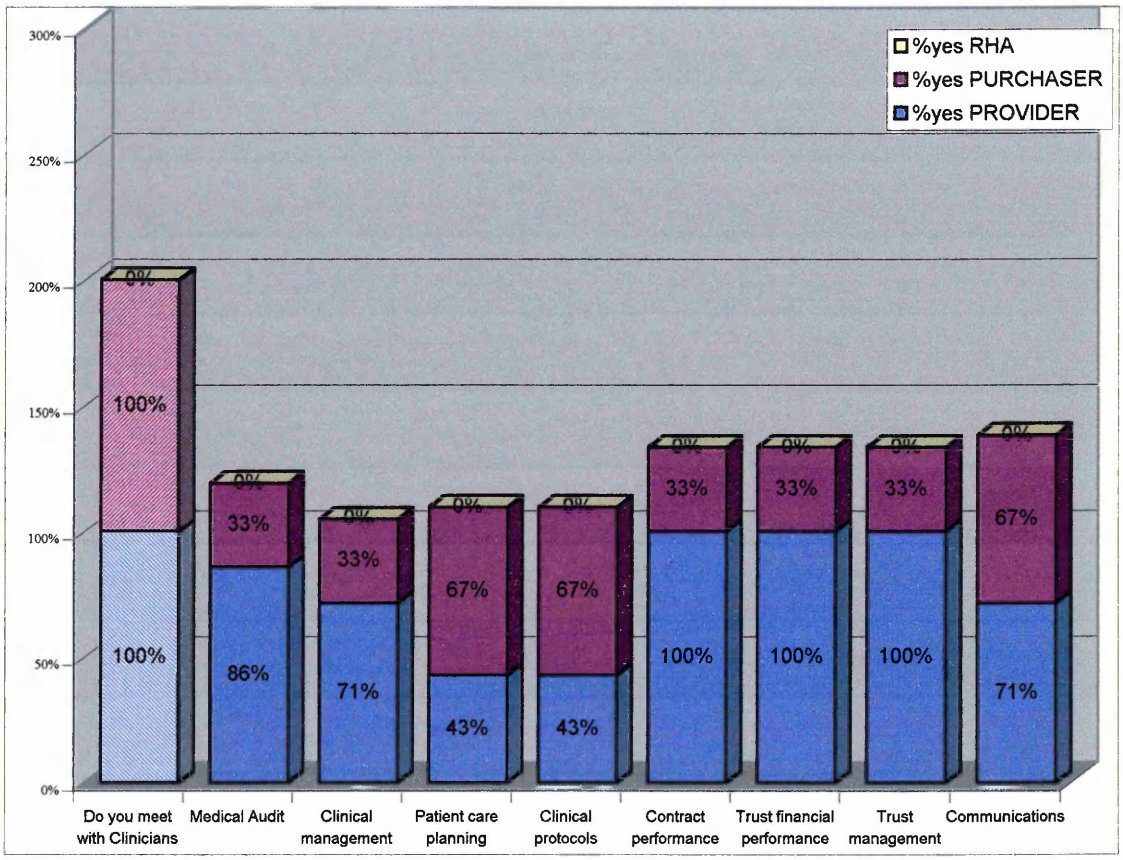
Essential to the General Managers being able to fulfil their information needs is their ability to communicate with key stakeholders in the organisation. There are many stakeholders on the "list". However, Consultants, GPs, patients and their representatives are high on a list of those with whom the General Manager has to form essential communication links.

Communication with Clinicians & patients

The majority of the General Managers met with the Clinicians; the minority who did not were from the Regional Executive organisations. This can be explained by the fact that most Clinicians within the NHS now have contracts held by Trusts, and have managerial roles within clinical directorates within those Trusts. The General Managers see this key management role as being crucial to them delivering the organisations aims and objectives. The demarcation of roles between Regional organisations and Purchaser and Providers looks likely to be re-enforced with the introduction of the White Paper (1998) and the reorganisation that re-employed Regional staff as civil servants.

Analysis of the subjects discussed at these meetings is shown in Figure 47 and reveals that the matters most frequently discussed by General Managers were related to the management of their organisations, financial performance, contract performance, and communications. Clinical subjects relating to patients and performance came lower in the General Managers' priorities. A detailed analysis of the responses indicated that the General Managers from Provider organisations were very positive about medical audit, clinical management and financial and contracts performance. This is not surprising as these matters are core to their business. The General Managers from Purchaser organisations were positive about patient care planning, clinical protocols, and communications, indicating their somewhat differing roles and priorities. patient care planning is core to their business, as are clinical protocols that have an effect on the cost of providing services by the Providers. The Regional Executive organisation General Managers felt that communications with Clinicians was not part of their core activities.

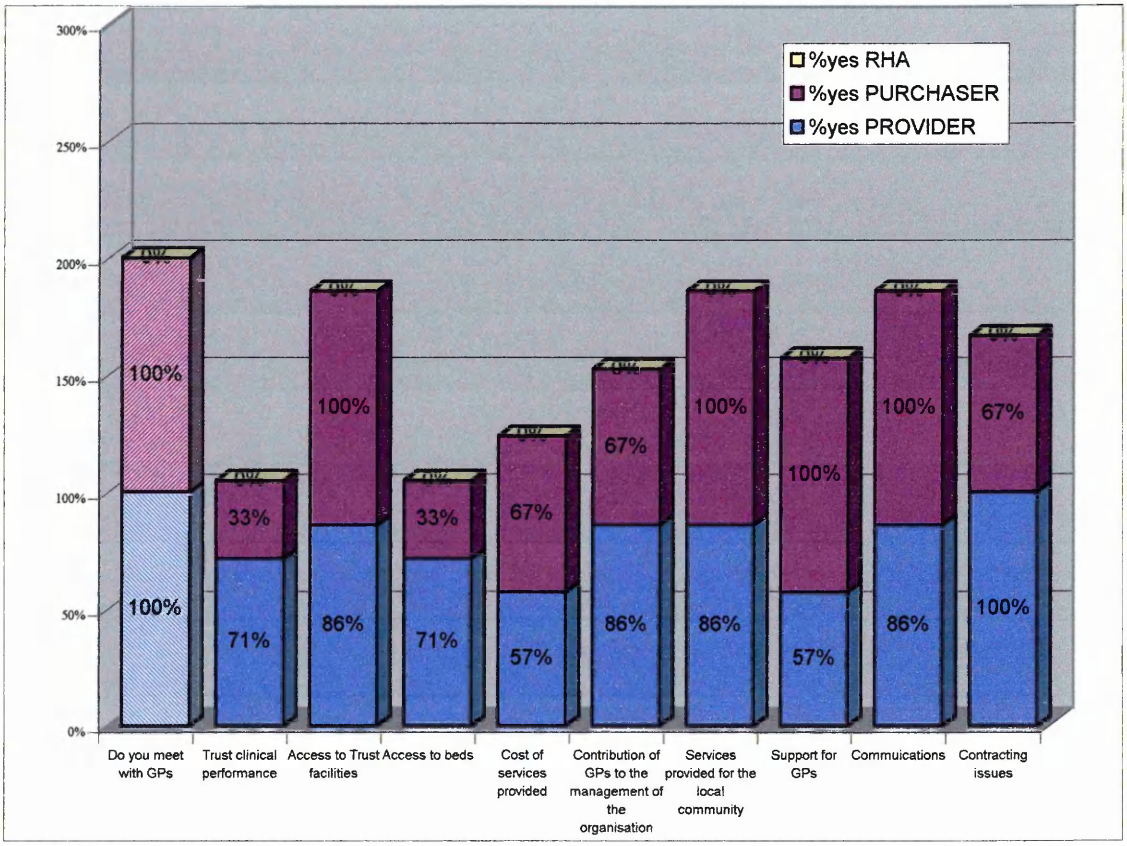
Figure 47: Subjects Discussed with Clinicians[58]



Similar to the patterns of communications with Clinicians within the organisations were the General Managers' views on the importance of communicating with GPs (Figure 48). Access to the Provider organisation facilities, provision of local services, communications and contracting issues were also a high priority for discussion at these meetings. Next came GPs' input to the management of the organisation and support for GPs. Access to, and the cost of, facilities and Provider organisations' clinical performance received only minority support from the whole group but majority support when viewed from the Purchaser and Provider organisation perspective only.

[58] Figure 47: Subjects Discussed with Clinicians Q15: Table of Results

Figure 48: Subjects Discussed with GPs[59]



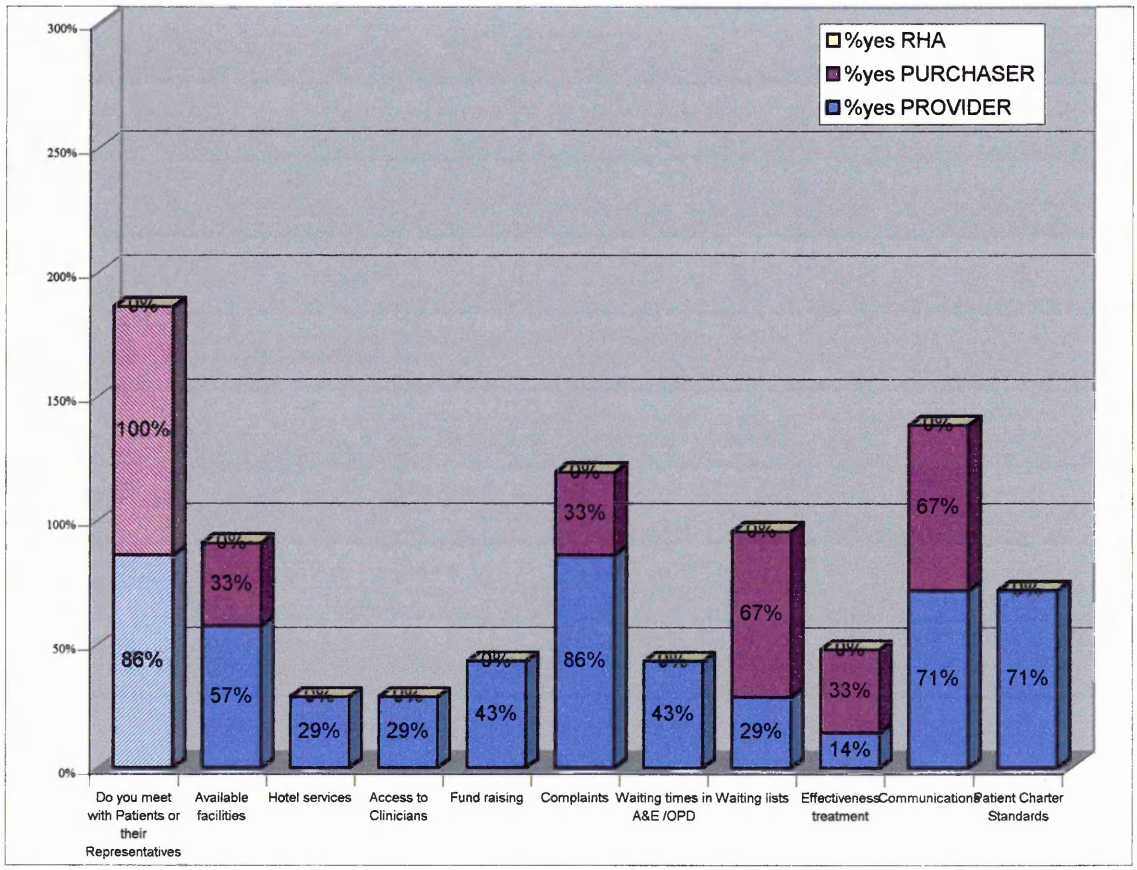
The majority of the General Managers from the Purchaser and Provider organisations met with patients and /or their representatives (Figure 49). However, the General Managers from the Regional Executive organisations believed that this was not part of their core activity.

Analysis of the General Managers' responses to the question "what matters were discussed with patients and their representatives", indicated that the most frequently discussed issues were complaints and communications, followed by available facilities, Charter Standards and waiting lists (Figure 49). It is interesting to note that Charter standards were favoured by Provider organisation General Managers and waiting lists favoured by Purchaser organisation General Managers. In view of the directives, (patient's Charter 1991) given by the DoH at the time, one would have expected both to share equally in importance with Purchaser and Provider organisation General Managers. The quality of the "Hotel services", accessibility to

[59] Figure 48: Subjects discussed with GPs Q16 Table of Results

Clinicians by the patients, and the effectiveness of treatment came low on the list of priorities of patients and their representatives according to both groups of General Managers.

Figure 49: Subjects Discussed with patients/patient Representatives.[60]



Analysis of the results appears not to show any deviation from the expected as complaints and communication problems had figured highly on the agendas of both the Purchaser and Provider organisation General Managers since the reform of the NHS in 1991. Increased expectation from the patients, more stringent finances and growing demand, have all played their part in shaping the priorities of the organisations and their customers. However, waiting lists figure high in the Government's strategy as a measure of improved performance for healthcare Providers, but the General Managers do not appear to attribute such high priority to waiting lists in their discussions with patients and patients' representatives.

[60] Figure 49: Subjects Discussed with patients/patient Representatives. Q17: Table of Results

Table 13: Information Discussed

Subject matter	Clinicians	GPs	patients or patient representative
Communications	✓	✓	✓
Management issues	✓	✓	
Financial performance of the organisation	✓		
Contract performance of the organisation	✓	✓	
Clinical protocols		✓	
patient care planning	✓		
Clinical management		✓	
Medical audit	✓		
Support for GPs		✓	
Services for local communities		✓	
Cost of services provided		✓	
Access to beds		✓	
Access to the organisations facilities		✓	
Access to Clinicians			
Complaints			✓
Availability of facilities			✓
patient Charter standards			✓

Analysis appears to indicate that the General Managers, in taking actions to fulfil their information needs, believe (Figure 47, Figure 48, Figure 49) that communications with their major stakeholders is important. When considering the meetings held with Clinicians (hospital Consultants and GPs), and patients together, a wide spectrum of information was covered in discussions at these meetings. However, the information areas covered, when viewed by individual groups, are very focused on the things important to that particular group. It can be noted that there is little common ground between the groups (Table 13), whereas when taking note of DoH opinion and guidance, areas such as services for local communities, access to facilities, Charter Standards and clinical protocols should have provided areas for commonality. The areas where commonality is found are in the business performance of the organisations and not in service provision.

Perception of Future Information Needs

The General Managers from all three organisational groups shared views on their future information needs that followed common threads although differing in descriptive details.[61] They required improved information covering all aspects of the services they managed. This

[61] Q65: Table of Results

information, and the systems through which it would be provided, should be integrated to improve links with GPs, the community and communications in general. The source of the information needed to be patient focused; originate from the patient and in the Purchaser scenario from "localities", so that the information was patient orientated, relevant and providing outcome and clinical effectiveness data. Finally, the systems would need to provide ease of use and access whilst providing accurate, timely and useable information from complex data.

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Understanding how General Managers Work with Information

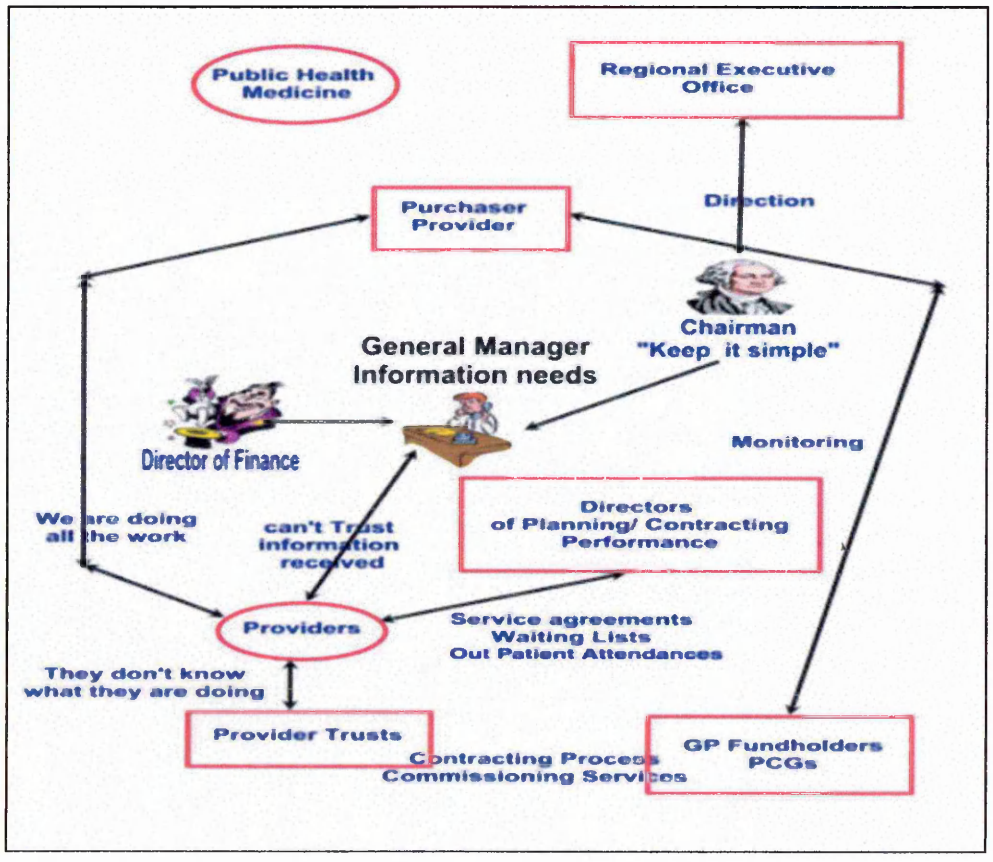
To assist in the analysis of understanding how the General Managers worked with information, requires an understanding of their working environment and how that environment effects their information needs. The views of the General Managers as to the type of organisational culture in which they worked, suggested that the majority of them believed that their organisation was responsive to changes in DoH policy, used health policy as an opportunity for change, was dynamic in "nature", and had coped well with the ensuing changes caused by the evolving healthcare policy. The General Managers believed that they had coped well with these changes by the use of scenario and contingency planning in their decision-making processes. An overview of their information world, the "Rich Picture" is described in Figure 50.

The General Managers believed (Figure 51) that their values, aims and objectives had changed because of health policy and as part of their value systems, the General Managers believed that managers should work by a code of practice, which included honesty and trustworthiness, confidentiality, and privacy as key parts of the code. However, only the General Managers from the Provider organisations believed that this code of practice should include professional guidance. The General Managers believed that their organisations were given direction and purpose primarily through the clinical and financial information of their healthcare business and that of the groups of stakeholders within their organisations, the Clinician were the most influential of the groups. Their view of their information needs was qualified by further analysis of those needs, which indicated that the majority of the General Managers did not view the information that they received as meeting their needs, with only a third believing that it did so. The General Managers also suggested that their organisations had become sensitive to publicity and, therefore, media influence, and as a result of this had responded by developing a media policy that was outwardly positive to the Media.

As discussed in Chapter 6, the General Managers' perceptions of their roles and in particular their relationships with their key organisational stakeholders, has a major effect on their working environment. In summary (Figure 52, Figure 53), the General Managers' relationships with patients and doctors, indicated that since 1986 the relationships between them and the doctors had changed from one of a functional but authoritarian prior to 1986, to one of co-operation in the present day. However, the relationship with the patients had

moved from one that didn't exist prior to 1986, to the present day where the General Managers described the relationship as co-operative. It is only in the present day environment that all three groups of General Managers shared the view that the relationships between the doctor and the General Manager, and the doctor and the patient had become ones of co-operation. Analysis also indicated that a majority of the General Managers believed that the NHS should be in the marketplace. However, they believed that it was a managed marketplace as opposed to a free marketplace and that the managed market in the areas of contract performance, local Purchaser demands, and patient Charter performance affected their information needs. The Provider and Purchaser, but not the Regional Executive General Managers saw their needs for information relating to income and expenditure as important.

Figure 50: The General Managers' "Rich Picture" of Information Needs



The General Managers' Perception of their Role

The General Managers perceive their role in the light of their understanding of the environment, key stakeholders with whom they work and the effects of their organisations' influence. The perceptions of roles, influences, the environment and the way the General

Managers respond to environmental changes all have an effect on their decision-making, performance and achievements. The aims and the objectives of the General Managers and the freedom they have to make decisions, the information the General Managers now need, the effects of their decision-making and whether or not there is healthcare empowerment of the individual, play a part in the real world of the General Managers.

Figure 51: Summary Analysis of the General Managers' Views

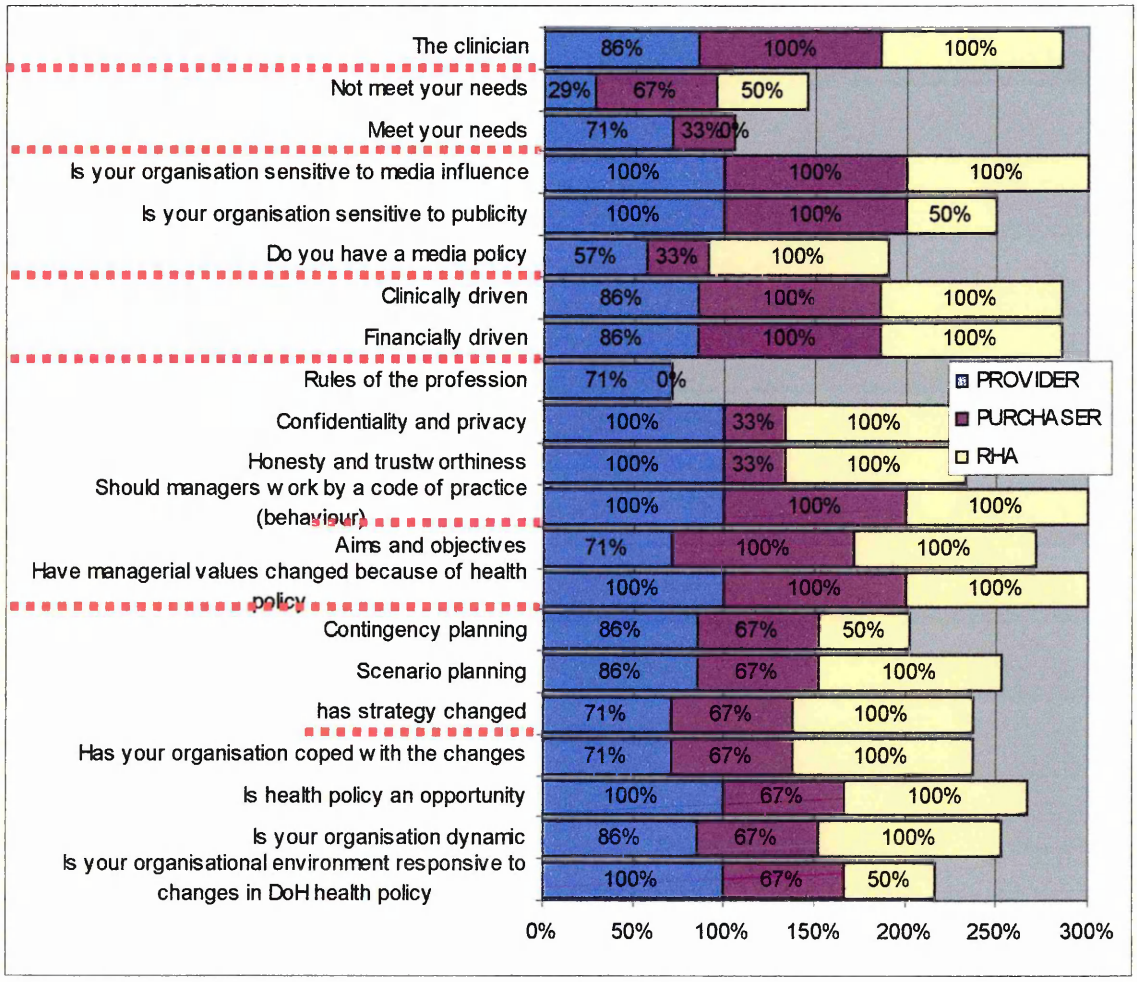
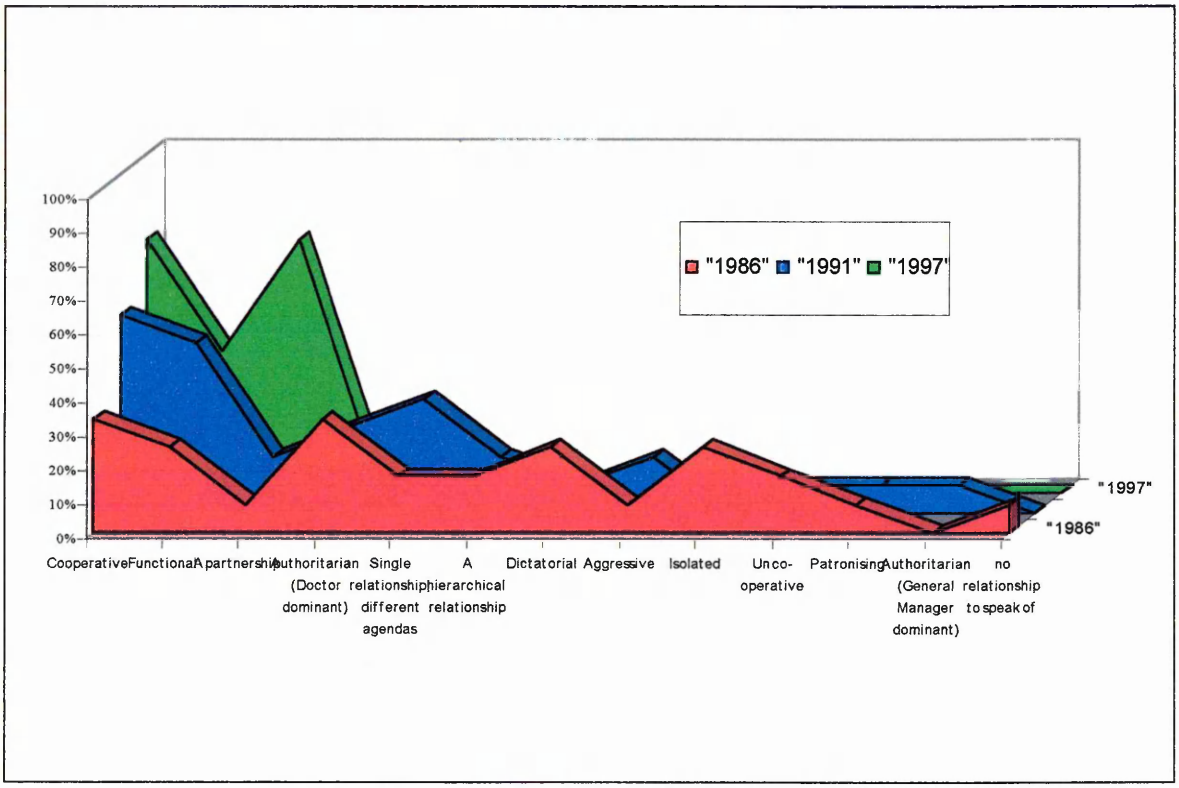


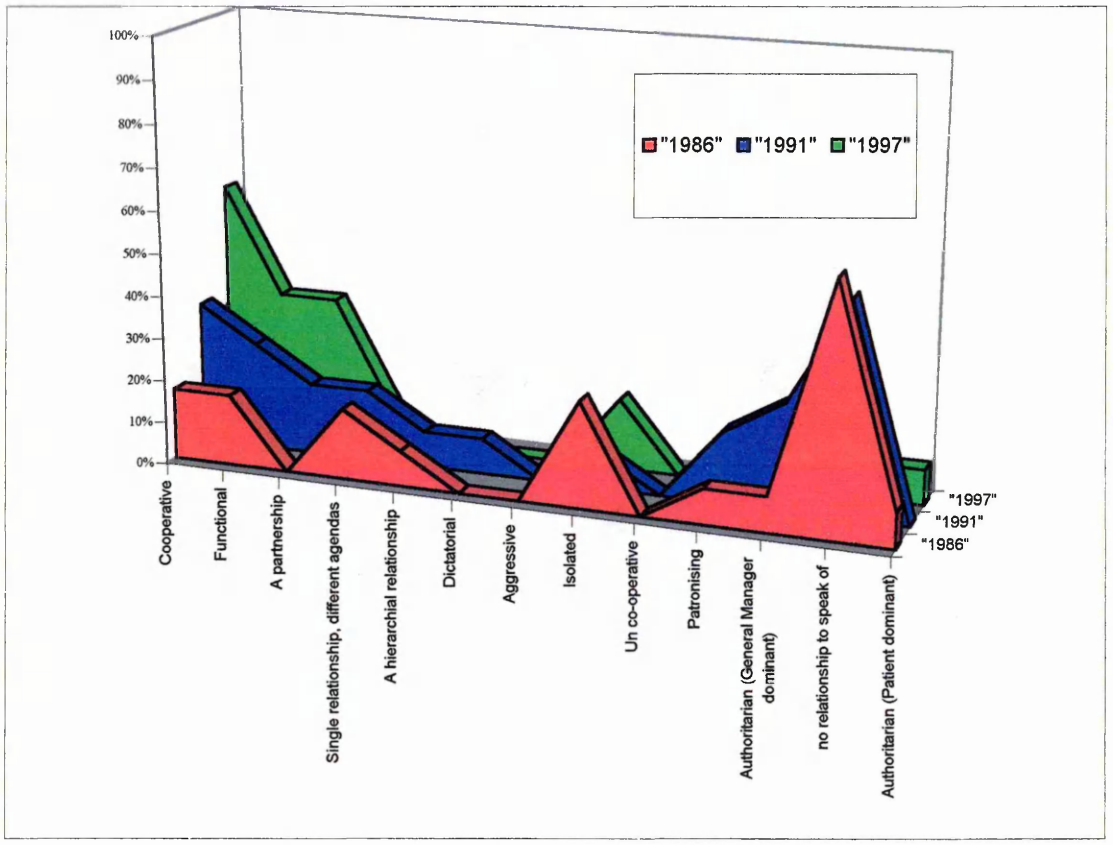
Figure 52: The General Manager/doctor Relationship Through 1986,1991 to 1997[62]



The General Managers work in a consumer environment with a theme of protecting the interests of the Purchasers of the services and those who receive them. An important aspect of their role is the relationship with their key stakeholders who include doctors, patients and General Managerial colleagues. Analysed over the years, these relationships have progressed from a more negative stance to the present; a functional partnership with doctors and General Managers and a co-operative attitude to patients (Figure 52, Figure 53). This early negative stance was perceived as ranging from not constituting a relationship between patients and General Managers, to a co-operative but authoritarian (i.e.: doctor dominated one) between doctors and General Managers. The role of the General Manager today has also been affected by the increase in influence enjoyed by the patient, Purchasers, the DoH, and local community. As shown in Figure 34, the General Managers believe that the patients, GPs and Purchasers have benefited most from these developments. The General Managers' views also reflect that the Clinicians remain at the forefront of deciding healthcare for the patients, whilst the General Managers' roles are diminishing (Figure 33).

[62] Figure 52: The General Manager/doctor Relationship Q42,45,48: Table of Results

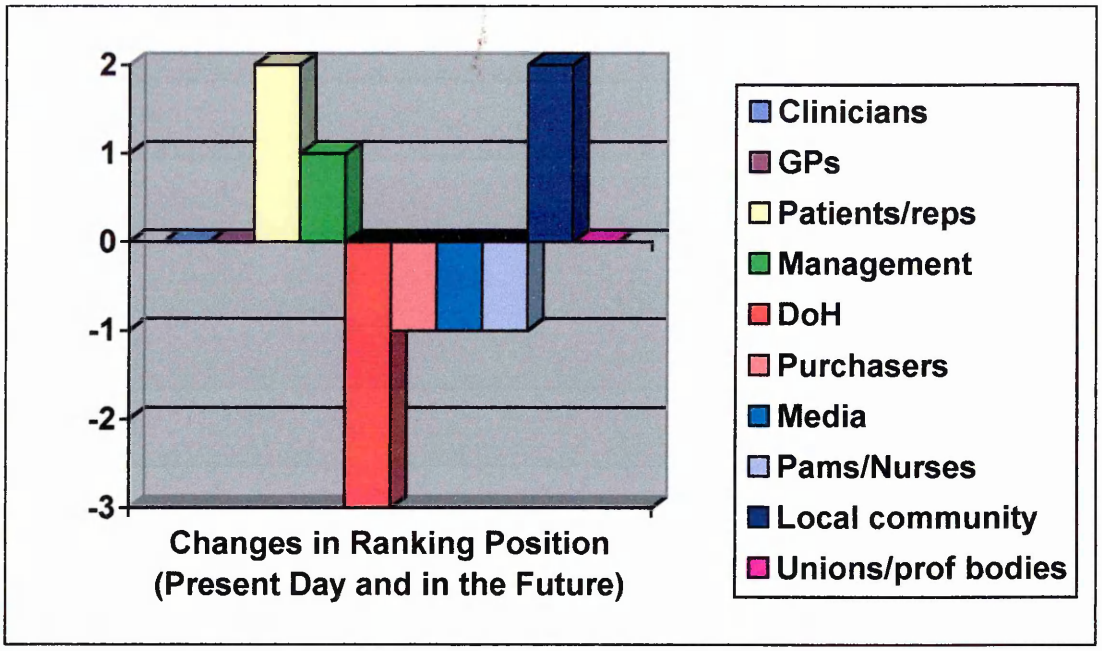
Figure 53: The General Managers/patient Relationship through 1986, 1991 to 1997[63]



These views are countered by the belief that, as a group, the General Managers are holding their own spheres of influence and were likely to further improve their position in the future. Figure 21 indicates the General Managers' belief that they know best about healthcare and that this opinion subordinates the patients' views on their healthcare needs. This view of the General Managers is supported by their belief that the existing environment did not empower the patients in determining their healthcare. However, all General Managers felt that the patients should be involved in determining healthcare provision. This indicates a conflict in the General Managers' attitudes in that they clearly believed that they knew best for the patient but at the same time needed to involve the patient in their decision-making (Figure 22). There was also a desire to involve the local community in providing direction for local services. Overall, the General Managers felt themselves to be influential, not to the same degree as Clinicians, but on a par with GPs and governmental agencies such as the DoH.

[63] Figure 53: The General Managers/patient Relationship through 1986, 1991 to 1997 Q43,46,49: Table of Results

Figure 54: Ability to Influence; Comparison of Changes for each Group Ranking[64]



The General Managers are adaptable and have a proactive response to the changing environment, acknowledging their social responsibilities and the effect of consumer participation in the healthcare environment. However, the overriding influence on the roles of the General Managers was that of the business orientation and market culture within the present healthcare environment. This placed a high level of importance on the need to communicate with their stakeholders, the need to focus on quality issues, and customer satisfaction (Table 14).

Table 14: Stakeholders

Internal Stakeholders	External Stakeholders
Clinicians	DoH
patients	patient representatives
Staff	Staff representatives/Professional. Organisations
GPs GPFHs	Purchasers Health Authorities
General Managers	Tax payers
	Regional Executives
	Local communities

This positive attitude acknowledged the need to involve the customers in the provision of healthcare as a result of the increasing influence of patients as a group. Although the General Managers are able to define their roles in terms of influences, recognising key stakeholders and the environment culture in which they are working, when the General Managers

[64] Figure 54: Ability to Influence; Comparison of Changes for each Group Ranking Source data Table 8

identified their information needs, they recognised what did not meet their needs, but appeared to accept the existing situation.

Communications

Analysis indicated that the General Managers clearly believed that communications with their major stakeholders was important and that during meetings with clinicians, both hospital Consultants and GPs, and patients, their discussions covered a wide spectrum of subjects. However, the areas covered were focused on topical issues important to that particular managerial group involved in the meeting. Further analysis showed that there was little common ground between the groups in what they discussed, other than business performance of the organisation (Table 13).

Codes of Conduct and Practice

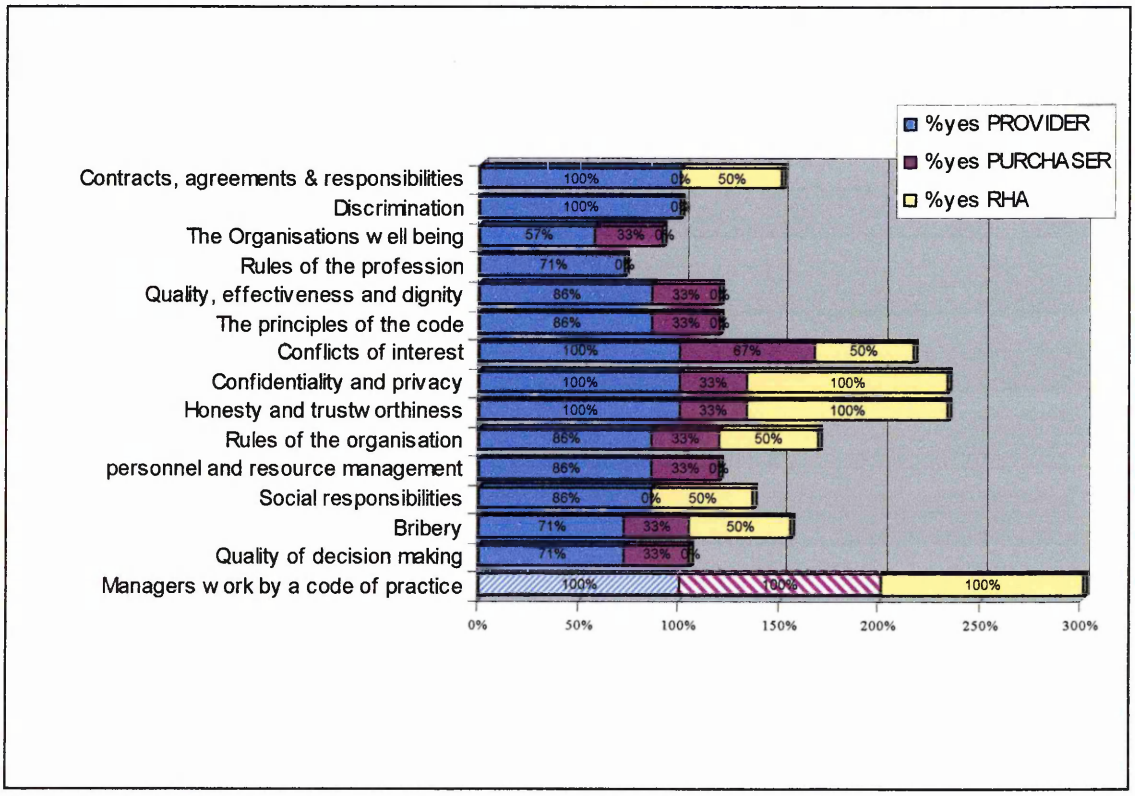
All the General Managers believed that they should work by a code of practice. However, only a minority worked in organisations that had such codes of practice. The General Managers believed that these codes of practice should include "trustworthiness, conflicts of interest and confidentiality" through to "the rules of the organisation and social responsibilities". Figure 55 indicates the wide range of issues the General Managers believed should be covered. Only a minority of the General Managers worked by the codes, although the majority had the codes enshrined in their contracts; codes which were also applicable to all staff and had adherence to them monitored.

Being Successful

Meeting financial targets, a high approval rate from users, followed by meeting contract and DoH targets, were seen as key success factors in doing a successful job by the General Managers (Figure 41). The General Managers monitored the performance of their organisations as part of the process of achieving success, especially in those areas they attribute to achieving that success. Peters (1988) argues that being successful entails: the organisation being customer responsive, having an innovative approach that can cope with an ever faster changing environment and flexibility through the empowerment of people and an information strategy that enables sharing of all information with all employees of the organisation. However, even though the NHS is considered to be a "people organisation", human resource performance came bottom of the General Managers' priorities. Their

success is concerned with the common information requirements of the General Managers which cover: income and expenditure, costs associated with the provision of service, patient Charter standards, local population healthcare needs and outcome data. It is apparent that the business orientation of the NHS market environment influences the goals and objectives and therefore the needs of the General Managers (Figure 43, Figure 44).

Figure 55: General Managers Working to a Code of Practice and Areas Which Should be Covered[65]



The General Managers' Working Environment

The General Managers believed that they work in an organisational cultural environment that seeks consensus, is devolutionary, analytical and collaborative in approach, and at the same time challenges beliefs. Miles & Snow (1991) suggest that the General Managers' attitudes tend to reflect the culture of the organisation in which they work. Therefore, the assumption that the General Managers show attitudinal tendencies that are devolutionary, analytical and collaborative is supported by their views over conflicts, empowerment and benefits of consumerism to the patient (Figure 13, Figure 14, & Figure 15). They steer a middle course, maintain the status quo as far as possible, and look to the future in developing their services

[65] Figure 55: General Managers Working to a Code of Practice and Areas Which Should be Covered Q22: Table of Results

onwards. However, the majority believed that the evolving NHS market was a mechanism for change as well as providing the climate in which change could take place.

The General Managers believed that they exhibited a leadership and managerial style that entailed devolved decision-making, and was both consensus and democratic. With the underlying belief that this cultural attitude affected the way their organisation worked and, as a consequence, their information needs. The majority of the General Managers believed that the "protection of the interests" of the Purchaser and the patient closely matched their understanding of consumerism (Figure 12). Less than half of the General Managers agreed that the NHS was operating in a consumer environment, but a majority felt that consumerism had helped the patient and given direction to the Purchaser organisations in developing strategies for healthcare. A majority of the General Managers felt that the NHS should work in a consumer environment.

The General Managers were equally split as to who knew best about healthcare; they indicated that the Purchaser and Provider, but not the patient, were key. However, having recognised this situation, the General Managers felt that the Provider must involve the patient (customer) in the type of service provided, and that the (Provider) General Managers had social responsibilities in relation to the service provision as well. This particular view was strongly held by the majority of the General Managers. The role of the local community was believed to be in the areas of the direction of local service provision and in ensuring the survival of the healthcare services in a locality.

Analysis of the views of the majority of the General Managers indicates their organisations to be devolutionist, collaborative and challenging. However, it is unlikely that any of the organisations could follow such behaviour patterns as described by Miles & Snow (1991) because the NHS infrastructure is so large and unwieldy and the bureaucracy so large that flexibility is limited. The General Managers and the way in which they work tend to reflect the culture of their organisation and as such the organisations in which they work are essentially conservative defender organisations, where low risk strategies, the confidence of secure markets and well-tried solutions are valued. Typically, a defender organisation is concerned with stability, consensus and decision taking, which are often rigid, whereas the entrepreneurial organisation is about growth and change and less formal structures for decision making and planning. Miles and Snow emphasise that the two organisational cultures behave in different ways in similar environments. The entrepreneurial cultural web,

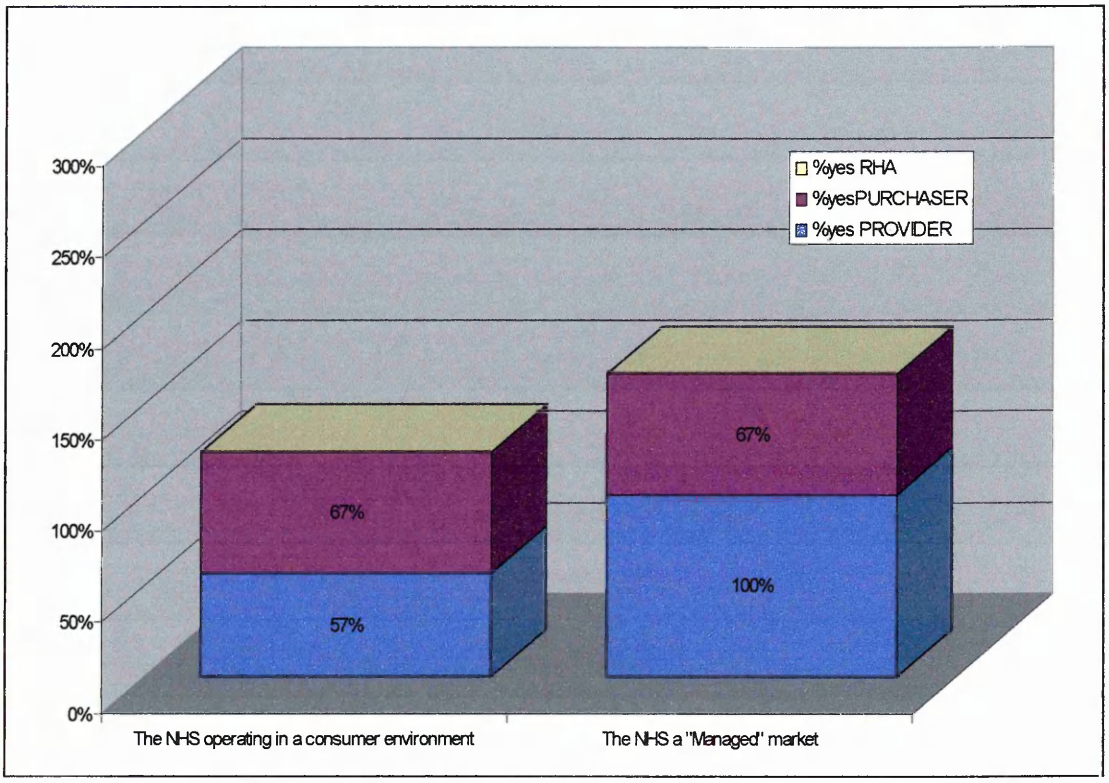
as described by Miles & Snow (1991) has a number of characteristics such as objectives that exploit new services and market opportunities, but also a desire to integrate new services into existing ones. The General Managers' organisations preferred strategies that secure growth through service development, constant monitoring of environmental change and multiple technologies, but mixed with steady growth (due to financial constraints), exploitation of evidence-based medicine and are essentially following a market. The organisations' planning and control systems emphasise flexible decentralised control and the use of ad hoc measurements, with complicated co-ordinating functions such as intensive planning and project management. One of the main criticisms of this in NHS organisations is the emphasis on the stewardship of funds as opposed to the quality of service.

The NHS and the Market Place

The General Managers have an understanding of how their information needs have moved in response to changes in the environment. That understanding of the environment is one of a managed market and a questioning of whether the NHS should be in the market place at all. The General Managers believed that they worked in a market environment where services were competitive, efficient and cost-effective, and that may be then influenced by stakeholders in terms of the services provided, behaviour and accessibility. However, this belief was tempered by a minority view that the market environment was an ideology unsupported by the evidence of success.

However, by way of contradiction, analysis of some of the key success factors highlighted by the General Managers suggested that the "market place" environment of the NHS had achieved some measure of success. Table 1 indicates the improved purchasing power of the GPs, to purchase services for the community, the improved clinical effectiveness of clinicians and the focus by Provider organisations on healthcare efficiency and outcomes. When the General Managers' views on consumerism are included, then clearly a majority believed that the patient had been helped. However, the contradiction is that only a minority believed that they worked in the consumer environment and a majority believed that the environment had not empowered the individual (Figure 57).

Figure 56: The NHS "Market Place"[66]

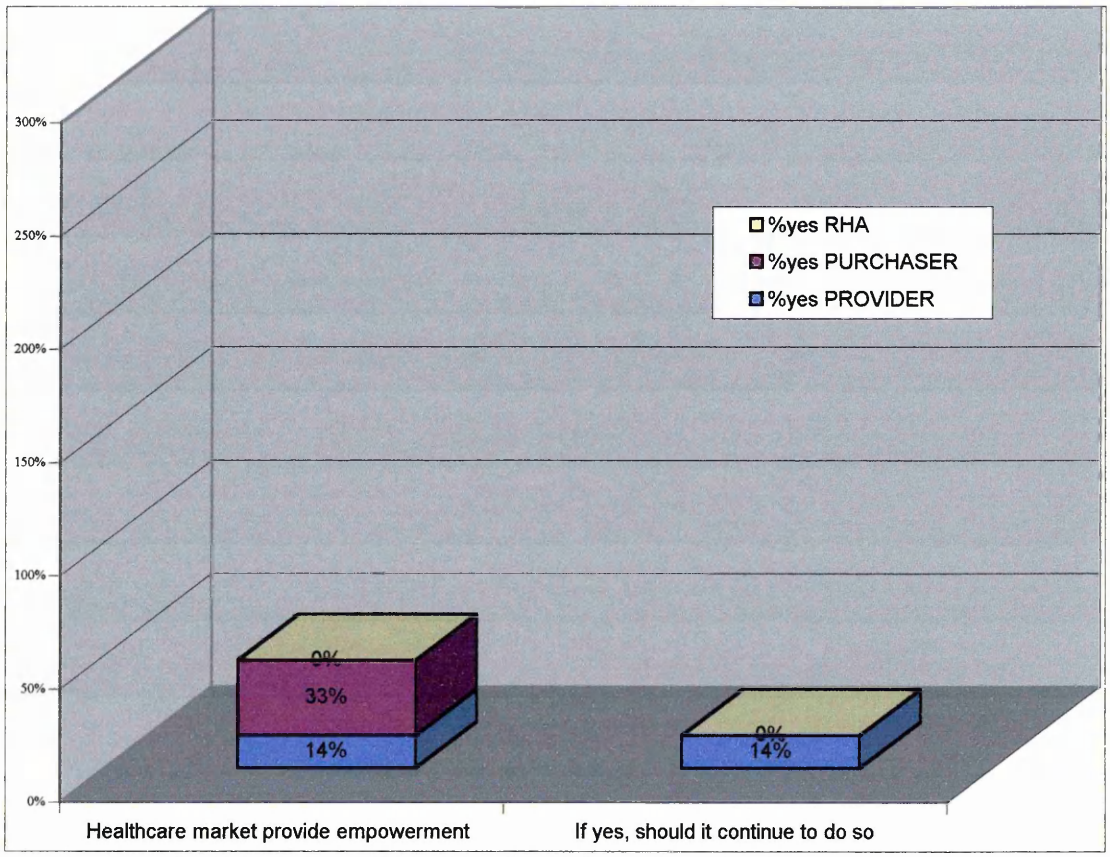


The Healthcare Market as a Mechanism for Change

The majority of the General Managers from the Purchaser and Provide organisations believed that the market was a mechanism for change. This opportunity for change brought by the market environment enabled the General Managers from those organisations to focus on local provision and be more responsive to local needs and services. The healthcare market influenced the General Managers to be proactive through innovation that originated both internally and externally. As part of the General Managers' concepts of management information in the NHS, there was commonality in key areas of change from the General Managers of Provider and Purchaser organisations. This commonality covered efficiency of outcomes, a drive towards clinical effectiveness and competition between Provider and Purchaser organisations. The General Managers were very positive and able to adapt their information needs to meet the changing healthcare environment.

[66] Figure 56: The NHS "Market Place" Q2, 60: Table of Results

Figure 57: Empowerment of the Individual[67]



Influences that Affect the General Managers' Working Environment

The Major Influences

The General Managers identified many influences that affect their working environment, which were many and varied. However, one of the major influences came about as a result of the General Managers' interactions with their key stakeholders such as those within their organisations, for example; direct contact with patients, GPs, contracting arrangements with Purchasers and directives from the DoH. There were also more subtle influences exerted by the local communities, group influences within the organisations, changes in philosophy from the DoH, and the effect of changes in information needs caused by changes in priorities, accountability requirements and the need to perform.

[67] Figure 57: Empowerment of the Individual Q68a, 68b: Table of Results

Group Influences.

For many General Managers, influences in the group situation provide much of the context for their decision-making and that context, which screens, filters and modifies information, is actually the source of information for the General Managers. In Chapter 6, the perceived importance of a group depends on the sanctions applied and the power to influence the individual General Manager's decision. In the present environment, General Managers view Clinicians, GPs, the DoH and management groups as the most influential. Table 3 presents the data in its basic structure and as a consequence is difficult to analyse and draw any conclusions on how the General Managers ranked the groups collectively in order of influence. Figure 28 gives a full picture of this group influence. The views vary by influence group and organisational group. The most obvious conclusion is that the different influences of the groups have different perceived powers of influence depending on the organisation and this does not necessarily reflect the overall perceived power of influence. Table 4 shows influencing power by ranking; with Clinicians at the top and Unions and local communities at the lower end of the scale.

Changes in Influence

In the future, the General Managers believe that changes will take place. However, they saw no change in the role of the Clinicians and GPs as the strongest influencers and they recognised that the patients and their representatives together with local communities are likely to exert the most influence. This view prevailed with the General Managers when they considered the influence over healthcare provision, in which the clinicians would continue to have the most influence through prescribing and treatment of the patient. However, the General Managers suggested that patients and local Purchasers would increase their influence in the future.

Movement of Information in Response to Changes in the Healthcare Environment

As the environment has become more business-orientated, General Managers have needed to achieve performance targets and be seen to be successful. This has influenced their information needs, requiring as it does success indicators in the area of finance, contracting and user approval. Their information needs also required the monitoring of information such as income and expenditure, contracting, benchmarking and business planning as key

indicators. Figure 44 shows that the General Managers believed their information needs to have been influenced by the managed market. Though the views of the General Managers from the Regional Executive organisations do not figure in these opinions, the majority of the General Managers' information needs have become business-orientated, but influenced by patient Charter standards, healthcare needs and outcomes. This influence has made the information required more complex, focused, and coupled with a desire for improved accuracy (Figure 45).

Key Changes in Environment

These changes in the environment such as the improved purchasing power of GPs, which focused on efficiency and effectiveness in clinical outcomes; increased sense of competition and performance monitoring and market-led healthcare purchasing strategies, by their very nature bring influences to bear on the General Managers' empowerment, the way they work and influence their information needs. The general atmosphere in which they worked was influenced by the need for a business-like approach. The environment has become more competitive because of the need to meet the performance targets being set by the organisations, which in turn, had to be seen to be successful.

The Shift in NHS Ethics to Business Ethics and the Effect on the Information Needs of General Managers

The General Managers believed that they should be working in an NHS that is a consumer environment. This belief has its roots in an appreciation that a business organisation should be aligned to its environment.

Influence on Information Needs by Changes in Balance of Power

The change in the balance of power in the environment has influenced the General Managers' information needs over the years. As shown in Figure 46 those information needs, which exert influence, cover the business elements of the information, which the General Managers need.

How Consumer Participation and the Social Responsibility of the Provider have affected the Information Needs of the General Manager

The General Managers believe that the market environment had not empowered patients. The General Managers supported that view in that they believed that the Clinicians showed little enthusiasm for patient empowerment. Even though the evidence showed little support for consumer participation in influencing the General Managers' information needs, when these are combined with the General Managers' beliefs in the business orientated environment, there is evidence to suggest that those influences impelling the organisation to succeed, have had a positive effect. The General Managers need to meet performance targets; they are being monitored on financial, contracting and outcomes data; and it is this last influence that enables Purchasers, patients and the consumer stakeholders to bring their influence to bear on the organisations and their General Managers to achieve change. This influence is, however, less obvious, and more subtle than the others previously analysed.

The Stakeholders

The environment in which the General Managers are working affects their relationships with the stakeholders and the stakeholders affect the environment. Because the General Managers felt that they should be in a consumer's market, it is reasonable to expect that their relationships with their customers and stakeholders might reflect that view. The history of consumerism shows that there is a relationship between changes in culture and changes in consumption patterns. It further shows that those changes move away from communal values toward individualism and materialism. Research (Hospital episode statistics 1994-95) indicates that there is an increased level of consumption in the "healthcare services", part of a trend in general consumption that began in 16th century England. The relationships of the General Managers with the stakeholders varied according to the perceived importance and effect that the stakeholder had on the General Managers' working environments. The list of stakeholders could be very long, however, in this instance only the "obvious" contenders are considered (Table 14).

The General Managers viewed their relationships with Clinicians, patients and fellow General Managers as having altered over the years. The General Managers' relationships have become more co-operative and, in the case of the doctor, more of a functional partnership. This is mirrored to a lesser degree with regard to the patients. The roles of the General Managers

have altered as a result of these changes in relationships. The General Managers' roles are becoming more positive in that not only is the business environment strengthening their influence but also by developing partnerships with key stakeholders of the healthcare environment, the General Managers are strengthening their role in the organisation.

Who The General Managers Believe their Customers to be

Table 2 indicates a wide spectrum of customers for the General Managers' organisations. However, the commonality only covers GPs, Government, patients & relatives and the local community. As groups, these customers influence the General Managers in their information needs both passively and actively.

External Policies of the Organisation

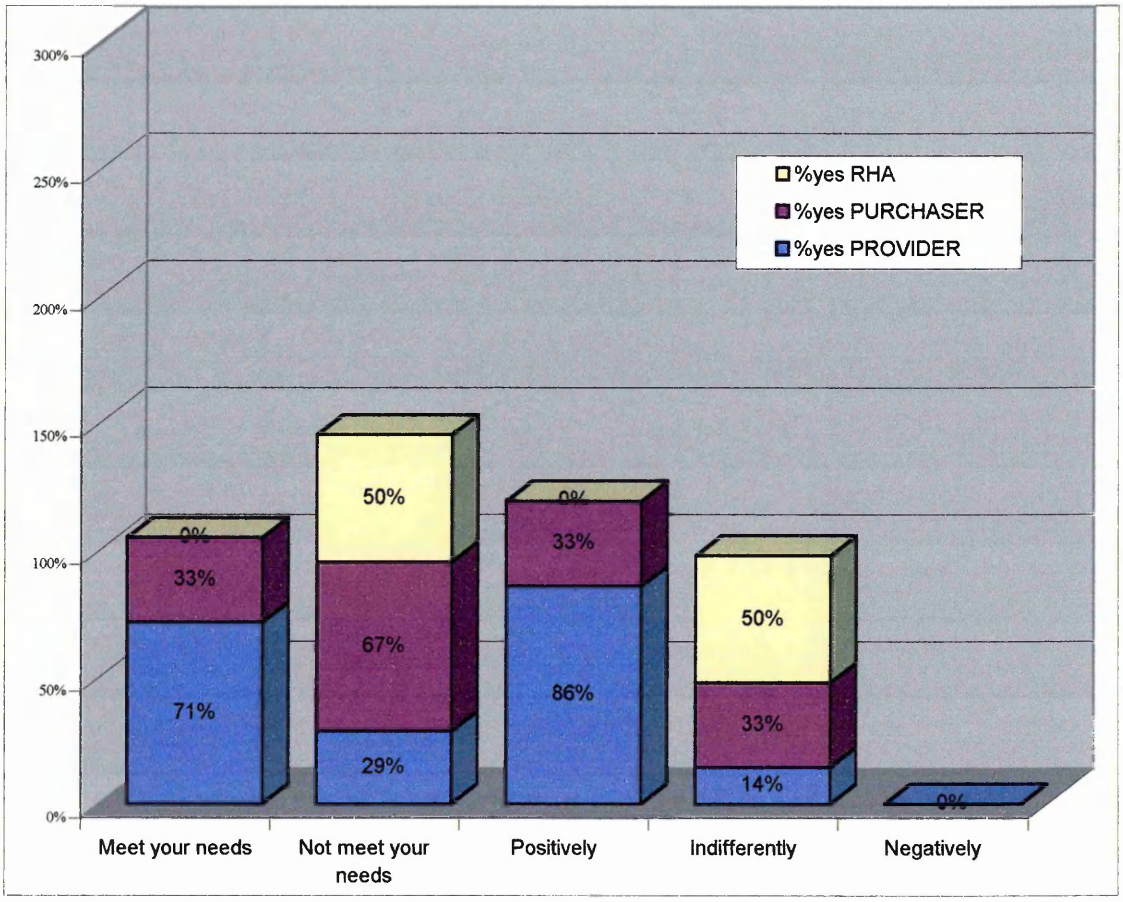
The majority of the General Managers believed that their organisations had changed in response to a plethora of healthcare policies (Figure 35). The most common areas of change, as a result of DoH policies, were in the business of the organisations and primary healthcare. Organisational aspects closely followed. This correlates with others views expressed by the General Managers, that the environment they worked in was continually changing in respect to business influences which in-turn caused the organisation to respond in its internal structures. The General Managers' working environment are organisations that are business challenged and responding to that challenge by evolving their organisational structures. The external policies of the organisations are their interfaces and interactions with the external stakeholders and customers. However, these interactions are influenced by the external policies of the DoH as well as by the internal organisational influences described in Figure 35 & Figure 36.

Response of the General Managers to Environmental Changes

Information

The NHS is renowned for the abundance of information available. Ackoff (1967) identified five assumptions about the way managers use information, which do not generally reflect real decision-making behaviour. These assumptions are: lack of relevant information; knowing which information the managers want and really need; effective use of the information given; coupled with better communication; which means better performance.

Figure 58: Information Received.[68]



As discussed in Chapter 3, General Managers in the NHS are often confronted with an abundance of irrelevant information, which they perceived as a problem and in an effort to overcome this problem they cling to as much information as possible in the hope that some of it would be useful to them. Ackoff (1967) argues that the problem solving is often so complex, that even "perfect information" does not guarantee success. He argues that the conflict of "who knows what" against "who has a right to know" can interfere with the hierarchical structure of the organisation and reduce the effectiveness of decision-making. However, the foregoing appears to contradict Peters who argued for a well-informed workforce, "including performance data", in order for a successful organisation to ensue.

Analysis (Figure 58) shows that only one third of the General Managers received information that met their needs and of that one third, the majority were from the Provider organisations. It is interesting to note that some of the General Managers were prepared to admit that the

[68] Figure 58: Information Received.Q33 & 34: Table of Results

information they received did not meet their needs. Assumptions could have been made that corrective action would have been taken by these General Managers to receive information that met their needs and therefore saved them from having to admit that the information they received was irrelevant. However, slightly more than one third reacted positively to the information received even if it did not appear to meet their immediate needs.

Sensitivity of the Organisation to Media Influence

The majority of the organisations for which the General Managers worked had a positive media policy that was sensitive to publicity. Analysis of the General Managers' views on the media (Figure 59) indicates their sensitivity to issues covered by the media, (health and the organisation) and that the organisations have formed partnerships with the media. However, analysis did not show how recent publicity in the health arena had influenced the organisation's handling of day-to-day managerial issues and policy.

The Reaction to Changing Information Demands and Information Needs in the Future

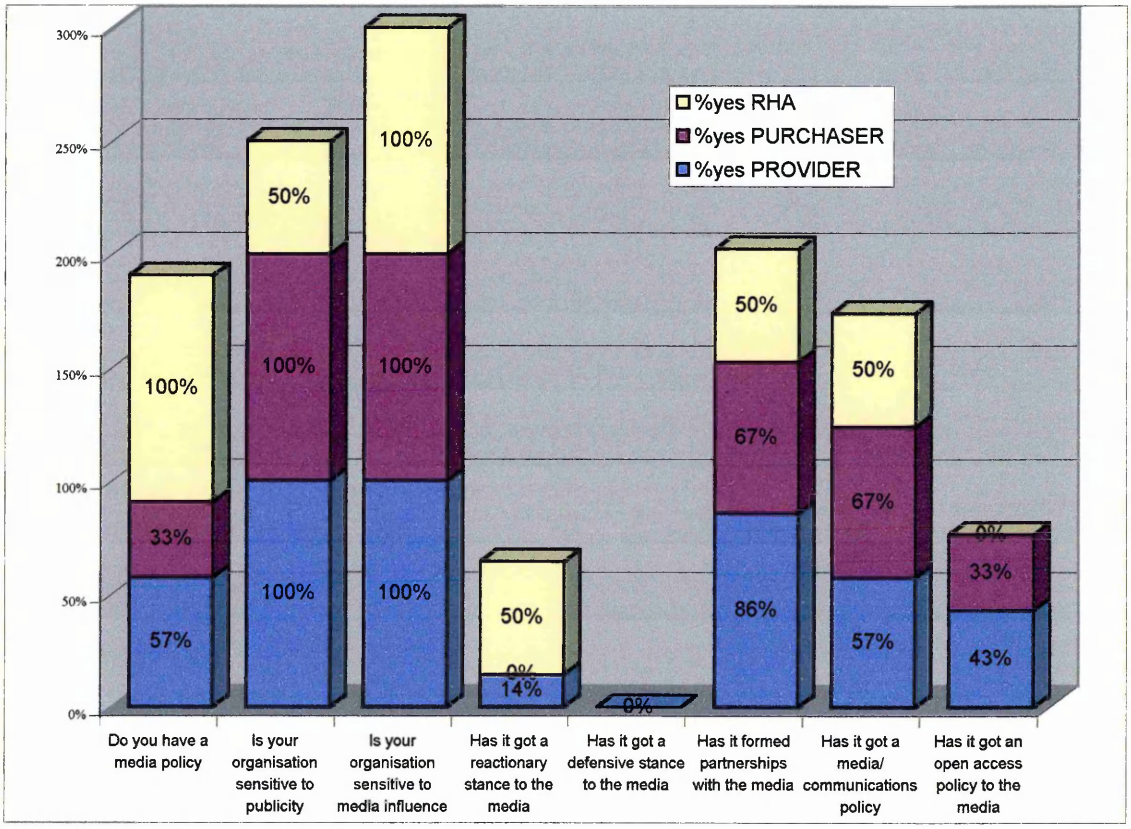
As demonstrated in Figure 40, the priority of details and subject matter of the information needs of General Managers have changed. More of the General Managers required more information than they did in the past (Table 10). The General Managers' responses to changing information demands indicated that their needs reflected the pressures upon them from the environmental influences within which they worked. They work in a business-orientated climate, where the monitoring of performance is part of their environment, and their information needs reflect that situation. As a result of this climate, and its assumed continuance into the future, they expect their needs to become more complex, focused and requiring increased accuracy as the healthcare environment changes.

Moving Information Needs

The General Managers' response to moving information needs has been to engage many of the stakeholders of the organisation in regular dialogue so that information can be exchanged freely. Those meetings have characteristics and content that reflect the needs of the participants. Table 12 shows this breakdown by major stakeholders. Clearly, the General Managers responded to moving information needs by prioritising those needs. That prioritisation discerned business orientated needs as being the most important. However,

despite the amount of communication General Managers had with their major stakeholders, i.e.: Clinicians, GPs and patients, other stakeholders, namely, the DoH, Purchaser and Regional Executive organisations had equal influence on the General Managers as their other major stakeholders (Figure 46).

Figure 59: The Organisation & the Media[69]



The Responses to Changing Balance of Power

The General Managers recognised that their information needs had been influenced by the changes in the balance of power within their organisations and in particular the influence exerted by contract performance, Purchasers' demands, Charter performance and income-expenditure. The next most influenced needs were outcomes, health information targets and service planning. However, for the General Managers, responses to the changes in the balance power were more difficult to identify. The General Managers recognised the Clinicians as powerful influences today and into the foreseeable future. However, they know that the patients, GPs and Purchasers are improving their position of influence. The General

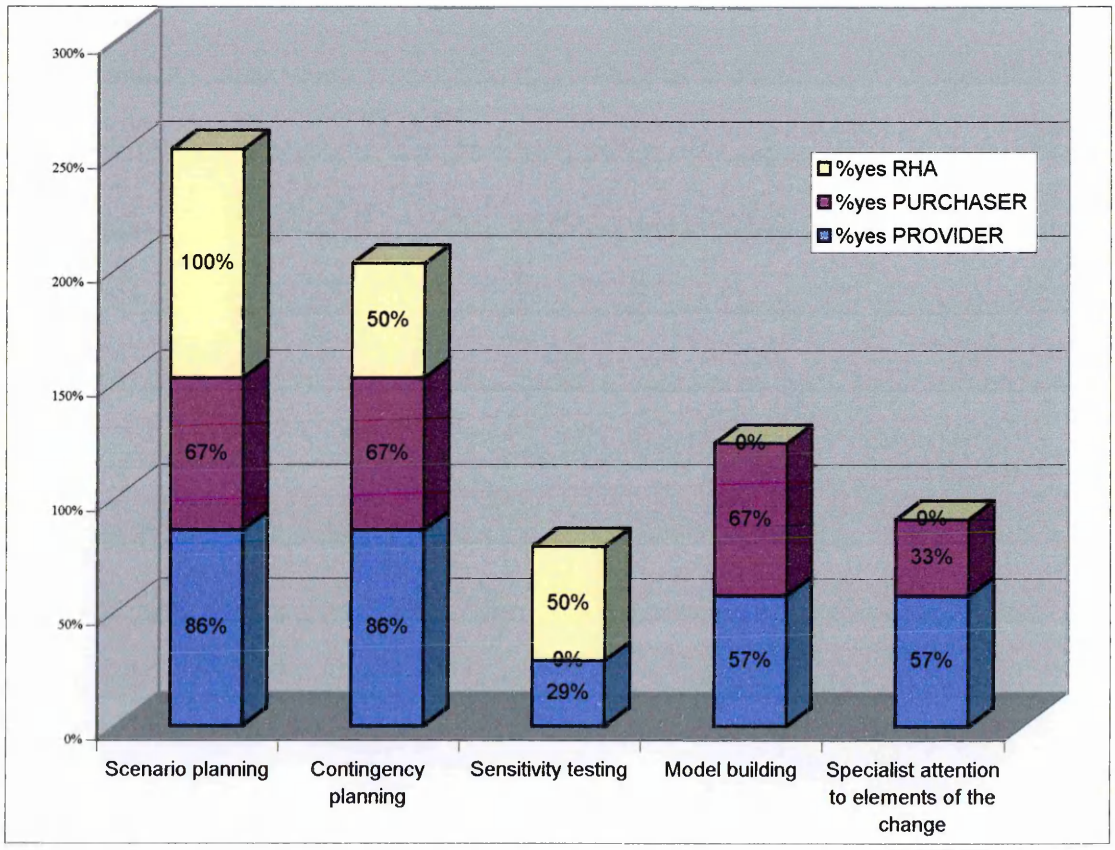
[69] Figure 59: The Organisation & the Media Q24,25, &26: Table of Results

Managers' responses to this appear to show recognition of working in co-operative partnerships with Clinicians, (Figure 25) and improving their co-operation with patients. There was little indication as to whether these responses were a direct result of environmental-organisational pressures on all parties to succeed or whether it was an outward sign of stakeholders jockeying for position.

How do General Managers Cope with Environmental Change

The General Managers were asked how they coped with environmental change. Analysis of the results (Figure 60) indicated that the majority coped; using scenario planning followed by contingency planning and model building. It was noted that sensitivity testing was the least favoured option.

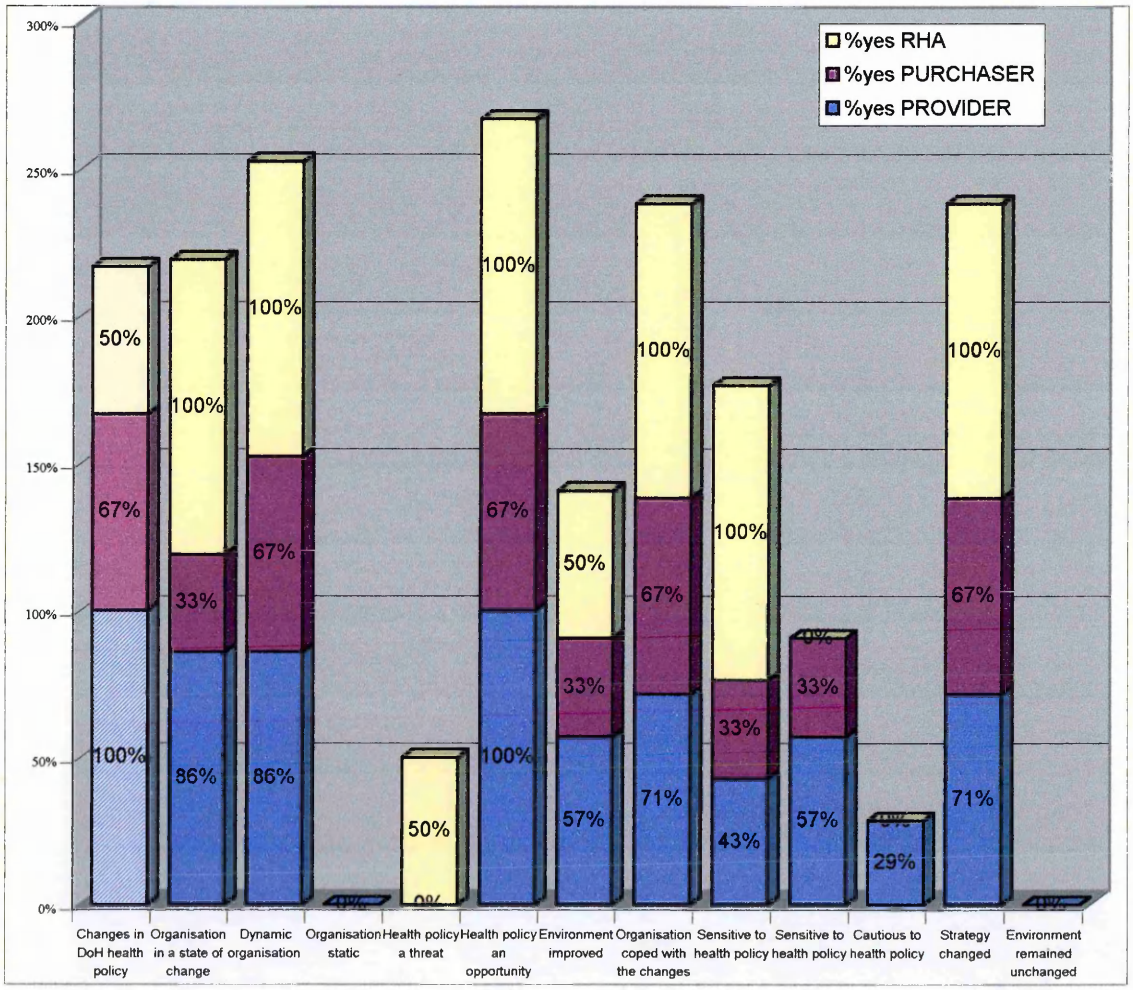
Figure 60: Coping with Environmental Change[70]



[70] Figure 60: Coping with Environmental Change Q20: Table of Results

The General Managers were asked if their managerial values had changed, as a result of changes in health policy; all believed that they had (Figure 62). They believed that their aims and objectives were of paramount importance followed by decision-making, training, development, and sensitivity to customer demand. That finding was not unexpected when analysis of the data shown in Figure 61 indicated how responsive the organisations appeared to be to changes in DoH healthcare policies. Figure 61 showed that the majority of the General Managers believed the environment of their organisations to be responsive to changes in DoH healthcare policy.

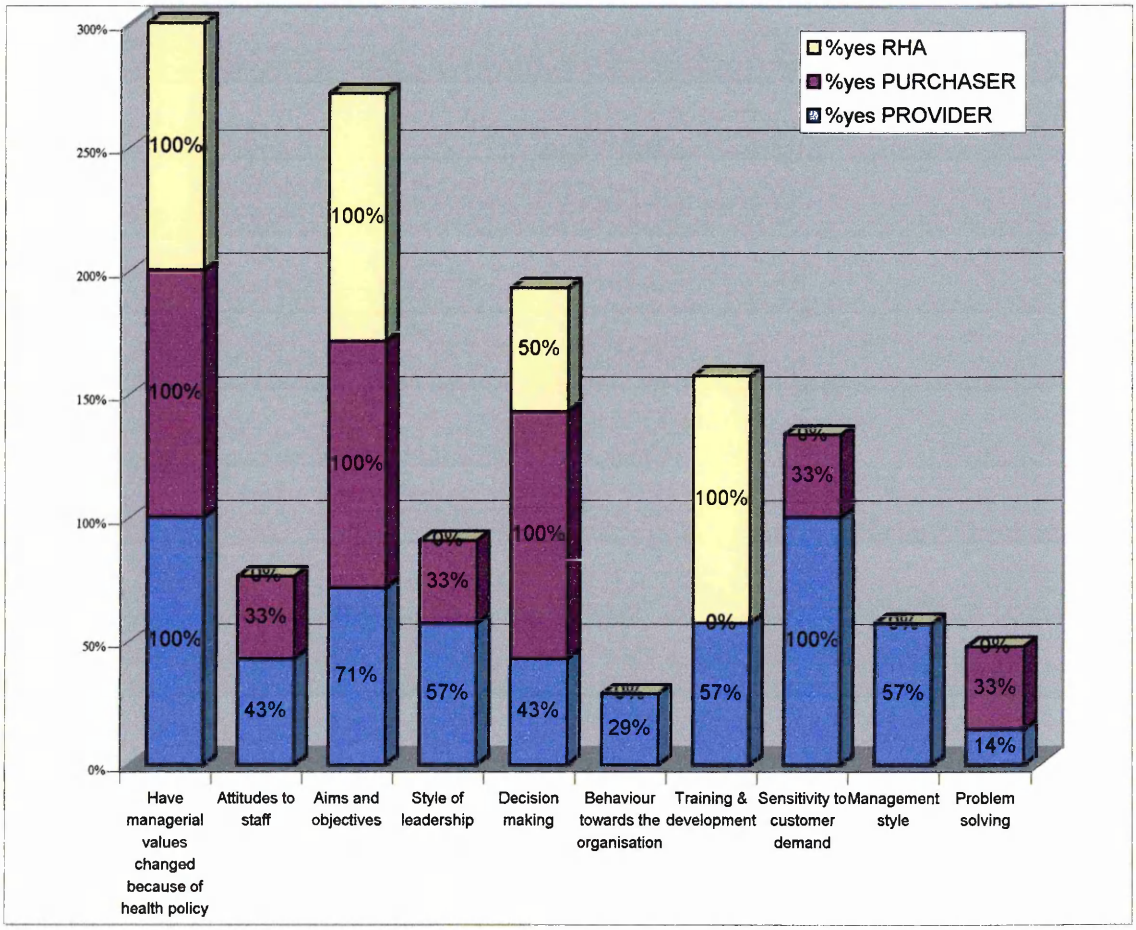
Figure 61: Responsiveness of the Organisational Environment to Change[71]



[71] Figure 61: Responsiveness of the Organisational Environment to Change Q19: Table of Results

Further analysis indicated that the majority of the General Managers believed their organisations to be dynamic, in a state of change, viewing health policy as an opportunity and coping with the changes brought about by the healthcare policies of the DoH. They also believed their organisations to be extremely sensitive to healthcare policy and reflected a majority view that strategy has changed in response to changes in healthcare policy.

Figure 62: Changes in Managerial Values[72]



Knowledge Management

To apply knowledge management successfully, the General Managers need to be able to address the changes occurring in their work environment and information needs and direct that understanding to improving healthcare services for their patients. The challenge for the General Managers is to turn the complex and large amounts of information in their environment into something that not only makes sense to them, but also enables them to

[72] Figure 62: Changes in Managerial Values Q21:Table of Results

improve their working environment that in turn improves the prospects for better healthcare. An important aspect of knowledge management is making relevant information available to all in a useable form at every level throughout the organisation. This aspect can be seen from the analysis of the General Managers' responses to the questionnaire, as at the heart of knowledge management is a simple notion that everybody in the organisation should be able to access the information they need, wherever it happens to reside. Just as importantly, the notion becomes an act of faith on the part of the employee that they will share the information that they have obtained with others.

To appreciate knowledge management the General Managers need to understand the complex history of information technology. However, the healthcare services by tradition have been run through information systems that are sets of databases; but fragmented into separate ones for personnel, patient services, order processing and accounting. Very often during the General Managers' working day it was impossible for them to take a direct look into another computer system within the organisation. This problem occurred because technically their computer systems could not communicate with each other and when they needed information from neighbouring and competing organisations, it was virtually impossible to ascertain the relevant information they needed because of excessive secrecy. Analysis of the General Managers' views indicate that the World-Wide Web, albeit highly regarded by laymen as a source of knowledge, had not been mentioned as a possible vehicle for developing cohesive and accessible information systems. Knowledge management embraces existing technologies from group work-to-work flow and document management, and puts it under a new healthcare orientated banner based on Internet technologies. As a result, the corporate knowledge of the organisation should become available to those who need it. A crucial element to knowledge management is that General Managers in the organisation buy into the idea of sharing information at every level. The General Managers within their organisations that have tackled information management policy successfully should be able to point to commendable productivity and efficiency benefits in the end. It is a potent competitive tool for a new, even more competitive healthcare environment. Healthcare empowerment to the individual, albeit "a holy grail" which was part of the objectives of the changes that have taken place in the NHS over the last few years, was not seen by the majority of the General Managers as having reached the patient or the individual nor in helping them to decide their healthcare needs.

Effects on Decision Making

It is clear from the analysis (Figure 40, Figure 41, Figure 43, and Figure 44) that the General Managers have had their information needs shaped by varied and powerful influences and that they are required to satisfy those needs in order to do their job successfully. These influences range from their insight into the environment of their organisations and the type of organisation for which they work, to the power of the stakeholders in making demands and applying pressure to that manager. An example of this stakeholder power is the General Managers' perceptions of the Clinician as being still the embodiment of power when it comes to influencing any healthcare organisation. External stakeholders, such as the HAs, GPs, Regional Executive organisations and the DoH, provide other influences.

The General Managers acknowledged (Figure 45) that those pressures had changed their information needs in that those needs had become more complex and business orientated, requiring sophisticated communication links and equipment. Analysis also indicated that the business-orientated influences, as part of the drive to improve performance monitoring, have improved the priority given to patients' influences and their healthcare needs. The General Managers are beginning to address those influences of patient demands, demands being made by external stakeholders such as local communities, patient carers and patient representatives, by measuring the quality of outcomes generated through clinical audit. This is because the General Managers have a need to provide evidence of improving quality of service through monitoring performance.

However, the only information available within the analysis on the effects on the decision-making of the General Managers is related to their views on priorities of resource allocation as shown in Figure 65. Figure 65 also indicates that the General Managers' views relating to their information needs, and changes brought on by the influences described previously, have been moved in a similar direction.

The Freedom of the General Managers to Make Decisions in the Present Environment

The General Managers believed that they had to make decisions in cognisance of the present healthcare climate as the introduction of legislation and contracting has reduced their freedom to move resources within the system in response to identified needs at Provider

level. However, devolution of budgets within the organisation gives local managers freedom to make limited decisions. Those local freedoms are further restricted by the external and political environmental constraints. Performance management is a strong control mechanism on organisations and these controls can appear to make freedoms very restricted. Orders from the "centre" continue to deluge the organisations and all action seems to have short-term political objectives.

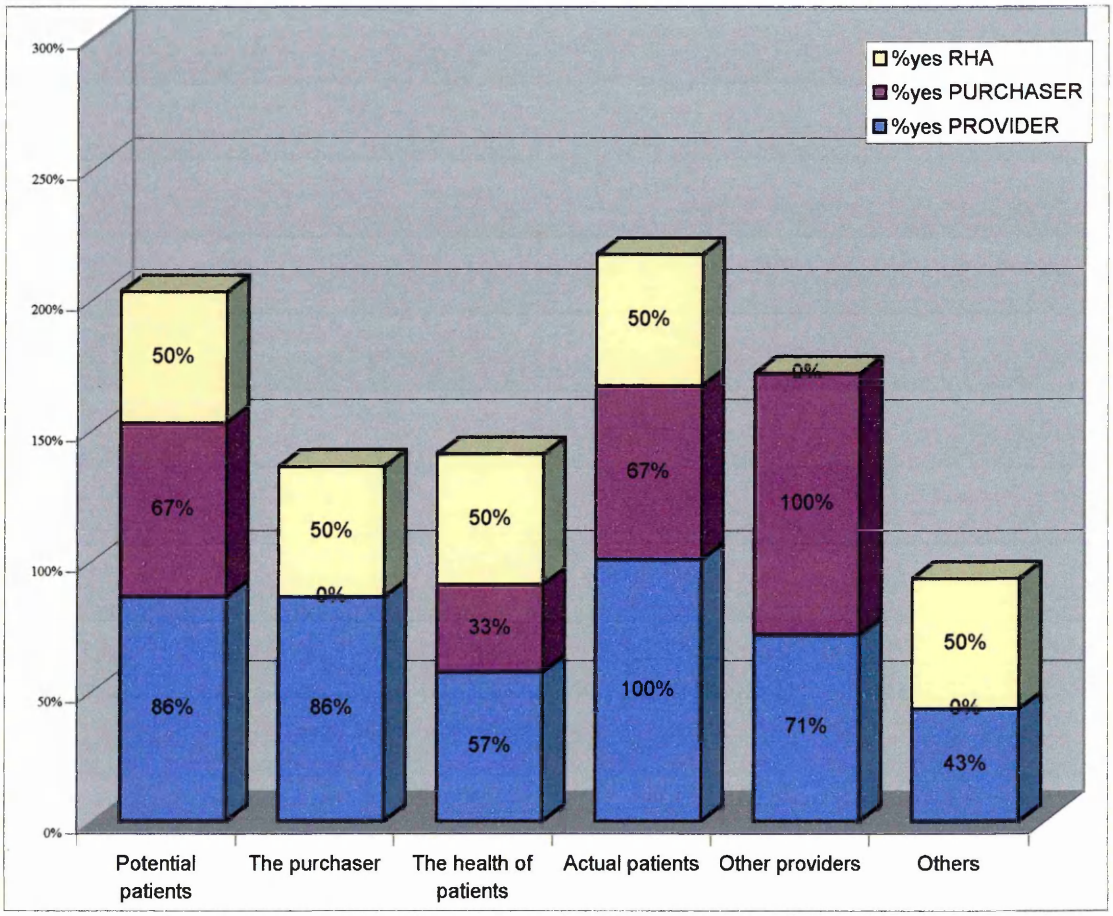
It was felt by General Managers from the Provider Organisations[73] that good General Managers could have sound influences on healthcare in the present environment, but that limited finance could be a constraining influence, whereas contracting processes, Charter standards, the demands of GPs and Purchasers and clinical considerations have the potential to impose constraints.

The General Managers from the Purchaser organisations indicated that the range of freedoms varied according to context, and where they sit in the organisation. The constraints on the General Managers, in the form of contract, DoH and organisational policies, the HAs' strategic framework and policies and resource constraints would heavily influence their freedom to manage. The Regional Executive organisation General Managers felt that their freedoms to make decisions had to be seen at the micro level of healthcare provision and that they did not influence the macro healthcare policies.

The Effect of the General Managers' Decision Making on Empowerment of the patient

Analysis of the General Managers' responses to the questionnaire, the results of which are shown in Figure 63, sought to identify whether the General Managers believed that their decision-making had a direct effect on the patients either in the hospital or upon those who may be potential customers of the hospital in the future, and whether decision-making by them directly affected Purchasers and how decision-making affected other Providers. Also, it was sought to discover whether decision-making empowers patients in maintaining their health or how managerial decision-making improves the health of the organisation's customers and determines the healthcare they actually need. The majority of the General Managers believed that their decision-making directly affected the patients, potential patients and other Providers (Figure 63).

Figure 63: The Direct Effect of Decision Making[74]



Even though less than a majority of the General Managers believed that the Purchaser organisations were affected, this minority view owed its existence to the Purchasers not having a view, otherwise the General Managers from the Provider and Regional Executive organisations viewed their decision-making as having a direct effect on the Purchaser organisations. The General Managers clarified their minority selection of "others" as a direct effect on social services by stipulating carers and the work force. Other groups and organisations directly affected included GPs and GP Fundholders, local authorities and the DoH.

A majority of the General Managers believe that their decision-making affects empowerment, (Figure 64) and that the empowerment of patients both present and future to influence their healthcare was directly affected by their decision-making.

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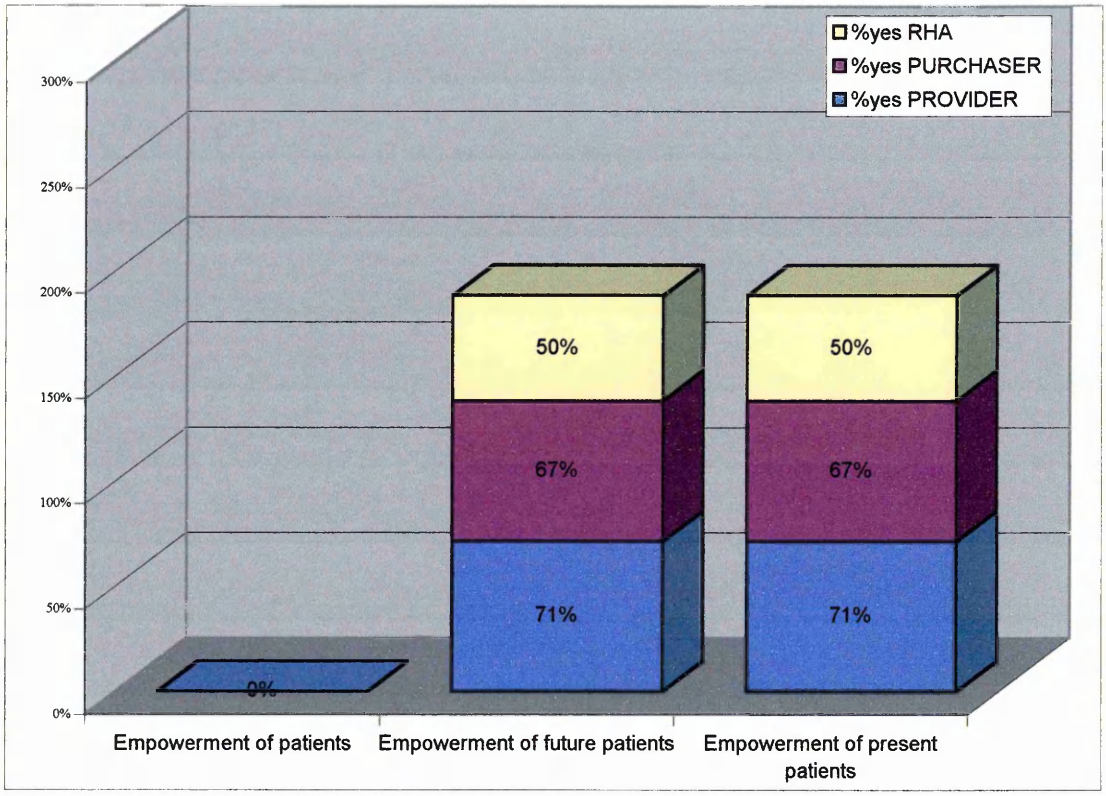
[73] Appendix III: Qualitative responses to Questions

[74] Figure 63: The Direct Effect of Decision Making Q 35: Table of Results

Figure 64: The Direct Effect of Decision Making on Empowerment[75]



In the General Managers' day-to-day working, the majority believed that their decision-making had a direct effect on the patients and to a lesser degree on potential patients, Purchaser organisations, the health of patients and Provider organisations. Overall, they had a positive opinion about the way in which their decision-making affected the patients, the empowerment of the patients and other organisations associated with their own.

Example of Resource Allocation Priorities

Prioritising resource allocation is an every day decision-making activity for the General Managers and analysing how they prioritise will lend support to the views they expressed on the influences affecting their decision-making and the choices made. The General Managers prioritised how they would spend their organisations' resources, assuming that they have only finite resources available to them. The subject matter that they had to focus on is listed below:

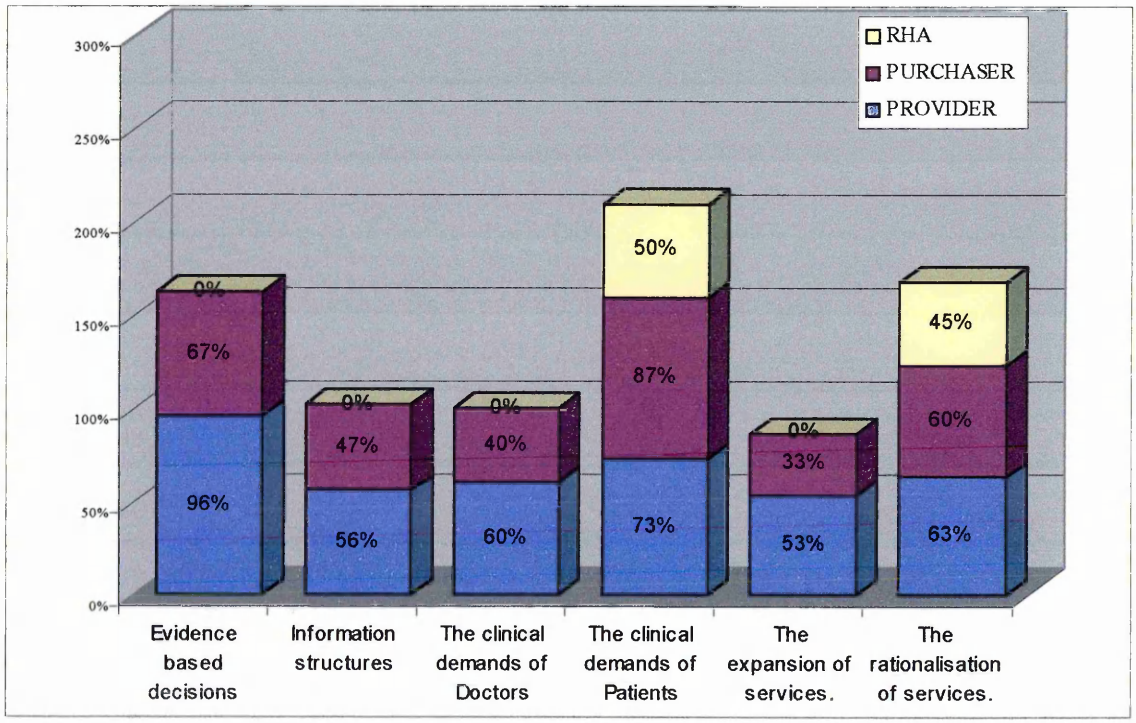
- Evidence based decisions

[75] Figure 64: The Direct Effect of Decision Making on Empowerment Q37: Table of Results

- Information structures
- The clinical demands of doctors
- The clinical demands of patients
- The expansion of services
- The rationalisation of services

Not all the General Managers completed this question. As noted at the beginning of this chapter, responses to questionnaires can be varied depending on the circumstances of the interviewees and their environment. Reasons given by the General Managers related to their understanding of the question and the relevance they attached to its importance to their organisation.

Figure 65: Results: Priority Given to Resource Allocation.[76]



The General Managers' views on their priorities of resource allocation are shown in Figure 65, this indicates that the clinical demands of patients followed closely by the rationalisation of services gained the high priority for resource allocation. Evidence based decisions came a close third. Only a minority of the General Managers supported the other priorities. It is noteworthy that if the General Managers from the Regional Executive organisations are

[76] Figure 65: Results: Priority Given to Resource Allocation. Q62 Table of Results

excluded, then the priorities of the other two groups of General Managers are very similar in that evidence based decisions and clinical demands of patients have the highest priorities both as groups and individuals. This result underlines the understanding that evidence based decisions, talked about for many years, is being used in practice within the organisations. Clinical demands of the doctors are not viewed as a high priority for General Managers, nor were the expansion of services and information structures. It is interesting to note that knowledge management should form the basis for all successful organisations. However, the General Managers place a low priority on information structures for resource allocation.

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Summary

The research sets out to enhance the body of knowledge required to develop a way forward for information management within the NHS, by developing a better understanding of the General Managers' perceptions of their information requirements and how they use that information to develop their roles in improving the patients' ability to satisfy their healthcare needs and, to fulfill the gap between the theory and practice of information management by the NHS General Managers.

The NHS, as a group of organisations, has an abundance of information and yet has difficulty in evaluating information for the purposes of determining its success factors. Over the last twenty years, the NHS has developed a number of indicators, which have been used to demonstrate its performance. These indicators ranged from the number of beds in use; quality outcome indicators; to clinical outcomes. In response to the policies of the previous 1979-1997 Government, the organisations within the NHS initiated a series of reforms, which moved the healthcare environment towards one in which "market forces" influenced the type and cost effectiveness of the services provided.

It was within this healthcare environment that the aims of this research were developed, the purpose of which was to explore the possibility of developing a model of information needs that would allow a judgmental view of an NHS organisation's performance. The hypothesis of the research asserts that it is not possible to link a market-led healthcare environment, General Managers' attitudes and behaviour, patient empowerment and the information needs of the General Managers in such a way as to develop a model of information needs that was common across Purchasers, Providers and the NHS Executive organisations and thus develop Key Success factors. The research analysed the information needs of the NHS General Managers from Purchaser, Provider and NHS Executive organisations and their understanding of their roles in the General Manager/patient/doctor relationship and how they viewed their responsibilities and accountability for the patients' interests. These roles, responsibilities and accountability and the influences exerted on the General Managers' information needs were explored. The research also analysed the potential areas of conflict arising when the patients' interests clashed with the Market-led (business) interests of the healthcare organisations, the changing environment within which the NHS operated, and the diverse needs of the Provider and Purchaser orientated General Managers. It also analysed

the potential areas of conflict arising when the patients' interests clashed with the Market-led (business) interests of the healthcare organisation. The research analysed the changing environment within which the NHS operated, and the diverse needs of the Provider and Purchaser orientated General Managers. Also examined was the attitude of the General Managers towards information; and the problems associated with identifying their information needs. These problems were examined for associated links with the difficulties that the General Managers experienced in defining their information requirements. An understanding of the effects of organisational resistance, organisational culture clash and system requirements and its effect on the information needs of the General Managers was sought.

The research addressed a number of questions about the changes that had occurred in the balance of power between the Consumer, the Purchaser and Provider organisations, the relationship between the role of the patient and the General Managers, the changes in the healthcare environment and how those changes had affected the General Managers' information needs. Other aspects of the research examined the General Managers' information requirements in a healthcare market environment, their attitudes and behaviour when making decisions and whether or not this environment had affected their decision-making. The General Managers' attitudes when making decisions were examined for associated links with the results of their decision-making and in particular, whether the General Managers' decision-making had assisted the patient to become empowered in enabling them to influence the satisficing of their healthcare needs together with the effects on the General Managers' information needs of the "continually evolving" stakeholder demands, and evolving organisational and environmental changes.

History of the NHS

The healthcare system, which had emerged within the United Kingdom, was a result of an incremental process of development emanating from the political decision-making process. Over the last 150 years the battle against ill health has been waged on four main fronts and in three overlapping phases. Initially, during the second half of the nineteenth century, emphasis was upon preventive measures and focused on environmental improvements such as housing and sanitation. Secondly, towards the end of the century a new trend in favour of a more personal approach to health with the protection and improvement in health of children took place. The early years of the 20th-century saw improvements in the medical sciences, and the

ever-growing use of drugs and the application of technological advances to tackle ill health. The third phase dated from the introduction of the National Insurance act, 1911. This provided increased access to health services for the population and paved the way for the enactment of the National Health Service Act, 1946.

Throughout the years leading up to the Second World War, the idea of a fully-fledged state health service was increasingly gaining favour in both the medical and political circles. However, the decisive event in the evolution of the Welfare state and the subsequent formation of the NHS was the Second World War (Bruce 1979). However, it was not until 1942 that the Beveridge report (1942) became the first statement of policy on social security and allied services. Two years later as a result of this report a White Paper (1944) proposed a free health service available for all, administrative areas based on joint local healthcare authorities, and health authorities that would incorporate voluntary Hospitals with local health authorities which will also run health services and health centres, and the general practitioners service which would remain independent would work under contract for the state health service and receive payments of capitation basis.

From 1979 successive Conservative Governments introduced into the NHS many managerial practices previously felt to be the province of the private sector and generally regarded as being inappropriate within a public sector context. The reasons given for the change in managerial purposes within the NHS from 1979 onwards, was embodied in the criticism of the political policies developed in the consensus years and criticism of the fact that achievements in the NHS had been modest in that the rate of improvement was no better than that achieved in the 1930s.

The Changes

By 1982 changes, which resulted in the reduction of the administration within the NHS, had been applied. There were annual reviews of the performance of Regional Health Authorities (RHAs) and from 1983 onwards performance indicators were informing these reviews, which were in turn reinforcing the importance on policies on priorities for enhancing upward accountability. In 1983 general management was also brought in to replace corporate and consensus decision-making in order to increase effectiveness and ensure that expenditure reached its intended target and that the management of the health service was geared primarily to the needs of the patient. By 1985, efficiency was the underlying rationale of

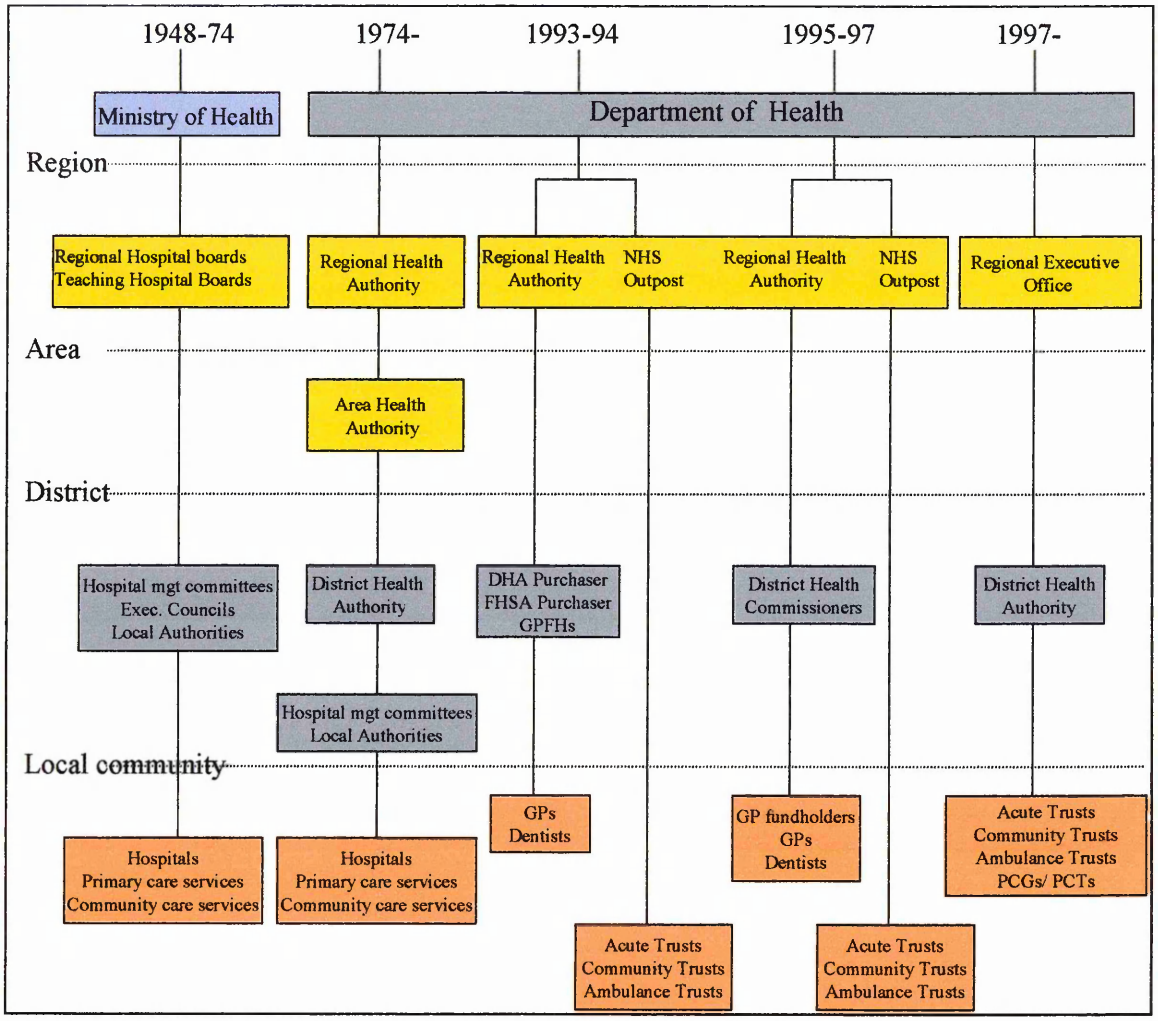
competitive tendering, which in itself, was seen as a way of securing cost reductions. However, by the election of June 1987 the NHS was again a major issue, as the service continued to be plagued by financial crises of major proportions. Increasing pressure, from both within and outside the NHS, prompted the government of the day to announce another review of the services. The findings of the review revealed in January 1989 contained a mixture of radical and consensus measures. The most radical proposals were to enable hospitals to manage their affairs independently of the health authorities of which they were part and to give GPs budgets, which they could spend on purchasing care for the patients. In April 1991, the recommendations of the review came into effect. To achieve the objectives of the proposals, some major changes were made to the organisations of the NHS from 1991 onwards. In particular, HAs and some GPs became purchasers of healthcare for their local populations and the local hospitals became providers of the services.

The Structure of the NHS

The management structure of the NHS has seen extensive changes since its conception in 1948. These changes are summarised in Figure 66. Essentially the NHS structure has had two tiers of management between the GPs, Hospitals and Community services and Government departments responsible for running them, with the exception of a short period from 1974 when a third tier was introduced, the Area Health Authority. Until 1994, the organisations that provided the services did so under the direct guidance of the tiers above them. However, from 1994 onwards changes that were more radical were implemented in the NHS. These changes conferred on Hospitals, GPs and Community services more independence in the type of services that they could provide and the tiered management organisations above them became monitors and purchasers of the services for the local communities. It was during this period 1995 to 1997 that RHAs and NHS Outposts were transformed into Regional Executive offices becoming extensions of the civil service, and DHAs and FHSAs were transformed into Commissioners of healthcare services.

In 1998 as a result of the incoming Government, a health service White Paper (1998) produced a blueprint for further changes in the NHS. In essence, instead of the internal market of the 1990s, there would be integrated care, founded on partnerships, and the overall provision of primary Care catered for by the development of PCGs in place of GP Fundholders and community Trusts.

Figure 66: Changes in NHS Structures 1948-1997



A Historical Financial Perspective

It was believed that, once the backlog of illness that existed up to 1948 had been cleared up, the level of illness would settle down into a steady state, and that the cost of the NHS and the demands on it would reduce in time. In reality, this has not happened as the population has grown by 14%. Nearly half that growth, about 4.3 million, has been in the age-group 65 years plus, who need far more healthcare per capita than the rest of the population, and within that group the number aged 75 years or over has been more than doubled. New technologies for diagnosis and treatment have been introduced, and improved the level of services given, and the demand for treatment has grown steadily to take up that service. By the early 1970s it was recognised that the NHS suffered inequalities of provision of service across the country and the action taken intended that the inequalities would be eradicated within a ten-year period. This was unsuccessful and in 1974, the first reorganisation of the NHS came about together with the Resource Allocation Working Party (RAWP). As a result

of the RAWP formula, the distribution of capital funds from 1977 to 1980 onwards was significant in that it gave each RHA a Capital allocation within which it had to work. Thus the NHS has gradually changed from capital-led resourcing, to a service needs-led and population served resourcing, on to a mixture of resource funding based on the RAWP formula, service outcomes, performance, efficiency savings, and a market-led general management ethos.

Changes in working practices

In 1991 the market-orientated reforms of the then Government started to have an influence on the way in which healthcare was delivered from the perspective of the professionals. The market-orientated environment within the NHS saw a large number of GPs become Fundholders, responsible for purchasing and providing healthcare for their patients. The Clinicians within the hospital setting saw these changes as a threat to their clinical independence. The General Managers within the Provider organisations found themselves under scrutiny with regard to the performance and effectiveness of their organisations. Current Government thinking has moved away from the notion of independent GPFHs towards PCGs that build fundamentally on the best of GPFH ideals, and brings together all GPs into powerful consortiums, which will fund, direct and purchase healthcare for their patients.

Managing Information Within the Health Service

The quantity of information available to organisations within the NHS has continued to increase over the years and the need to consider total information resource management, together with external and internal information are beginning to be seen as a very important function by General Managers to inform the strategic planning process. Clearly the General Managers have recognised that in the past, NHS organisations sought, retrieved and worked on information that was both expensive and not what they wanted, because their needs were poorly defined and lacking in clarity of purpose due to the absence of corporate objectives. Equally research and consumer survey data have become very important to all the General Managers, in their fight for survival in the "internal market" of the NHS.

Information Needs

The review of the research literature suggested that the root of the problem of identifying information needs, and the way in which the General Managers satisfy those needs and the resultant "information seeking behaviour" is the concept of information needs itself. Research indicates that need is considered to be a subjective experience, such as, for example, hunger and thirst, curiosity and sensory stimulation. An aspect of this "need" and associated behaviour is the concept of motive which plays a part in information seeking behaviour since it assumes for whatever reason a person experiences an information need and as such there must be an attendant motive actually to engage in such behaviour. As a result of these concepts, various categorisation of information need have been produced such as; the need for new information, the need to elucidate the information held and the need to confirm information held. The review of the research literature also suggests that when the individual is driven to seek information as a result of needing to know, all modes of questioning behaviour are exhibited, for example: to discover what is happening; to check that the person is on the right track; to form an opinion; or solve a problem and build on the knowledge of the subject. One of the elements of the problem of identifying information needs of the General Managers in addition to those described above and highlighted by the research was the effects of the rapidly changing environment in the NHS, the attitude adopted by the General Managers to the information received, the effects of the involvement of the NHS stakeholders, and the evolving organisational culture. However, contrary to expectations, the research indicated that the General Managers had a clear understanding of the environment in which they worked and the information required to meet their objectives.

Methodology

Issues of Competence

The pilot study addressed issues of competence and tested the design of the instrument of the research. The issues of competence identified were: the chosen methodology and the questionnaire; perceived attitudes of the managers to questionnaires; the impression that the researcher made on the interviewee and the quality and style of the questions. The evaluation of the pilot suggested that the aim of the methodology and presentation chosen was to create an air of credibility and thus encourage the interviewee to respond positively to the questions

presented to them, addressing the issues of comprehension of the interviewee to the purpose of the questionnaire and research.

The Methodological Issues:

(Ways in Which the Problems were Tackled)

The research sought to identify the information needs, the critical success factors; environment and culture; the key performance indicators of the General Managers and to provide an identifiable workable framework from which the General Managers could make the choice of information needs to meet their aims and objectives. The difficulty with any methodology is that it has to be able to cope with the complex, sometimes confusing, and abstract responses from the General Managers. The challenge was one of finding the methodology that would take into account these "real world" influences and help identify a framework of needs; a root definition of the organisations and the General Managers' requirements for their business and organisation. In selecting Multi-view methodology, which took into account all the arguments, as described by Avison and Wood-Harper (1990), the researcher recognised the arguments put forward by Mintzberg (1973) on the real world activity and also accepted that the methodology would have to be able to react to different organisational environments. Soft Systems Methodology, such as multi-view provided both a flexible approach and offered alternative contingencies as a result of the organisational culture and environment in which it was applied.

The Principle Methodological Approaches

The research was concerned with studying specific characteristics of the population of the particular point in time. The principle approach used in the research was qualitative and quantitative as the aim of the research was to identify and analysed specific characteristics of determining associations of need and requirements, with behavioural and environmental characteristics. The research employed three research methods, namely interviews, postal questionnaire and documentary analysis.

To ensure the validity and reliability of the research the small-scale pilot study explored with a small sample of the General Managers, their attitude to the proposed questionnaire and the research proposal. From that study, the framework of the questionnaire for the interviews

was completed. The pilot study enabled a framework to be developed that employed a flexible approach to the interviewee when being interviewed during the research programme.

The Methodology used as part of an action plan (research plan) developed to enable the researcher to manage the project in a timely and efficient manner, employed the designed questionnaire consisting of 70 questions, targeted each of the selected General Managers with an introductory letter, questionnaire and supporting information providing the interviewee with background information to the researcher, the research proposal and its aims and objectives. This letter was followed up by a phone call to confirm their support for co-operation in the participation of this research and to arrange the interviews and for completion and return of the questionnaires.

Analysis of the responses to the questionnaire identified from the General Managers' perspectives, the environment in which they worked, the type of decisions they made, how those decision-making processes needed information, and how those needs reflected on the General Managers. Through analysis of the General Managers' responses, an understanding of the decision-making and information needs, were put in context with their environment, attitudes, roles and relationships with other professionals, stakeholders and colleagues. A cultural web was developed illustrating their decision-making strategies in association with their style of management and links with the environment and culture of their organisations. Also an understanding of the information relating to the General Managers' views of consumerism in the NHS and whether the changes within their organisations had empowered the patients in their pursuit of good health, or recovery from ill health.

The General Managers' Concept of Information in the NHS

The hypothesis of this research is that there are no links between organisational climate, management attitudes, behaviour, the working environment and patients' empowerment to the information needs of the General Managers. Therefore, a model of information needs for the General Managers cannot be identified. Part of the testing of this hypothesis was the identification of the understanding that the General Managers had of the concept of information in the NHS.

The General Managers understood what constituted a market environment and its changes with its core features of openness to competition, cost effectiveness and efficiency. They

understood the attributes of the core service that reflected ease of access, quality and responsiveness to its customers' needs. The majority of the General Managers believed that the NHS was a managed market that was continually changing, a mechanism for change and where "market forces" enhanced the effects of consumer pressure. The majority of the General Managers believed that the NHS market would continue to evolve and their perceptions of these key areas of change was from an environment evolving as a result of influences brought about by clinical developments and GP Fund holder demands, to one shaped by the clinical demands and priorities set by the PCGs. They foresaw partnership working, the integration of services, long-term contracts, wider involvement, opportunities to meet needs, and collaboration. The General Managers believed that the changes involving purchasing power, outcomes, effectiveness and competition had taken place along side the development of performance monitoring for many aspects of the NHS. They also believed that as the healthcare market continued to evolve, the way in which the organisations adapted was to be flexible, employing a better use of technology, and reorganising to meet the challenges.

The Literature research indicated that many authors considered consumerism to be a 20th-century philosophy that described the buying and selling of goods and services, and that by its very nature was affected by the relationship between the buyer and the seller. The General Managers' understanding of consumerism was that it was a way of doing business where the protection of the interests of the purchaser and the consumer (the patient) were paramount. They also expressed the views that finance came low in their list of priorities in the consumerist environment, even though further analysis indicated that the General Managers were business-orientated in their approach to their information needs and decision-making. However, they also believed that the NHS was not working in the consumer environment, but acknowledged that it should be, because in their view it, "the Consumer environment", would help the patients and give direction to the Purchasers. The General Managers acknowledged that both local communities and Provider organisations had social responsibilities within the healthcare environment in which they worked and that consumerism played its part in directing healthcare provision. However, the Provider and Purchaser General Managers continued to believe that they knew best as far as the provision of healthcare for the patients was concerned. This picture built up from the General Managers' views on "Consumerism" appear confused in that they believe the NHS is not in a Consumer environment and yet have indicated that consumerism plays a part in determining

healthcare provision for the patients. A possible explanation for this is that the NHS is a vast collection of semi-autonomous organisations that are at different stages of change in response to the influences of Politics and local Consumer pressure and therefore the General Managers have yet to clarify their processes of thought and responses to the changes. The Provider and Purchaser General Managers shared a commonality of thinking in that they identified the patients, the local community, GPs, HAs as their customers. They also identified other agents of the patient (the indirect recipients) such as Clinicians, Provider Trusts, potential patients, and Taxpayers. The General Managers illustrated their understanding of the market environment by listing competition, efficiency, cost effectiveness and a focus of the service towards customers needs, as core elements of the environment. However, even though they believed that the NHS should be in the marketplace for healthcare that was tempered by their belief that this market environment was actually a managed market and a sizeable minority of the General Managers believed there were better ways of managing healthcare.

Review of the comments expressed in the News media and Professional journals indicated that the enactment of the White Paper (1989) "Working for patients" in 1991 was seen by many of its supporters as a means by which the patient would be empowered in influencing the healthcare that they received. In assessing the General Managers' views on empowerment, the research sought to understand how they felt about empowerment, and what they thought the Clinicians felt about empowerment. Only a small number of the General Managers believed that the healthcare market empowered the patient and they believed that the Clinicians had an indifferent attitude towards "patients' empowerment". As an adjunct to these views on empowerment, their views were sought on whether or not income generation and healthcare free at the point of access were philosophies that were fundamentally opposed to each other with an assumption that this conflict would reduce the effects of patient empowerment. The majority of the General Managers (Figure 14) did not believe that this would be the case.

The General Managers' Views of their Roles Within their Organisations

The General Managers' views of their roles were linked to the relationships they had with their managerial colleagues, Clinicians, and patients. Those views in turn were influenced by their relationships with stakeholders and their views on the role of the local community providing direction for the provision of healthcare services. These relationships have

developed over the years towards co-operation and functional partnerships. As the NHS environment has changed and become business orientated, that relationship had strengthened the roles of the General Managers, in a positive way, by developing partnerships with key stakeholders. With those roles came responsibility and accountability, in that the General Managers believed that they knew what was best for the patients. Albeit that this view was strongly influenced by the General Managers from the Purchaser organisations. The style and culture, together with group influences of the organisations had a marked effect of the General Managers' perceptions of their roles within the organisations.

The General Managers believed that the influence of stakeholder groups within their working environment was a major factor that affected their information needs. The Clinicians group was seen as a most influential in terms of the General Managers' decision-making and that this group in particular would maintain its prominence. However, this prime position of influence would be challenged by the increasing influence from the patient, General Manager groups, Government and local political influences which were gaining ground as a result of the developing business environment. As a result of the White Paper (1998) "A new NHS, Modern and Dependable, DoH", the General Managers believed that the future influence in the provision of healthcare was likely to change, with the Clinicians remaining the most powerful of the groups, but with PCGs being able to exert a substantial influence as they developed as organisations.

The Changes in the Healthcare Environment and its Effects of the Roles of the General Managers

The General Managers believed that the NHS was being moved towards operating in a consumer environment and supported that move even though at present they felt that it was not in one. That move they believed had been occasioned by the implementation of healthcare policies from the DoH, bringing a business environment to the organisations. Those changes had also sensitised the organisations to their size and structure through value for money and efficiency reviews, while focusing to a limited extent on the manpower resources, and by becoming sensitised to the media and politics of the day. The General Managers believed that the effects of the changes were most evident in the financial, clinical areas, and the evolving roles of the General Manager in response to those changes.

The General Managers' View of their Information Needs

The literature review identified one aspect of defining the information needs of the General Manager as the effect of organisational resistance, culture and leadership style of an organisation on those needs. Although the General Managers worked to a code of practice with confidentiality, honesty, trustworthiness and resolution of conflicts of interest highest on their agenda, less than 50% of their organisations had a business code of practice in place. The General Managers believed that the cultural attitudes within their respective organisations had affected their organisations as well as their own information needs. They described this culture as a democratic or consensus style of management with a leadership style characterised by devolved responsibilities, collaborative in nature, and an analytical organisation that challenged beliefs and collaborated with other organisations.

The General Managers believed that their information needs today, compared with 1991 have changed, in that the need was more evenly distributed across the range of the information available; the numbers of the General Managers who had identified their needs had increased; that they were more readily able to identify their information needs; there was an increase in information needs across all the areas of information, and all the General Managers showed an increased awareness of the importance of information in achieving job success (Figure 39).

The General Managers indicated through their responses to the questionnaire a wide diversification of information needs. These differences appeared to be due to the differing remits of their organisations and the effects of the stakeholder groups within those organisations. However, there was some commonality of information needs such as in their business areas of work. Since 1991, the role of the organisations have changed, and as a result the General Managers have become more performance orientated with the achievement of financial targets, monitoring processes and "approval" ratings, featuring heavily in their "success factors". An aspect of achieving their "success factors" was their ability to make decisions as a result of having business information, clinical outcome data, and local health needs intelligence that was accurate and timely. A key factor for the General Managers was the ability to cope with changes in their information needs that arose as their organisational environment changed in response to their customers (patients/GPs/local population) demands and pressures. Their working environment had become more business orientated, with finance, contracting, and quality of service providing the focus for their increasingly

complex information needs. The General Managers shared a common understanding of those influences and the resultant changes; they believed that it was the Purchasers and the recipients of the services that provided the energy for the changes, but acknowledged that the clinical environment continued to maintain a big influence on their information needs. The General Managers held differing views as to the detailed causes of the changes. However they believed that these changes would continue as part of the culture of the NHS in the future.

The General Managers recognised the importance of satisfying their information needs and the actions they took towards filling their information needs involved a number of strategies. These strategies included meeting their key stakeholders, to discuss their (General Managers) information needs, whilst meeting the needs of the stakeholders. The subject content of those meetings was noted for its diversification, with communications and the business being the only common high priority themes.

Perception of Future Information Needs of the General Managers

In 1991, the Government sought to change the way in which the NHS responded to demands being made upon it and provided healthcare. The Government's drive introduced competition into the provision of care using the customer to control the influence by demand as in the private sector. Analysis of the General Managers' responses suggested that changes to their information needs had been moderate and mainly in the areas of increased "business information" needs. As discussed earlier, the General Managers believed that the empowerment of the patients, enabling them to decide their healthcare needs had not been affected by the environmental changes. However, even though analysis indicated that the General Managers believed that the Purchasers and the Clinicians continued to dictate the patients' healthcare needs (Figure 21), there was an increasing demand by them for information covering clinical outcomes, local population needs, patient Charter standard performance, and patient satisfaction data. They also acknowledged the need to involve the patient/patient representatives in discussions even though the patient was not viewed as the sole customer, but included GPs and Purchaser organisations. The General Managers envisaged a positive future for the involvement of the patients and patient groups in determining healthcare provision, in that they believed that consumerism as it became more influential within the NHS would empower the patients in their self determination of their healthcare needs.

As the Information needs of the General Managers have changed since 1991 to the present day, which they associate with key changes in the environment, so was the belief of the General Managers that their needs would change in the future. In addition to the Business information that had moved up in importance since 1991, the General Managers saw their future information needs as more supporting data, which included demographic, political, purchasing intentions and customer expectations as well as comparator data for income and expenditure, contract performance, benchmarking, performance of the business plan and "informal reporting mechanisms", similar to their present needs. The General Managers from Regional Executive organisations believed that information relating to an organisation's "character" and fabric was required.

Key Areas of Change

The key areas of change are linked to the formation of the Purchaser/Provider structure within the NHS. Contract and outcome targets had become the measures by which the provision of healthcare was judged. The Government with varied results had imposed efficiency targets on Trusts and Purchasers alike. Information needs were adapted to cope with these fundamental changes, as well as the changes in Research & Education strategies, and the mergers of DHAs and FHSAs, which formed combined purchasing authorities. The information needs identified by the General Managers showed that the demands made on them had become business orientated, with performance, contracting and finance leading the approach to monitoring the performance of the organisation and those General Managers.

Table 15: Summary of Figures 40-43

Figure 40: General Managers' Information Needs as a Group and by Organisation	Figure 41: What Does Being Successful Today Entail	Figure 42: Information Needed for Monitoring Progress in the Organisation	Figure 43: Information Needed to Hand for Decision Making
a. Financial	Finance targets	Formal reports	Income & expenditure
b. Corporate	Approval rate of users	Income & expenditure	Contract performance
c. Statistics	Contract targets	Contract performance	Purchaser demands
d. Business	DoH targets	Informal reports	Local pop^{N} needs
e. Clinical		Benchmarking	Healthcare outcomes
f. Textual		Business plan	

The General Managers expressed their understanding of their information needs in the form of prioritising those needs as shown in Table 15, with business information such as finance, contract performance and user approval having a high priority in their view of importance. Even though the General Managers gave a clear understanding of their information needs, only half of them received information that they were satisfied with and met their needs. In conclusion they provided a cohesive view of their information needs that was influenced by the demands of the NHS business culture and the clinical nature of the services they provided.

Tom Peters (1988) has argued that the benchmarks summarised below identify a successful organisation. Applying the General Managers' understanding of their information needs to this benchmarking (Table 16) indicates that their thinking in information terms bodes well for a successful organisation.

Table 16: Benchmarking a Successful Organisation

Benchmark	Tom Peters	Managers
Listening to customers and stakeholders	✓	✓
Coherent vision	✓	✓
Involved workers	✓	
Common endeavour	✓	✓
Customer responsiveness	✓	✓
Innovative approach to cope with faster change	✓	✓
Flexibility through empowerment	✓	
Culture love of change	✓	✓
Cost effective management structure	✓	✓
Information sharing with all employees	✓	
Power flow to the field	✓	
Need to act fast	✓	✓
Adapt fast	✓	✓
Destroy traditional functional barriers.	✓	

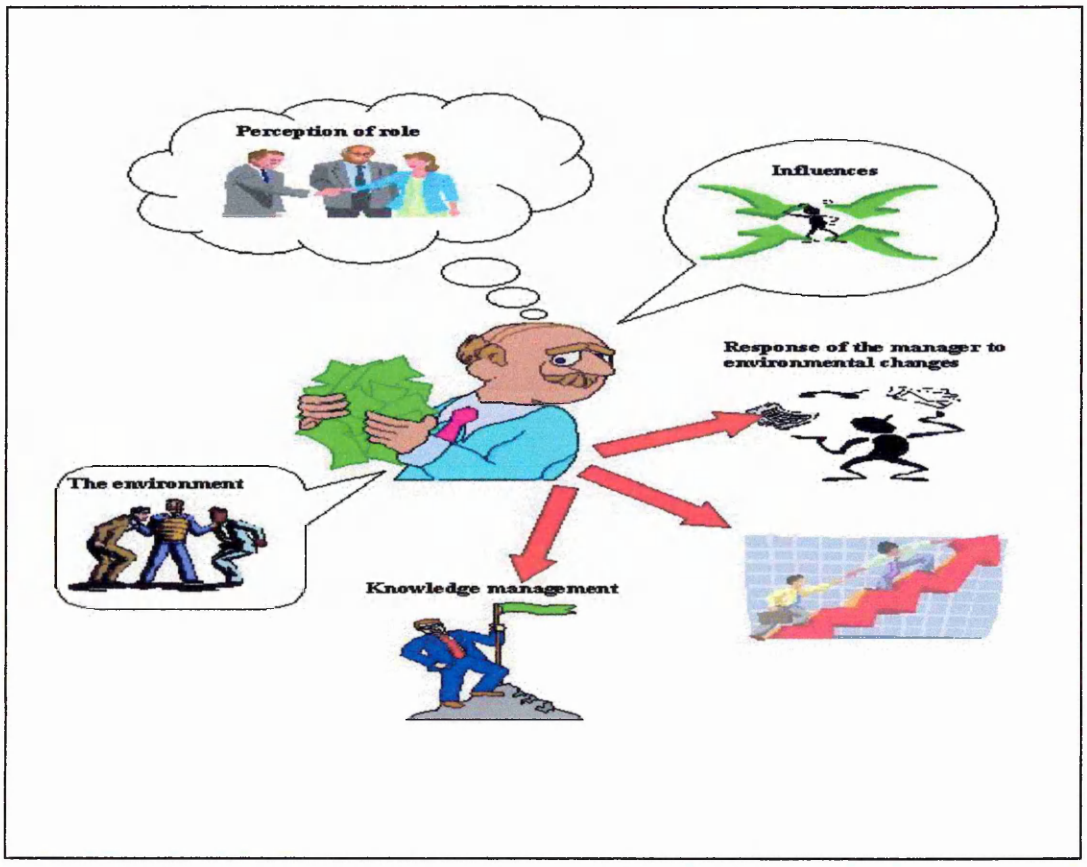
The General Managers' information needs (Figure 44 & Figure 45) have moved in response to changes in the healthcare environment, with the need to be more accurate, more focused but concomitantly more complex information. However, those needs appeared not to have been sensitised to the aims and objectives of their organisation, even though the General Managers believed that healthcare environment would continue to change and as their information needs moved to meet those changes, they, and their organisations would adapt to meet those changes. They also believed that the Provider and Purchaser organisations would take the lead in developing and implementing strategies of change with the Regional Executive organisations following in response to those leads. However, a minority of the General Managers suggested (Figure 11) that the environment would not change and that organisations would not be able to adapt as their needs changed.

To Understand how General Managers Work with Information

In analysing the General Managers information' needs, it was important to understand the work environment that influenced their information needs. The organisational environment of the General Managers (Figure 67) consists of a number of elements, which influenced the way in which they worked, behaved, and responded to the challenges within their organisations. These elements which all had some effect on the General Managers' information needs, consisted of their perception of their own roles, other people's perceptions of their roles, environmental influences within which they worked, their ability to handle environmental change and how they responded to those changes. Other elements

affecting the General Managers were the effects of their behaviour and actions; for example, meeting their organisation's aims and objectives, monitoring outcomes and how they managed their information and information needs; "knowledge management".

Figure 67: The General Managers' Organisational Environment



The General Managers' Perception of their Role

The General Managers worked in an environment that aspired to benefit the consumers, with a philosophy that put the interests of the Purchasers and the patients on a par. An important aspect of this environment and its role was the relationship with the General Managers' key stakeholders. These relationships have progressed from having a negative attitude, to the present-day where this relationship was a functional partnership with the managerial colleagues and Clinicians and a cooperative one with the patients. It was one that the General Managers believed would improve further in the future.

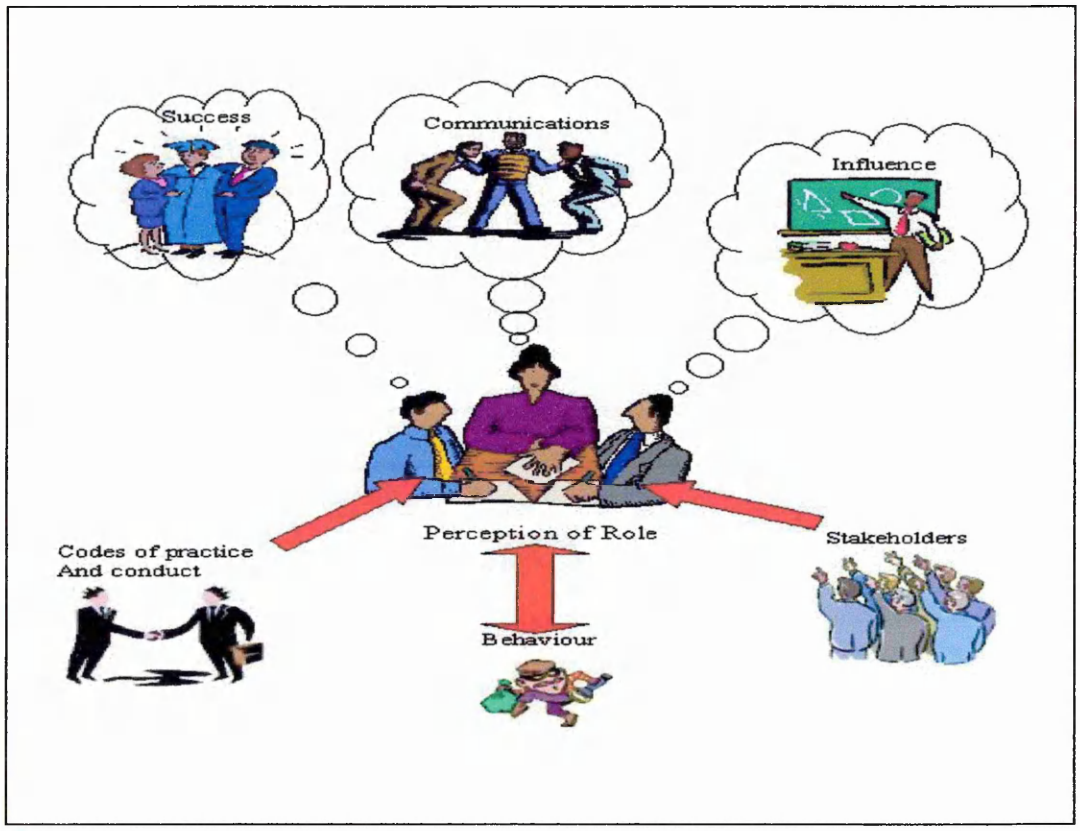
The roles of the General Managers have been affected by the increased influence enjoyed by the patients, Purchasers, the local community and the DoH. They believe that the patients and GPs have benefited most from this improved influence. However, the General

Managers' whilst acknowledging that the Clinicians remained at the forefront of the decision-making with regard to the healthcare needs of the patients, viewed the influence associated with their individual roles, as diminishing. This pessimistic view, however, was countered by the belief that as a group, the General Managers were maintaining their capacity to influence and was likely to improve in the future.

The General Managers believed that their ability to influence had weakened since 1991. However, they continued in the belief that they knew best about the healthcare that was needed for the patients, though recognising that this belief tended to subordinate their view that patients, even though they were not empowered at the moment, should have a major say in their healthcare. These views helped to present a confused picture of beliefs held by the General Managers. This recognition by the General Managers that patients should be involved in decisions determining the healthcare services they needed was extended to include the local community in those decision-making processes.

The General Managers were able to define their roles in terms of the influences that affected their working environment, the type of culture that they were working in and key stakeholders. They were able to identify their information needs; including those unmet needs and communication issues. The General Managers recognised the need for codes of conduct, and corporate governance. However, their practice was not consistent with their expressed philosophies in that not all of them had mechanisms in place that supported clinical codes of practice and corporate governance.

Figure 68: Perception of Roles



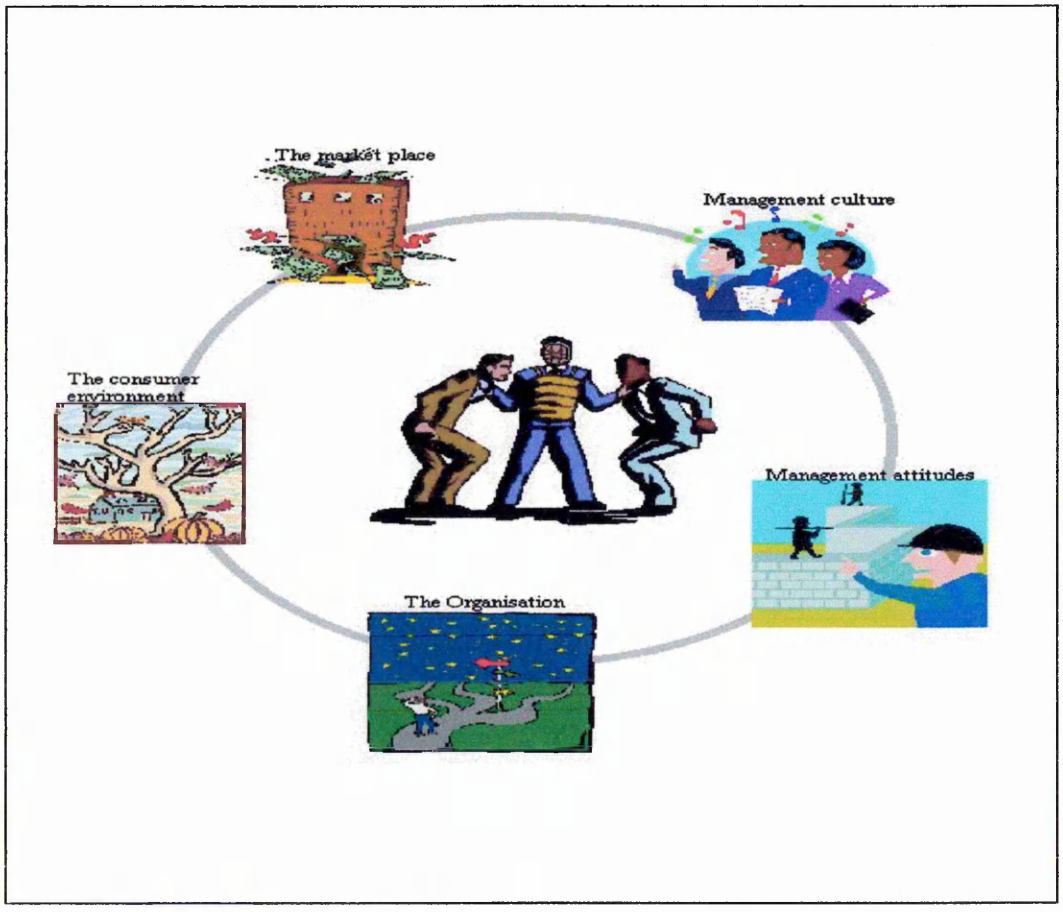
Being Successful in the Present Day

The business-orientated environment of the NHS needs of the General Managers have influenced the aims, objectives, and information. This was manifested in their beliefs that meeting financial targets, high user approval ratings, and the achievement of satisfactory contract performance levels were part of their working environment. It was these key objectives that were perceived as success indicators for determining what constituted a successful job. They also believed that their organisations had become customer responsive, innovative, and able to cope with a fast changing environment, and, to remain successful. Their organisations had to become flexible, which would be achieved through the empowerment of the patients for whom they provided services. Their envisaged strategy of success required an associated information strategy, which facilitated the sharing of information with both their employees and key stakeholders within their organisation. However, there appeared to be elements left out of their beliefs, in that they did not regard their employees as an important resource, even though they considered the organisation and that of the NHS to be "a people organisation".

The Managers' Working Environment

The General Managers' working environment was a reflection of their organisational environments, its cultures, leadership styles and working practices. They shared a leadership and managerial style influenced by their organisational culture, which they believed to be consensual, analytical and collaborative in its decision-making, and devolutionary in its responsibilities. They believed that their work culture challenged beliefs, but tended to steer a middle course, maintaining the status quo. They believed that all these elements of their working environment affected their information needs.

Figure 69: The Environment



Other aspects of the General Managers' working environments were described as being essentially conservative, where low risk strategies, secured markets and well-tried solutions were valued, preferring strategies of growth through service development, constant monitoring of performance, environmental change and multiple technologies, mixed with a steady growth slowed by financial constraints. They also noted that their organisations had yet to develop through evidence-based medicine and were essentially "followers" in the

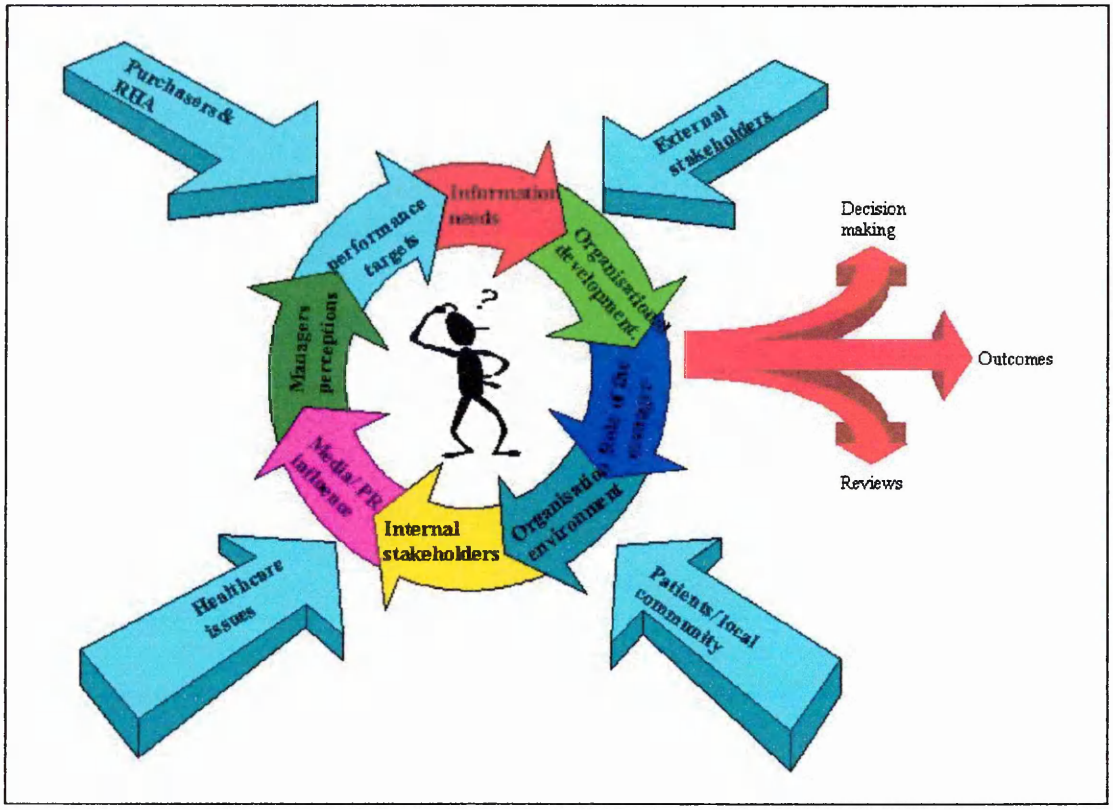
market. One of the main criticisms by them of their organisations was the organisational emphasis being placed on the stewardship of funds as opposed to the quality of service provided.

The majority of the General Managers believed that they worked in a competitive, efficient and cost-effective environment that was influenced by its stakeholders in the areas of services provided, behaviour and accessibility. The success of this environment was seen as embodying the improved purchasing power of the GPs, purchasing services for the community; clinical effectiveness; a focus on efficiency; and clinical outcomes. The healthcare market was regarded as a mechanism for change, which brought opportunities that had enabled the General Managers to be more responsive to local needs and services while focusing on local provision of healthcare services. This, in turn, influenced the General Managers to be proactive through innovation.

Many of the influences identified by the General Managers were the result of contact with their stakeholders. However, more subtle influences were identified as being exerted, such as the influences of the local communities, stakeholder groups, and directives from the DoH. Other influences that were considered to be important were the General Managers' view of the future and what it held for them, the influence of the Clinicians as a group and the perceived increasing influence of groups such as the patients and Purchasers.

A more indirect influence on the General Managers was the movement of their information needs in response to changes in the working environment. Those changes have come about because of the pressures from stakeholders and, in particular, directives from the DoH. Initial analysis of the General Managers' views indicated that the business climate had sublimated clinical outcomes, effectiveness and quality of delivery of service to the patients. However, further analysis of the views of the General Managers indicated that as a result of the business environment rising to the top of the agenda, it had brought about benefits for patients. Those benefits included demands for better performance; the monitoring and meeting of performance targets; clinical outcomes; patient satisfaction; and clinical effectiveness and efficiency.

Figure 70: Influences Affecting the Managers Working with Information



Key changes in the General Managers' Environment

The General Managers identified a number of key changes in their own environment such as the improved purchasing power of GPs; a re-focusing on efficiency and effectiveness, increased competition; performance monitoring; and improved clinical outcomes. Those changes had been brought about by concomitant changes in healthcare purchasing strategies as a result of the market environment experienced by the NHS. The General Managers believed that the environment in which they were working had been influenced by a more business-like, competitive and success orientated climate and as a result of that, their information needs had begun to reflect those changes. The relationships forged by the General Managers and the stakeholders of their organisations varied according to the perceived importance of the stakeholders within their work environment with that perception exerting a direct effect on the type of relationship, which the General Managers enjoyed with Clinicians, patients and fellow General Managers. The external policies of their organisations were the conduit for interaction the external stakeholders and customers of the General Managers and their organisations. The managerial external and internal policies of their organisations reflected in a similar manner, the influences of their stakeholders. The

organisations responded by focusing on their internal structures on measures designed to facilitate improvements in efficiency and effectiveness. The General Managers described their working environment as being "business challenged". They had responded to that challenge by involving their organisational structures in any changes that they made. A result of that involvement and the changes brought upon the structures was that the organisations had become both flatter and more efficient.

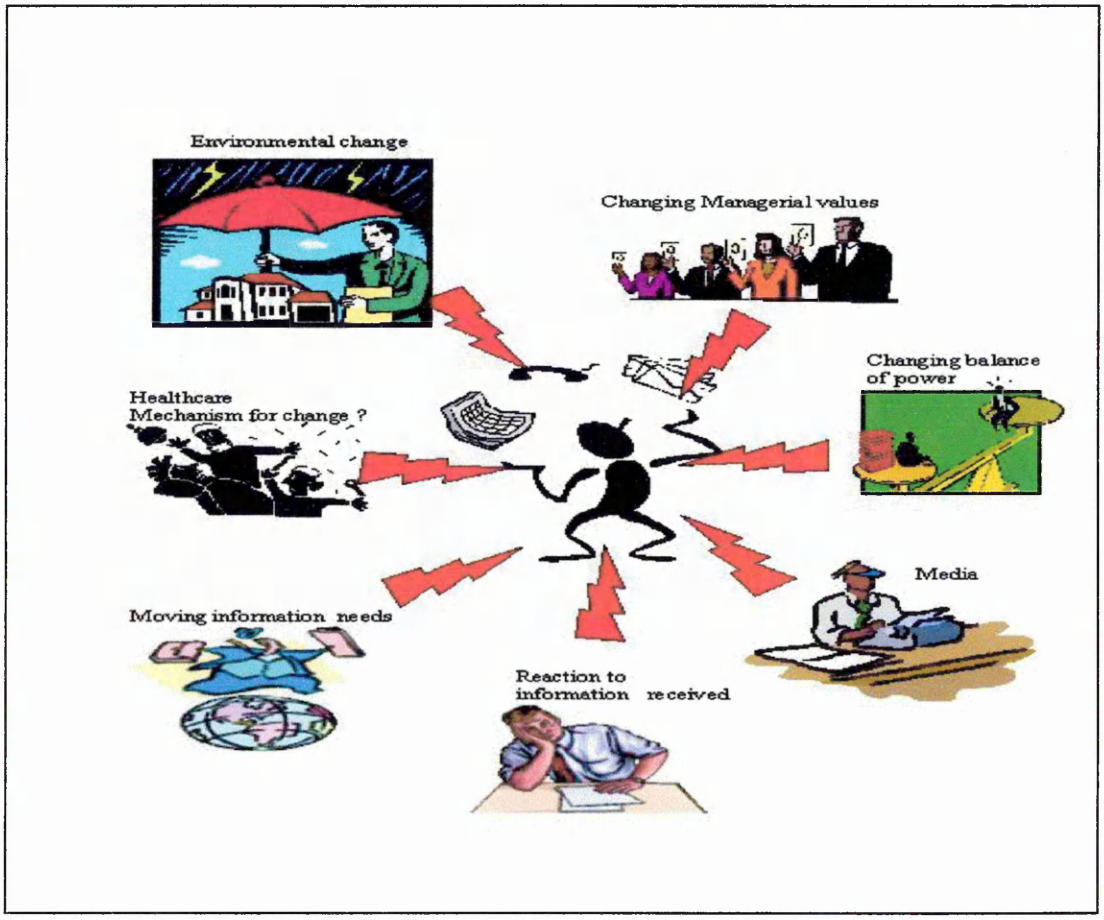
The General Managers expected their information needs to become more complex, more focused on aspects of their business and they described a requirement for increased accuracy as the healthcare environment changed and they responded to their moving information needs. A key element of their response to this was to prioritise those needs and engage their stakeholders in regular dialogue in an effort to meet those information needs. However, they indicated that two-thirds of the information that they received did not meet their current needs but they appeared not to react adversely to this and accepted the situation.

Effects of the General Managers' Decision-Making on their Information Needs

The processes that the General Managers used in their decision-making in the course of carrying out the functions of their job, such as scenario planning, contingency planning and model building in order to find solutions, had an influence on their information needs. However, their information needs have become more complex; more business orientated, and required sophisticated communication and equipment. An aspect of this shaping of their information needs resulted in the General Managers instituting a drive to improve performance monitoring; improvement in the priority given to the influence of the patients; and their healthcare needs. The General Managers are beginning to address those issues of patient demands, and the demands of stakeholders, by measuring quality outcomes, through clinical audit and review. These pressures to address these issues are coming from the Purchaser organisations, the Regional Executive organisations and the DoH. Decision-making by the General Managers is affected by their working environment and its influence on their information needs. Devolution of the General Managers' budgets within their organisations have given local managers the freedom to make decisions, with a majority of the General Managers believing that their decision-making directly affected the patients, potential patients and other Providers. The General Managers believed that performance management was a strong control mechanism that restricted their freedom to make

decisions. For example; limited finance would inevitably be a constraining influence; similarly, the contracting processes, Charter standards, demands of GPs and Purchasers, and clinical considerations all had the potential to impose constraints on their decision-making.

Figure 71: Response to Environmental Change



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Conclusion

Rationale for the research

The "real world" research that I undertook set out to identify the information needs of the NHS General Managers and in doing so sought to highlight the information that they needed to meet their organisations' key success factors. These key success factors serve as the means by which their organisations' performance would be judged. The research sought to identify the effects of the General Managers' working environment on their information needs and at the same time develop an understanding as to whether the patient, a key stakeholder, had benefited in the healthcare empowerment stakes as a result of the re-delineation of the General Managers' information needs and the impact upon their decision making. The thrust of my research was to understand the links between a market-led healthcare environment, the General Managers' attitudes and behaviour towards information, their information needs and patient empowerment and to identify a common model of information needs across the General Managers' organisational groups that would allow, when assessed against key success factors, a judgmental view of the ability of both the General Managers and their organisations to deliver their aims and objectives.

Limitations of the Research

Research strategy

There are a number of approaches that could have been used in the research strategy, for example the interpretive approach in which theories and concepts arise during and as a result of the enquiry or the positivistic approach in which the enquiry tests a hypothesis and sets out to achieve stated goals. A hybrid of the interpreted approach was used, because although the research set out to test a null hypothesis and achieve stated goals, it was anticipated that theories and concepts would arise from the enquiry. Background research was not an essential starting point for the enquiry; however, it was used to set the enquiry agenda through a partnership with the General Managers. This background research and the development of the agenda formed an essential activity to persuade the General Managers to co-operate in the research.

A **simple survey strategy** was adopted, involving the collection of the same standardised data from a differentiated group of General Managers over a short period of time. A **sampling strategy** of stratified random sampling was used. This involved dividing the sample General Manager population into a number of groups or strata, where the groups shared similar characteristics i.e. the Purchaser, Provider and Regional Executive Organisations. These were homogenous groups in terms of characteristics and also they possessed a narrow range of variables in common with each other.

The purpose of the enquiry was both exploratory and descriptive in that the enquiry sought to understand what was happening. It also sought new insights, through the asking of questions, and assessed phenomena in the light of the new information generated in the form of answers to those questions. Quantitative and qualitative data was sought to discern an accurate profile of the General Managers' situations.

Instead of "small" amounts of data collected from a large sample population, a "large" amount of data was collected from a small population using a standardised questionnaire. Attempts were made to understand the individual General Managers' points of view in their particular contexts. The quantity of data collected was extensive, albeit from a small number of individuals and it was passive in that it sought to describe, analyse and explore the General Managers' environment as it was. The focus was upon the individual General Managers and what they thought about a situation or topic.

Having adopted the survey strategy both the potential disadvantages as well as the advantages of such a strategy were recognised. The disadvantages of the survey strategy, such as the data being affected by the characters of the General Managers and the interviewer, were noted and addressed by the accurate and diligent codification of the responses with the completed questionnaires being returned to the General Managers for validation of the accuracy of the codification of their responses. The possibility can be discounted that General Managers will not necessarily report their beliefs and attitudes etc accurately. This was countered by a guarantee of anonymity and confidentiality in the expectation of securing an honest representation of their views.

The advantages of the survey strategy stem from its simple and straightforward approach, which can be adapted to collect generalisable information with the semi-structured survey collecting large amounts of data in a standard way. This together with introductory letters,

follow-up 'phone calls and "conversational" meetings prior to the completion of the questionnaire helped reduce the "surprise" reaction to the survey and ensured commitment from the General Managers who had agreed to participate. These approaches also allowed the interviewer to clarify questions, encouraged participation and assess how seriously the survey was being addressed by the respondents.

Real world enquiry

Developing the research proposal helped provide the clarity and focus for the study and limited any constraints that might influence the research; because the researcher, in partnership with the General Managers, was making the decisions relating to the enquiry. Constraints, both real and unreal, were identified partly through the testing of the proposed questionnaire for construct validity. These constraints were time available, access and co-operation from the enquiry sample population.

Building bridges between the researcher and General Managers involved collaboration, dissemination of the results, and because the researcher wanted client involvement and ownership of the results, the promise of regular feedback on the progress of the survey.

Threats to external validity

The threat to external validity where findings are too specific to the General Manager of the organisation being studied was reduced by the selection of different organisations from which the sample population of General Managers was chosen. This also applied to the threat of the findings being too specific to the context in which the study took place.

Objectivity and creditability

Each questionnaire completed was checked with the interviewee at the time of the interview and any anecdotal information provided by the General Manager was recorded on pocket memo immediately after the interview, and then transcribed later before being analysed and coded as part of the data analysis process. Once the data had been coded to a database, the completed questionnaire was returned to the individual General Manager for validation, to enable them to comment on whether the completed questionnaire was a fair reflection of what their views, preferences, perceptions etc. This enhanced the accuracy of the codification of the completed questionnaires.

Lack of transparency to other parties

With representative sampling, non-response can be a serious problem. The strategy used in the research helped to reduce this problem by utilising postal questionnaires, follow-up phone call and 1-2-1 interviews with face to face questionnaire completion.

Threats to internal validity:

Changes in the environment, working practices and interviewing techniques are cited as potential threats to internal validity of the research. However, the only change that occurred was the way in which the General Managers were interviewed where the interview technique was adjusted to meet the atmosphere of the environment on the day of interview. This resulted in the researcher's approach to the interview changing from a semi-structured to structured interview format depending on the personality of the General Manager being interviewed. None of the General Managers dropped out of the survey, nor did they appear to change their views and opinions in the course of the enquiry and the "characteristics" of the General Managers by organisational group appeared to remain constant throughout the survey period.

The effects of the researcher himself influencing the results of the enquiry, through intimate knowledge of the environment in which the enquiry was being conducted, were reduced by checking the codification of the questionnaires with the General Managers after the interview had been completed.

Sample Size

In the research plan a sample size of 64 NHS organisations distributed across the middle of the UK from Wales in the west to the East Coast and down to Oxfordshire was reviewed. From that original sample population, 20 NHS organisations with similar revenue and population characteristic profiles were chosen. The response rate from the sample chosen was very positive to participation in the survey. However, after 12 responses to the survey had been analysed, it became apparent that the data being retrieved was becoming saturated. It was at this stage of data collection that the survey was concluded.

Methodology chosen

The research carried out fell into the latter one of two camps: enquiry carried out in the laboratory and enquiry carried out in the field; often described as real world enquiry. By carrying out real world research I had made the assumption that the researcher had knowledge, skills and expertise of the survey enquiry environment. However on a cautionary note, the researcher who is centrally involved in the situation being researched cannot show credible or objective enquiry. Similarly if the audience or decision-makers are not able to take ownership of the results of the enquiry, then a report that does not communicate changes to them fails in one of its prime objectives which is to provide creditable solutions to problems.

Semi-structured interviews were used to allow the interviewees to discuss issues that they thought important as well as responding to the questionnaire. However, semi-structured interviews often allow the interviewer to feel comfortable but not the interviewee, with the latter being resistant to the structured interviews. Protocols were also observed in that the Chief Executive Officers of each of the organisations involved were consulted about the research. The research strategy and process was explained to each of the interviewees prior to proceeding and the responses to the questionnaire were kept confidential.

The Aims & Objectives of the Research

The research sought;

To define the General Managers' concept of management information and examine their information requirements in the market climate together with their attitudes and behaviour when receiving information and making decisions. The research sought to understand the relationship between the General Managers' information needs and their decision making and whether those needs were linked to patient empowerment which enabled the patients to meet their individual healthcare needs. Also it was sought to examine the potential areas of conflict when the patients' individual interests clashed with the business interests of the hospital. The General Managers' concepts of management information were shaped by the influences of the environment in which they worked and by the challenging demands made upon them by their key stakeholders. These demands fell into two categories; firstly the need to deliver performance targets set by the DoH, and secondly the need to deliver services that met the demands and expectations of their customers.

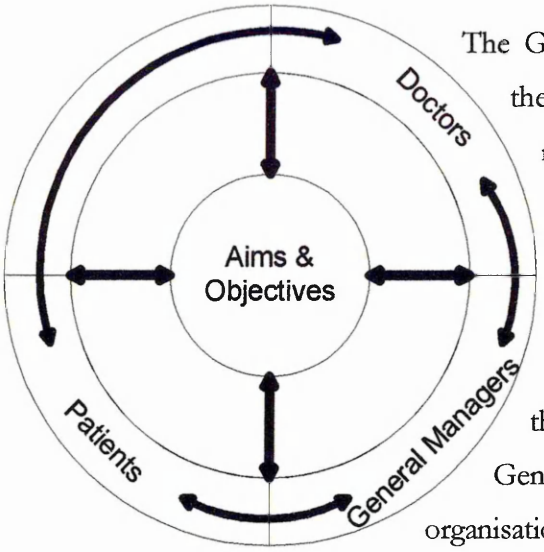
The General Managers required information that was financially and contractually performance orientated, that was not only accurate and timely but indicated how their organisations were meeting the DoH patient Charter standards. They required information for their decision-making processes that was similar in content and shape to that of the demands from the market; this included healthcare outcome data and the needs of the local population. The General Managers' reaction and attitudes to the information they received appeared not to reflect the importance of the type and content of the data required; in that the information received did not meet their needs but they appeared to accept this situation.

The decisions that they made reflected the influence of the business environment in which they were working; which in turn was reflected in their information needs. Table 17 indicates the type and nature of the information required for their decision making. The General Managers shared the views that the environment in which they were working i.e. "The healthcare market" did not enable the patients to influence or decide on their healthcare needs. However when identifying their information needs, the General Managers did indicate that patients should be involved in decisions relating to the provision of services and that the local community likewise should be involved.

The researcher assumed that the philosophies of a NHS service free at the point of entry and a business-orientated environment would be a source of conflict that would affect the empowerment of the patient. However, the views expressed by the General Managers did not support this and in reality the constraints of a financial nature were more likely to affect the patients' empowerment and the provision of healthcare services as a whole.

To identify the General Managers' understanding of the General Manager-patient relationships and changes in that relationship, and describe the General Managers understanding of their roles in the organisation and how that understanding affected their information needs. The research looked at the changes in the balance of power between the consumers (the patients), Providers and Purchasers and how those changes had affected the information needs of General Managers, the General Managers' relationships with the patients and how those relationships have changed are well understood by the managers. They have changed in line with the need to involve the patients in the services being provided in recognising that the services could not be improved without patient support and involvement. To this end the General Managers placed an importance on meeting with their stakeholders in order to satisfy their own information needs.

Figure 72: The General Managers' Collaboration to Achieve their Aims & Objectives



The General Managers' understanding of their roles in the organisation and the effects on their information needs is deduced from their responses to questions about their key stakeholders. The understanding took into account the relationships, the meetings, the nature of the information needed from them and the roles that the stakeholders should play in the provision of the healthcare services. The General Managers are the formal leaders of their organisations, however, to deliver the aims & objectives of those organisations the General Managers have had to forge partnerships with their key stakeholders to meet their information needs and deliver their objectives. These roles identified by the General Managers have taken on board the changes in the balance of power between the consumers (the patients), Providers and Purchasers and this 'in turn' have been reflected in changes in their information needs. Table 17 indicates that the particular areas of information needs that have been affected were contract performance data, local purchaser demand data and competitor performance.

Table 17: Category of Information Needs

Category	Category of information needs	Changes in Information needs	General Information needs	Future Information Needs	Stakeholders, Org_grps Influence	Decision making	Market influence	CSF, Aims & Obj	Roles of the General Mgrs, Balance of Power	Purchaser split	Provider split	D o H influences
Finance	Cost effective data		■									
	Income & Expenditure/ Financial data	■	■	■	■	■	■	■	■		■	
General	Political	■	■								■	■
	Simple understandable data		■									
	Staff opinions	■									■	
	Accurate, Timely and quality data		■	■			■					
	Complex unlimited data		■				■					
	Sensitive data to aims & Objectives		■				■					
	Communications with GPs		■	■								
	Communications with the Community		■	■								
	Communication data	■	■	■	■							
	Patient focussed data			■								

Category	Category of information needs	Changes in Information needs	General Information needs	Future Information Needs	Stakeholders, Org_grps Influence	Decision making	Market influence	CSF, Aims & Obj	Roles of the General Mgrs, Balance of Power	Purchaser split	Provider split	D o H influences
Marketing	Marketing data	■									■	
	Local Purchaser demands		■			■	■		■		■	
	Purchasing intentions data	■					■				■	
	GP requirements	■					■				■	
	Patient / Customer feedback	■								■		■
Monitoring	Reporting mechanisms							■				
	Statistical Data	■	■					■				
	Corporate data	■	■					■				
	Management data for the Organisation	■			■							
	Business Plan Monitoring data		■					■				
	Organisation monitoring data							■				
Performance	Quality performance data	■										
	Contract performance data	■	■		■	■	■	■	■	■	■	
	Waiting list data		■									■
	Patient Charter Standards		■				■	■	■			■
	Performance Monitoring data	■			■		■	■				■
	Stakeholder Complaints data		■									■
	User Approval data							■				
	Competitor performance data						■		■			
	Benchmarking data	■						■				■
	DoH target data							■				■
	Performance Target data								■			■
Planning	National trends/ Demographic data	■								■		
	Patient Healthcare needs data								■	■		
	Local population health needs data	■				■				■		
	Service Planning data	■	■				■					
Results	Clinical Effectiveness/outcome data	■		■			■	■				
	Clinical (Descriptive data)		■									
	Customer satisfaction data	■	■	■								
	Evidence based medicine data				■		■					
	Non Clinical Outcome Data		■		■		■			■		
	Health outcome data					■				■		■
	Medical Audit		■									
	Efficiency data		■		■		■					

The General Managers believed that their responsibilities for patients' interests rested in their organisation which had as its main function the delivery of healthcare services. However, even though they believed that the patient should be involved in the provision of those services through consultation and representation, they held the view that the General Managers from the Provider and Purchaser organisations knew what was best, in healthcare

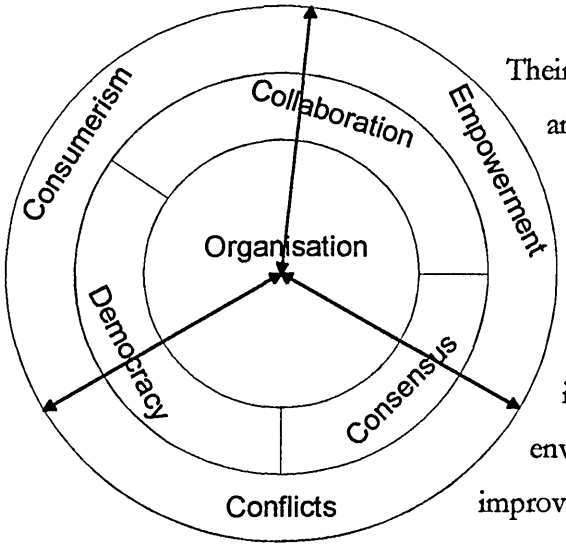
terms, for the patients. These responsibilities focussed their information needs towards delivering patient Charter standards, waiting list targets, healthcare needs and clinical outcome data.

The fulfilment of the General Managers' information needs took the form of regular update and discussion meetings with their stakeholders and in formalising the corporate reporting mechanisms within their organisations; whilst at the same time fostering improved relationships with colleagues, patients and Clinicians.

To identify the information needs of the General Managers and understand any difficulties that they may have in defining those needs. The General Managers did not appear to have any difficulties in identifying their information needs which are summarised in Table 17. Their information needs reflected the business and performance orientated environment in which they worked. Any effects of organisational resistance and culture clash associated with that environment appeared to have had little effect on their information needs. However, they described their organisations as being followers in the market place and their information needs reflected the demands of their stakeholders and not any innovations which they themselves might seek to implement..

To understand how General Managers worked with information within their working environment The way in which the General Managers worked with information was influenced by organisational and environmental changes, health policies and stakeholder demands that affected their information needs, values, and aims and objectives.

Figure 73: Pressures of the Work Environment on the Organisation

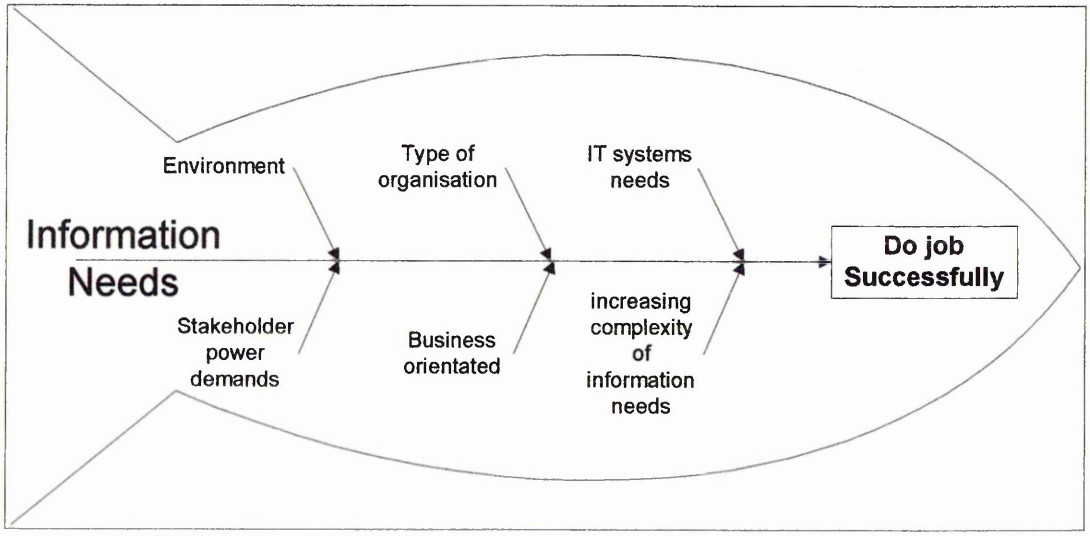


Their organisations had become sensitive to publicity and media influence and, even though the information that they received did not meet their expectations, the clinical and financial information gave direction and purpose to their roles and activities. Due to the overriding influence of the business and market environment (Figure 73) which had led to improved communications with the stakeholders on

issues such as quality and customer satisfaction, the General Managers have become proactive to change and their relationships with their stakeholders more positive. The General Managers preferred a strategy of securing growth through service development, constant monitoring of the environmental changes and their information needs supported by the implementation of multiple technologies. Their leadership was characterised by devolved, consensual and democratic decision-making, in which they steered the middle course of trying to maintain the status quo. However, when they responded directly to questions about change they indicated that the evolving NHS was a mechanism for change that was constrained by finance.

Stakeholder demands together with organisational and environmental changes have affected the General Managers' information needs. In particular Clinicians, patients, local community groups, internal organisational groups and changes in priorities from the Department of Health have all influenced those needs. The external influence of the Department of Health and the business environment has not only changed the General Managers' information needs but affected the balance of power between the stakeholders as well. In turn this has further affected those information needs.

Figure 74: Pressures on the Information Needs of the General Managers



The General Managers needed more accurate, timely and complex information due to the changes in the balance of power between the stakeholders especially the increasing influence of the patients and the local community in the provision of local healthcare. These changes in information needs reflected the pressures (Figure 74) placed upon them and even though the General Managers' responses to changes in the balance of power are difficult to identify, one

response was to engage as many stakeholders as possible in regular dialogue to ascertain their needs. It is difficult to decide whether this response was as a result of environmental and organisational pressures experienced by all parties, or whether it was a result of an outward sign of the stakeholders jockeying for position.

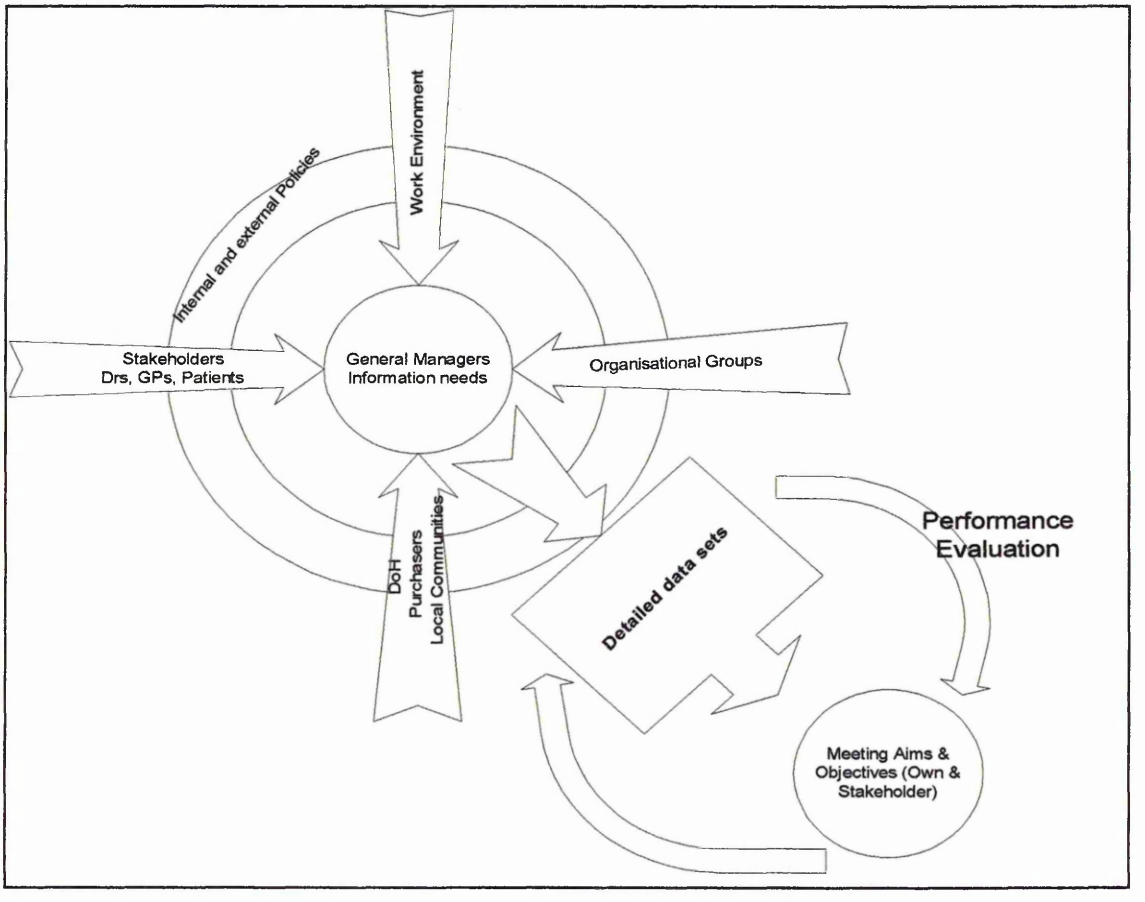
Analysis of the results of the enquiry suggest that there are a number of specific areas of their information needs which the General Managers deem important enough to distinguish from among their more generalised views. In particular, the Provider General Managers indicated that financial and contract performance data, local purchaser demands, the purchasing intentions and requirements of GPs, and marketing data together with staff opinion and data of a political nature was required. On the other hand, the Purchasing General Managers required local population health needs data, health outcome data, national trend and demographic data. The information needs of the General Managers are related to the function of their organisations.

To understand the effect of the changes in the healthcare environment from one of a monopolistic to a market (business/client demand) led environment on the General Managers' information needs. The General Managers viewed the changes in the healthcare environment as one in which their performance would be monitored against financial targets, the delivery of cost effective and efficient services and being able to respond to their customers needs. The shape of their information needs, as discussed earlier, encompassed clinical outcome data, knowing what the local population needs were and being able to respond to political imperatives from the DoH. A majority of the General Managers described those needs as "Business Information".

To identify a model of information needs for the General Managers. The research has identified through the enquiry process, the General Managers' information needs. Table 17 describes the categories of the General Managers' information needs and the links to the influences that affect those needs. For example the 'influences' have either affected the information need or have helped to generate that need. The table brings together those information needs into a matrix consisting of 'type'/'use of' data groups and the General Managers' needs and influences (i.e.:Future needs/stakeholders). The data in Table 17 indicates that the pressures and influences of the General Managers' working environment have been reflected in their information needs. The data has enabled a series of outline models of information need to be developed reflecting the requirements of the General

Managers. Information is seen by the General Managers as a key resource whose vital processes within their organisations consist of gathering, classifying, processing data and using and evaluating the information obtained. The diagrams shown start to describe the information needs model for the General Managers. Figure 74 and Figure 75 show models of the pressures and influences that affect the General Managers' information needs.

Figure 75: Model of Influences affecting Information Needs

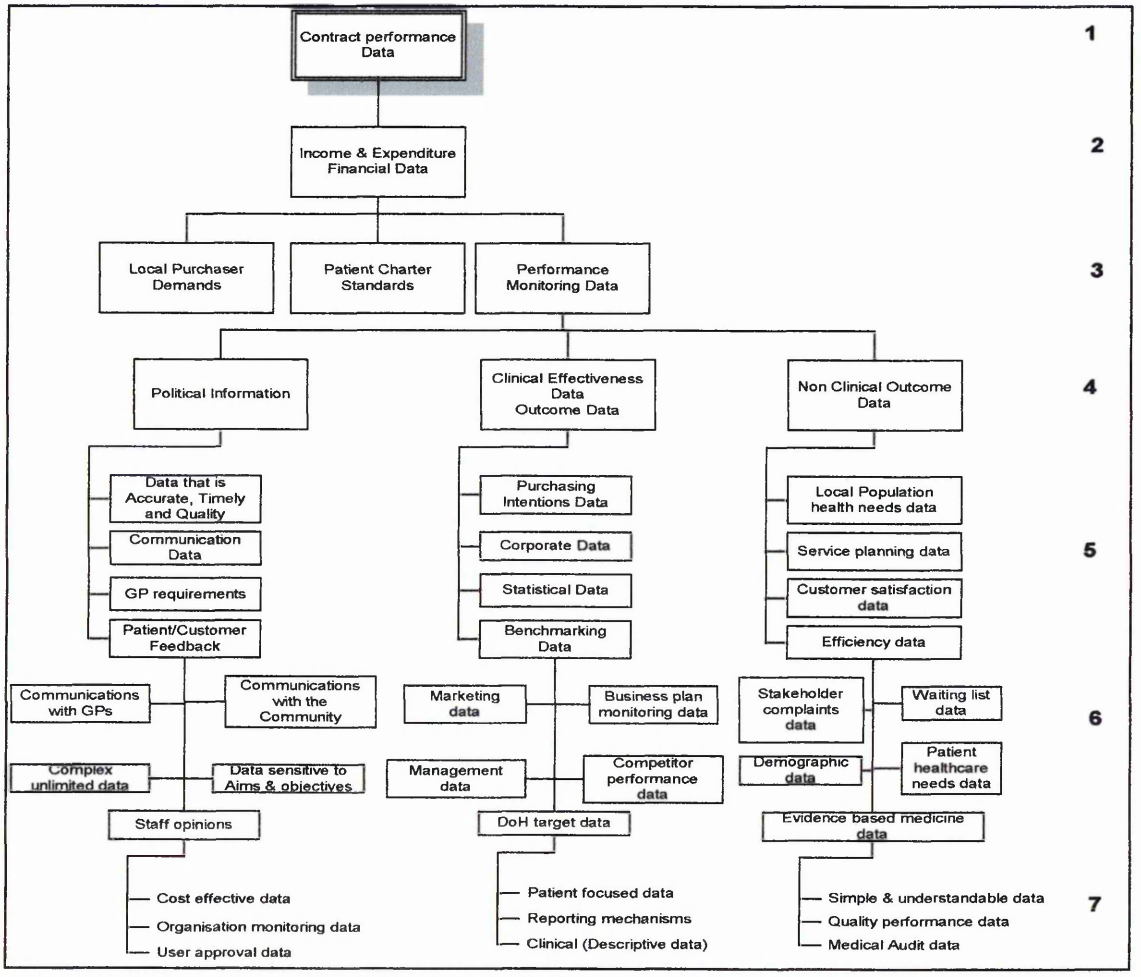


The diagram shown in Figure 76 is a simple model showing the General Managers' information needs by category and level of importance. In the model (Figure 76) the level of importance has been derived from the data in Table 17 which indicates how often a category of information need is associated for example, with an influencer or change agent such as a stakeholder or DoH policies.

These models of information needs are only the first steps in developing a more complex and common model of information needs across the General Managers' organisational groups that will allow, when assessed against key success factors, a judgmental view of the ability of both the General Managers and their organisations to deliver their aims and

objectives. However, further research would be advantageous in looking at the changes (if any) that have occurred in the General Managers' information needs as a result of the current political and organisational climate. This would be in the anticipation that the research together with the models of information needs described, would help to facilitate the future development of a model of information that would permit a consistent view of organisational performance to be made.

Figure 76: Model of Information Needs



Further Research

The initial research carried out as described above has the potential for further enquiry to look at the changes (if any) that have occurred in the General Managers' information needs as a result of the current political and organisational climate. Also the links between the business orientation of the NHS environment and patient empowerment and the apparent lack of influence of patients in achieving control of their own healthcare needs is worthy of further enquiry. Furthermore, a wider sample could be drawn to help validate some of the

conclusions offered in this work and a comparative analysis of the information needs of those occupying the equivalent position to General Manager in the NHS, in other public health services offer additional validation. Finally, the possibility could be considered that a comparison with those performing similar roles in the private sector, and particularly in the independent healthcare sector, would afford additional insights into the specificity and generality of the conclusions emanating from this research programme.

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Appendix I. Introductory Letter

Mike Stanley
124 Leeming Lane North
Mansfield Woodhouse
Mansfield
Notts
NG19 9ET

Mr
Chief Executive

21 August, 2001

Dear Mr

May I introduce myself before asking for your help. My name is Mike Stanley and I have been in the NHS for 29 years, first as a nurse, then in general management as a Business manager and presently as the Commissioning Manager for the South Manchester University Hospitals Trust.

I am seeking your help for the research that I am doing into "The Effect of change on the National Health Service General Managers' Information Needs". I would be very grateful if you will allow me to interview you as part of this research, which should only take about 45-55 minutes of your time. *(Please be assured that all interviews will have complete anonymity).*

I do appreciate how busy you are and that you may consider it appropriate to delegate the interview to one of your colleagues. I am very happy to follow your advice.

In anticipation of your agreement, may I take this opportunity to thank you in advance for agreeing to see me. I shall contact your office for an appointment within the next two weeks. I look forward to meeting with you.

Yours sincerely

Mike Stanley

Please Note:
The purpose of this research is summarised in the research proposal attached to this letter.

Appendix II. Questionnaire

Sheffield Business School, part of the Sheffield Hallam University

THE EFFECT OF CHANGE ON THE NATIONAL HEALTH SERVICE GENERAL MANAGERS' INFORMATION NEEDS

Questionnaire: part of PhD thesis into The Effects of Change on the National Health Services General Managers' Information Needs.
By Mike Stanley MBA. BSc. DMS. Dip. Nursing. RMN. SRN

Research Proposal

The effect of Change on the National Health Service General Managers' Information Needs

The Aims & Objectives of the Research

The healthcare sector, like other sectors, which have been affected by the policies of the previous government (1979-1997) under the influence of consumerist philosophy, initiated a series of reforms aimed at updating the health system to meet the "real" needs of society. One form of this updating was the movement of healthcare from a monopolistic one to a market-led one, in which market forces influenced the type and cost effectiveness of the service provided.

It was, therefore, proposed to look at the information requirements of the NHS General Managers from Purchasers, Providers and Regional Executive organisations in the present climate.

The conceptual framework of this research addresses several questions:

- The question of changes in the balance of power between the consumer and service providers and how that affects the information needs of General Managers.

- The question of changes in the patients' and the General Managers' roles and their effect on information needs.

- The changes in the balance of power between the patient, the Purchaser and Provider and how that affects the information needs of the General Managers.

- The changes in healthcare environment from one of monopolistic to market/ business/client demand led and its effect on the General Managers' information needs.

- Whether or not the NHS environment has moved from a "free healthcare for all" ethos to a business orientated ethos and, if so, its effect on the General Managers' information needs.

Other aspects of this research are:

- To examine the information requirements of the General Managers' in the market climate and their attitudes and behaviour when making decisions. Additionally to question whether or not the environment affects this informed decision-making and their information needs.

- To question whether or not the General Managers' information needs are linked to patient empowerment, thereby enabling patients to meet their individual healthcare needs.

- To identify a model of information needs which will allow a judgmental view of an organisation's performance as to whether or not it is successful.

- To seek to clarify the General Managers' understanding of their own role in the General Manager/patient relationship. This will explore how General Managers view their own responsibility and accountability for the patients' interest and how that influences their need for information and the actions they take towards fulfilling those needs. It will also shed light on the potential areas of conflict when patients' individual interests clash with the business interests of the hospital.

- To explore the problem of identifying the information needs of the General Managers. This will look especially at the rapidly changing environment of the NHS and the continually diversifying needs of the "Provider" orientated General Managers as opposed to the "Purchaser" orientated General Managers.

- To determine the attitude of the targeted General Managers to information. This will include a study of the problems of organisational resistance and organisational culture clash associated with information needs and system requirements. De Long (1988) argues that the adoption of executive support systems by senior managers will help them develop enhanced business models to test alternatives and to make effective decisions, whilst at the same time citing that more than 50% of traditional Executive Information Systems fail within two years.

- To research into the difficulties, which General Managers have in defining their own information needs. This will study a number of reasons, for example: the inability to express their needs; their not being sure of their information needs; or simply asking for something which they subsequently realise is not what they actually want after they are given it.

- To understand how General Managers work with information in their existing work environment. What information they use and the effect on the managers of continually evolving stakeholder demands within the organisation, together with the evolving organisational and, consequential, environmental change.

- Develop theory in this area and recommend practice for change.

The research will attempt to enhance the understanding of the concept of management information in the NHS through general and health specific literature. The literature review will look at the nature of the concept of information and at its supporting mechanisms. It will also seek to identify the concept of the new healthcare and its implications for information.

QUESTIONNAIRE

throughout. ✓=yes x = no

Questionnaire

te: 21 August, 2001. _____ Ref. No:

egory:

What phrase fits closely to your understanding of consumerism? Tick all appropriate boxes.	Looking after the Purchaser/patient	❐
	A financial philosophy within the NHS	❐
	A philosophy that satisfies the Purchaser/patient	❐
	Protection of the interests of the Purchaser/patient.	❐
	A philosophy based on a sound economy.	❐

Is the NHS operating in a consumer environment? ❐ 3 Has consumerism helped the patient? ❐

Should the NHS operate in a consumer environment? ❐ 5 Has consumerism directed the Purchaser? ❐

Healthcare needs; Who knows best?	The patient	❐	The Purchaser	❐
	The Provider	❐		

Should the Provider involve the customer in the type of service provided? ❐

Has the Provider any Social responsibilities in relation to service provision? ❐

How would you describe the role of the local community in the provision of healthcare?	Ensuring Survival	❐	Increasing local competition	❐
	Financial	❐	Providing direction for local services	❐

When was the Trust created? [ ] Are you a 1st, 2nd, 3rd, 4th, or a 5th wave Trust? [ ]

Does your organisation have a Business Code of Practice?		❐
If yes, please complete the following.	Is the Code enshrined in the General Managers' contract?	❐
	Is adherence to the Code monitored?	❐
	Is the Code applicable to senior managers only?	❐
	Is the Code applicable to all staff?	❐

throughout. ✓=yes x = no

Is your management culture one of the following ?	Authoritarian management	❒	Democratic management	❒
	Consensus management	❒		

Has this cultural attitude affected your organisation?		❒				
w would you describe your organisation?	Defensive	❒	Entrepreneurial	❒	Analytical	❒
would you describe your leadership e?	Centralist	❒	Controlling	❒	Devolutionist	❒
es your organisation encourage	Collaboration?	❒			Competition?	❒
es your organisation	Conform to beliefs?	❒			Challenge beliefs?	❒

Do you meet with Clinicians?	❒			
es please tick subject matter ssed as a regular issue.	Medical Audit	❒	Contract performance	❒
	Clinical management	❒	Trust financial performance	❒
	patient care planning	❒	Trust management	❒
	Clinical protocols	❒	Communications	❒

Do you meet with GPs?	❒			
es please tick subject matter ssed as a regular issue.	Trust Clinical performance	❒	Services provided for the local community	❒
	Access to Trust facilities	❒	Support for GPs	❒
	Access to beds	❒	Communications	❒
	Cost of services provided	❒	Contracting issues	❒
	Contribution of GPs to the management of the Organisation			❒

Do you meet with patients or their representatives?	❒			
es please tick subject matter discussed as a regular e.	Available facilities	❒	Waiting times in A&E /OPD	❒
	Hotel services	❒	Waiting lists	❒
	Access to Clinicians	❒	Effectiveness of treatment	❒
	Fund raising	❒	Communications	❒
	Complaints	❒	patient Charter standards	❒

throughout. ✓=yes x = no

Has DoH healthcare policy changed your organisation? ❒

es please tick as many boxes as ropriate.

In the area of contracting	❒	The patient care environment	❒
In areas of primary healthcare	❒	In the area of clinical practice	❒
In the area of management	❒	In the area of marketing	❒
In the area of strategy	❒	In areas of financial control	❒
Size of organisation	❒	In areas of human resources	❒
In the area of services offered	❒		

Is your organisational environment responsive to changes in DoH healthcare policy? ❒

es please indicate in which areas by ticking as many boxes as appropriate.

Is the organisation in a state of change?	❒	Has your organisation coped with the changes?	❒
Is your organisation dynamic?	❒	Is your organisation very sensitive to health policy?	❒
Is your organisation static?	❒	Is your organisation sensitive to health policy?	❒
Is health policy a threat?	❒	Is your organisation cautious to health policy?	❒
Is health policy an opportunity?	❒	Has strategy changed?	❒
Has the environment improved?	❒	Has the environment remained unchanged?	❒

How do you cope with environmental change; by:

Scenario planning?	❒	Model building?	❒
Contingency planning?	❒	Specialist attention to elements of the change?	❒
Sensitivity testing?	❒		

Have managerial values changed because of DoH healthcare policy? ❒

es please indicate in which as k all appropriate boxes.

Attitudes to staff	❒	Training & development	❒
Aims and Objectives	❒	Sensitivity to customer demand	❒
Style of leadership	❒	Management style	❒
Decision making	❒	Problem solving	❒
Behaviour towards the Organisation	❒		

Should General Managers work by a code of practice (behaviour)? ❒

es please indicate areas which uld be covered in the code of ctice.

Quality of decision making	❒	Conflicts of interest	❒
Bribery	❒	The principles of the code	❒
Social responsibilities	❒	Quality, effectiveness & dignity	❒
Personnel and resource management	❒	Rules of the profession	❒
Rules of the organisation	❒	The organisation's well being	❒
Honesty and trustworthiness	❒	Discrimination	❒
Confidentiality and privacy	❒	Contracts, agreements & responsibilities	❒

throughout. ✓=yes x = no

Are the external policies of your organisation

Financially driven?	❒	Political in nature?	❒
Clinically driven?	❒	Other policies?	❒

Do you have a media policy? ❒

25 Is your organisation sensitive to publicity? ❒

Is your organisation sensitive to media influence? ❒

es, please indicate how sitive your organisation

Has it got a reactionary stance to the media?	❒
Has it got a defensive stance to the media?	❒
Has it formed partnerships with the media?	❒
Has it got a media/communications policy?	❒
Has it got an open access policy to the media?	❒

throughout. ✓ *=yes* x *= no*

What information did you need to do your job successfully in 1991? Please tick appropriate boxes.	Clinical information	❒	Statistical information	❒
	Media information	❒	Textual information	❒
	Financial information	❒	Business information	❒
	Corporate information	❒		

What information do you need to do your job successfully now? Please tick appropriate boxes.	Clinical information	❒	Statistical information	❒
	Media information	❒	Textual information	❒
	Financial information	❒	Business information	❒
	Corporate information	❒		

What additional information not indicated above is required to meet the objectives and goals of your organisation?
Please specify.

_____

_____

_____

_____

_____

What do you believe being successful today entails? Please tick most appropriate boxes.	Meeting contract targets	❒	Meeting all DoH targets.	❒
	Meeting financial targets	❒	Being uncontroversial	❒
	High approval rate from users	❒	High number of five star ratings	❒

What information do you need for monitoring progress in the organisation? Please tick appropriate boxes	Formal reports	❒	Charter Standard targets	❒
	Informal reports	❒	Business plan monitoring	❒
	Bench marking comparisons	❒	Contract performance	❒
	Treatment costs	❒	Human Resource performance	❒
	Income vs. expenditure	❒	Accuracy of communications	❒

What information do you frequently need to hand when making decisions? Please tick appropriate boxes.	Contract performance	❒	Costs of provision of services	❒
	Income & expenditure.	❒	Health of the Nation targets.	❒
	Return on investment	❒	patient Charter performance	❒
	Return on capital	❒	Local population health needs	❒
	Local Purchaser demands	❒	Healthcare outcome data.	❒
	Service planning programme	❒	Competitor performance.	❒

Does the information you receive:	Meet your needs?	❒	Not meet your needs?	❒

throughout. ✓=yes ✗ = no

When receiving information, how do you treat it, especially if it does not appear to meet your immediate needs?	Positively	❒	Negatively	❒
	Indifferently	❒		

Do you believe that your decision making has a direct effect on:	Potential patients?	❒	Actual patients?	❒
	The Purchaser?	❒	Other Providers?	❒
	The health of patients?	❒	Others?	❒

If others, please specify briefly. _____

_____

_____

_____

_____

Do you believe that your decision-making has a direct effect on:	Empowerment of past patients?	❒	Empowerment of present patients?	❒
	Empowerment of future patients?	❒		

Who or what decides what health care the patient really needs? Please tick appropriate boxes.	The patient	❒	The General Managers of the organisation	❒
	The Clinician	❒	Nurses, Pams	❒
	Pressure of demand	❒	Availability of facilities	❒
	He who shouts loudest.	❒	Resource limits	❒
	The Purchaser	❒	Area that patient lives in.	❒
	The GP	❒		

throughout. ✓=yes x = no

Before 1986 who had influence over Healthcare provision? Please tick appropriate boxes.	The Clinicians	❒	The Government	❒
	The patient	❒	The local community	❒

Has the influence changed since 1986? ❒

If yes, how has it changed? Please specify briefly. _____

Who has benefited from the changes in influence? Please tick appropriate boxes.

The Purchaser as an organisation	❒	The Provider as an organisation	❒
The Government	❒	The patients	❒
Local government	❒	The Provider employees	❒
Local people (community)	❒	Clinicians	❒
Other healthcare providers	❒	GPs	❒

LATIONSHIPS BETWEEN doctors, GENERAL MANAGERS AND patients

How would you describe the relationship pre 1986 between doctors and General Managers?

dicate which best describes the ationships pre 1986 between ctors & General Managers. ease tick all appropriate boxes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian *(doctor dominant)*	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Unco-operative	❒	Functional	❒
No relationship to speak of	❒		

throughout. ✓=yes x = no

How would you describe the relationship pre 1986 between patients and General Managers?

dicate which best describes e relationships pre 1986 etween patients & General anagers. lease tick all appropriate xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (patient dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Un co-operative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship pre 1986 between patients and doctors?

dicate which best describes e relationships pre 1986 tween patients & doctors. ease tick all appropriate xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (doctor dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (patient dominant)	❒
Unco-operative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship during 1986 -1991 between doctors and General Managers?

dicate which best describes e relationships between ctors & General Managers. ease tick all appropriate xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (doctor dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Unco-operative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship during 1986 - 1991 between patients and General Managers?

dicate which best describes e relationships between tients & General Managers. ease tick all appropriate xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (patient dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Unco-operative	❒	Functional	❒
No relationship to speak of	❒		

throughout. ✓=yes x = no

How would you describe the relationship during 1986 - 1991 between patients and doctors?

dicate which best describes
e relationships between
atients & doctors.
ease tick all appropriate
xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (doctor dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (patient dominant)	❒
Un co-operative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship now between doctors and General Managers?

dicate which best describes
e relationships between
ctors & General Managers.
ease tick all appropriate
xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (doctor dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Unco-operative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship now between patients and General Managers?

dicate which best describes
e relationships between
tients & General Managers.
ease tick all appropriate
xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (patient. dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (General Manager dominant)	❒
Uncooperative	❒	Functional	❒
No relationship to speak of	❒		

How would you describe the relationship now between patients and doctors?

dicate which best describes
e relationships between
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xes.

Co-operative	❒	A partnership	❒
A hierarchical relationship	❒	Isolated	❒
Dictatorial	❒	Single relationship, different agendas	❒
Authoritarian (doctor dominant)	❒	Aggressive	❒
Patronising	❒	Authoritarian (patient dominant)	❒
Uncooperative	❒	Functional	❒
No relationship to speak of	❒		

throughout. ✓*=yes* x *= no*

power in an organisation is the ability of a group or individual to persuade, induce or coerce others into following certain urses of actions,

Please rank in order of ability to influence the organisation, the groups listed below: (1 is the highest in ranking order....etc)

Clinicians	☐	Management	☐
Pams/Nurses	☐	patients/patient representative groups	☐
Purchasers	☐	GPs	☐
DoH	☐	Media	☐
Unions/Professional bodies	☐	Local community	☐

Is this influence likely to change in the near future? ☐

To indicate any change, please rank in order of ability to influence the organisation, the groups listed below:
(1 is the highest in ranking order....etc)

Clinicians	☐	Management	☐
Pams/Nurses	☐	Patients/patient representative groups	☐
Purchasers	☐	GPs	☐
DoH	☐	Media	☐
Unions/Professional bodies	☐	Local community	☐

Have your information needs been influenced by any change in the balance of power over the last few years? ☐

If yes, please indicate in what areas your information needs have been influenced.
Tick all appropriate boxes.

Contract performance	☐	Management structures	☐
Income & expenditure	☐	Health of the Nation targets	☐
Return on Investment	☐	Patient Charter performance	☐
Return on Capital	☐	Local population health needs	☐
Local Purchaser demands	☐	Healthcare outcome data	☐
Service planning programme	☐	Competitor performance	☐

throughout. ✓=yes x = no

Briefly, indicate the areas in which key changes have occurred in the healthcare environment.

a _____

b _____

c _____

d _____

How have your information needs moved in response to the changes in the Healthcare environment? Please describe briefly.	Become more complex	❒	Improved accuracy	❒
	Become simpler	❒	More flexibility	❒
	Become more sensitive to aims & objectives of the organisation	❒	More specialised	❒
			More generic	❒
	More focused	❒	Less focused	❒

Will the healthcare environment continue to change? ❒

Will you be able to adapt as information needs move to meet changes in the healthcare environment? ❒

If yes, how will you adapt? Please specify briefly.

_____

_____

_____

_____

What do you understand by the NHS market environment? Please describe briefly.

_____

_____

_____

throughout. ✓=yes x = no

0 Is the NHS a "managed" market? ❒

If yes, in what areas of the General Managers' information needs are affected? Please tick all appropriate boxes

Contract performance	❒	Management structures	❒
Income & expenditure	❒	Health of the Nation targets	❒
Return on Investment	❒	patient Charter performance	❒
Return on Capital	❒	Local population health needs	❒
Local Purchaser demands	❒	Healthcare outcome data	❒
Service planning programme	❒	Competitor performance	❒

Should the NHS be in the "market place" for Healthcare? ❒

If no, are there better ways of managing Healthcare? Please specify briefly.

With finite resources available, please specify in order of priority, how a General Manager should spend his organisation's resources on the following?

Information structures		The expansion of services	
The clinical demands of patients		Evidence based decisions	
The clinical demands of doctors		The rationalisation of services	

The NHS market is continually evolving; please briefly describe your perceptions of this evolution.

Is the Healthcare market a mechanism for change? ❒

If yes, how are you preparing for these changes? Please specify briefly.

throughout. ✓=yes x = no

5 How do you perceive your information needs developing in the future? Please indicate below briefly.

_____

_____

_____

_____

6 Healthcare free at the point of access and income generation appear to be opposing philosophies, do you agree? ❒

If yes, how do these conflicts in philosophies affect consumer empowerment in the healthcare market? Please specify briefly.

_____

_____

_____

Who are the customers in the healthcare market? Please specify briefly.

Does the healthcare market provide empowerment to individuals? ❒

If yes, should it continue to do so? ❒

Are the Clinicians' views towards empowerment of the individual one of: please tick all appropriate boxes.

Passive support	❒	No opinion	❒
Disenchantment	❒	Disagreement	❒
Disregard	❒	Active support	❒

How free are the General Managers to make decisions in the present healthcare environment? Please specify briefly.

_____

_____

_____

_____

ank you for taking the time to complete this questionnaire. With your permission, I may need to contact you again to clarify me of your responses to the questions. The responses to this questionnaire are kept strictly anonymous.

Appendix III. Qualitative Responses to Questions

The General Managers were asked to respond to the following Questions (29, 36, 40, 55, 58, 59, 61, 63, 64, 65, 66, 67 and 70). Their responses are summarised below.

29	Describe any Additional information (not indicated in the other questions) required to meet objectives & goals of the Organisation.	Type of Organisation
	Three of the General Managers provided no responses. The other four indicated that the following additional information was required: marketing information, purchasing intentions, Purchaser requirements, and expectations, knowledge of GP requirements and expectations and the views and opinions of staff. Political and demographic information both at national and local level.	PROVIDER
	The three General Managers from Purchaser organisations indicated that information relating to clinical effectiveness outcomes was required and that this should be good and auditable. This information included national trends and feedback from patients.	PURCHASER
	The General Managers from Regional Executive Organisations suggested soft information as a requirement. Also intelligence about the strengths and weaknesses of NHS organisations within the Region.	REGIONAL EXECUTIVE

36	Identify (any other) direct effects of decision-making.	Type of Organisation
	Four of the seven General Managers provided no response. Whereas the remaining General Managers indicated that the effects of decision-making had a direct effect on Social services, Social service Carers and the work force.	PROVIDER
	Two of the General Managers from the Purchaser organisations provided no response. However, the others indicated that patients, GPFHs, Social services & local authorities would be affected directly.	PURCHASER
	The one General Manager from a Regional Executive organisation to respond indicated that the DoH would be affected.	REGIONAL EXECUTIVE

40b	How has influence over healthcare changed since 1986?	Type of Organisation
	Six out of the seven General Managers responded to this question indicating that the local Purchaser has much more influence particularly through his level of funding. There is a stronger political managerial influence. But also a stronger patient awareness. Standards are being imposed, and there is the Purchaser/Provider split which in itself has brought standards of performance and in a limited way improved outcomes. The patient has a greater input and the Government thinks it has a greater input, ie: Calman Cancer Care centres are a good example. Improved power of influence from patients, local communities especially GPs and Purchasers. The Community Health Councils (CHCs) have become more influential.	PROVIDER
	Development of the management culture, patient influence as a user and carer has increased their ability to influence healthcare services. Greater emphasis on health needs, more local decision making, and greater local flexibility in the provision of healthcare services.	PURCHASER
	Patients and GPs are more empowered in deciding healthcare service requirements.	REGIONAL EXECUTIVE

55	Identify areas in which key changes have occurred in the healthcare environment.	Type of organisation
	The General Managers from Provider organisations indicated that the following areas had had key changes occur: GPs have greater power if they are fund-holders; Purchasers and customers have become outcome orientated in the services that they provide. GP commissioning has had an influence on service provision and is seen as a key change as a result of the development of the Purchaser/Provider split in the internal market. More services are primary care led in terms of health evidence based provision. There has been a focusing on outcomes as part of contract targets. GP fund holding has stimulated a certain amount of effectiveness that has quickened service rationalisation. Changes have been brought about in the patient Charter standards and local commissioning; including competition between Providers and some Purchasers that has brought about an increased focus on efficiency and outcomes. Efficiency targets have been developed and implemented and improved Clinical effectiveness sought.	PROVIDER
	The General Managers from Purchaser organisations identified Clinical effectiveness as a key change together with the emergence of HAs as an effective purchaser. Education and research have improved cost effectiveness and efficiency strategies. The market-led provision of services, the development of Performance Protocols and the merging of HAs and FHSAs into unified organisations to purchase local healthcare services.	PURCHASER
	No responses were received from the General Managers from Regional Executive organisations.	REGIONAL EXECUTIVE

58b	How will you adapt as information needs move to meet changes in the Healthcare environment?	Type of Organisation
	Two General Managers from Provider Trusts indicated that they would not be able to adapt as information needs moved to meet changes in the healthcare environment. The remaining five General Managers described their adaptation as developing processes and systems that were flexible and adaptable. Learning and the increasing use of electronic information, collection and collation, were amongst plans that would be employed in response to changes in the healthcare environment. This was followed by a move to computer generated enquiry packages, ad hoc requests, and less formal reports were cited as mechanisms. Also, the tailoring information to General Manager and organisation needs.	PROVIDER
	The General Managers from the Purchaser organisation described information systems improvement, the re-structuring of the information and the re-organisation and merger of healthcare organisations as appropriate responses to environmental changes.	PURCHASER
	The General Managers from Regional Executive organisations felt that the adaptation would follow in the foot-steps of local changes at the HA and Provider levels.	REGIONAL EXECUTIVE

59	What is your understanding of the NHS market environment?	Type of Organisation
	Two of the General Managers gave no indication as to their understanding of the NHS market environment. The remaining five indicated the following understanding: Services that are open to competition, with a requirement to increased efficiency and accuracy. An environment that encourages the behaviour dynamics of identifying and justifying costs, within such people as patients, and Commissioners, and groups who act as gatekeepers of access to healthcare. An environment that has at its core service accessibility, time and distance qualities, and customer service. The need for Providers to respond to the needs of Purchasers. The buying and selling of health services in a fairly restricted environment. Some General Managers expressed a view that it was an ideology unsupported by evidence.	PROVIDER

59	What is your understanding of the NHS market environment?	Type of Organisation
	The General Managers from the Purchaser organisations expressed a view that a market environment does not exist, that it is a managed environment that encourages improved performance at reduced cost. It is a market environment that has constraints, even though the Purchaser is able to make choices, but only at the margins.	PURCHASER
	No responses were given by the General Managers from the Regional Executive organisations.	REGIONAL EXECUTIVE

61b	If the NHS should not be in the "market place" for healthcare, are there better ways of managing healthcare?	Type of Organisation
	Five of the General Managers believed that the NHS should be in the market place and therefore did not respond to this question. The other two General Managers indicated the following; There were other ways of managing the NHS such as a managed local or national service. The General Managers were comfortable with a competitive edge to the service provision but there was also a need for collaboration where this improved clinical effectiveness, cost efficiencies, and treatment outcomes.	PROVIDER
	Two of the General Managers believed that the NHS should be in a managed market. However, the 3rd believed that the NHS should not be in the market place but that disciplines from the market environment should be applied, such as cost effectiveness, efficiency and outcomes and retain the Purchaser Provider split, but replace contracts with longer-term agreements.	PURCHASER
	Both the General Managers from the Regional Executive organisations believed that the NHS should not be in the market place for healthcare, but maintain the concepts of the NHS as espoused in 1948.	REGIONAL EXECUTIVE

63	What are your perceptions of the NHS market environment?	Type of Organisation
	Five of the General Managers shared a perception of a continually evolving NHS. The evolution was described as a politically sensitive area, high profile, and with political tinkering. Clinical developments and the shaping of services were examples of reform; however, financial constraints controlled the rate of change. In some areas, expansion was quick due to high uptake of GPFH. However, it was now maturing and GPFH were less likely to take short-term decisions and were more interested in longer term contracts. Speculative responses indicated that locality commissioning might see resurgence. There will be a greater partnership between the NHS, the Private sector as the ability of the NHS to do elective work reduces. There will be fewer and more concentrated Providers. Some of the General Managers felt that there was a need for more integrated contracting to purchase more holistic healthcare rather than simple episodes. More local purchasing, smaller localities, commissioning GPs, GPs leading with patient and community involvement and longer term contracts between Providers of healthcare and Purchasers.	PROVIDER
	The General Managers from the Purchaser organisations felt that the NHS was going round in circles without addressing the real issues. There needed to be greater control of resources, wider involvement of GPs in the purchasing process, and the up-take of the opportunities for meeting needs much more.	PURCHASER
	The only General Manager from the Regional Executive organisation to respond to this question intimated a move to collaboration as opposed to competition, as the reality of not being able to make the market decisions work.	REGIONAL EXECUTIVE

64b	If you agree that the healthcare market is a mechanism for change, then what are your preparations for change?	Type of Organisation
	One General Manager believed that the healthcare market was not a mechanism for causing change within the organisations. However, the market gave the opportunity of anticipating locality purchasing, also to monitor the political development and policy changes and adjust priorities for clinical investment with the reconfiguration of services from low return clinical services to be provided elsewhere, thus becoming more cost/clinically effective. The view was expressed that the organisations should be preparing for a new Government. Changes identified included the focusing on local provision and being more responsive to local needs, and service reviews being undertaken with local providers to deliver comprehensive services.	PROVIDER
	Two out of three of the General Managers from the Purchaser organisations believed that the market was a mechanism for change, facilitating the development of a strategic framework for the next 5 years and signalling annual change in purchasing plans. Also enabling the Organisations to become pro-active through innovation both internally and externally.	PURCHASER
	The General Managers from the Regional Executive organisations responded that the market was not a mechanism for change. No further details were available to support this view.	REGIONAL EXECUTIVE

65	What are your perception of future information needs?	Type of Organisation
	Six of the General Managers identified the following needs: Improved hospital wide information system, networking to GPs that was patient based. A powerful database of aggregated information, allowing distant – medical orders framing diagnoses. Information systems need to be flexible, to respond to the changes. Ability to measure performance and outcomes of healthcare input. Existing systems need urgent development for community information systems linked to GP premises to improve communications. Improved IT strategies that can be implemented quickly and effectively. More rapid up-to-date information aimed by "sharp end" staff entering information as close to the actual time as possible. Information available quickly on financial contracts, patients and clinical activity and outcomes. Increasing emphasis on Value For Money (VFM) and competitive performance.	PROVIDER
	The General Managers from the Purchaser organisations responses indicated the following needs: Locality based information. More information as outcomes. More integration between primary & secondary care information. Information systems driven by population health profiles pan district. Improved information from Providers, such as whole population data, key indicators, performance measures, clinical effectiveness indicators such as for success intervention, survival, relevance of cancer, more automation, reduced complexity, improved accuracy and meaningfulness of data.	PURCHASER
	The view from the General Managers from the Regional Executive organisations was not specific, indicating that any requirement for information would depend on Government policy of the day.	REGIONAL EXECUTIVE

66b	What are the effects of conflicting philosophies on consumer empowerment?	Type of Organisation
	Five of the General Managers did not agree that free healthcare at the point of access and income generation caused a conflict. The other two perceived that a conflict of philosophies existed and may affect consumer empowerment because the needs of consumers may be jeopardised with the need to meet Purchasers' requirements to prioritise services.	PROVIDER
	One General Manager from the Purchaser Organisations agreed that there could be a conflict of philosophies with the need for income generation influencing customer empowerment.	PURCHASER
	Both General Managers from the Regional Executive organisations indicated that they did not believe there was any conflict of philosophies.	REGIONAL EXECUTIVE

67	Who do you believe are your Customers in the healthcare market?	Type of Organisation
	The General Managers were asked to list who they believed were the customers in the healthcare market and the following list indicates their views: patients, GPs and GPFHs, Purchasers, the Government, Tax payers, HAs, Relatives and Carers. Clinicians Local communities. Other Trusts.	PROVIDER
	The General Managers from the Purchaser organisations views are listed below: patients, GPs, Local community, DoH The Population in general, and Purchasers. Potential patients and Carers	PURCHASER
	No responses were received from the General Managers from the Regional Executive organisations.	REGIONAL EXECUTIVE

70	How much freedom do you have to make decisions in the present environment?	Type of Organisation
	The General Managers were asked their views on the amount of freedom that they believed a manager had when making decisions in the present healthcare climate. Their views indicated that the introduction of legislation and contracting had reduced the freedom of managers to move resources within the system in response to identified needs at a provider level. However, devolution of budgets within the organisation had mitigated the local managers' freedom to make limited decisions. But these local freedoms were further restricted by the external & political environment restrictions. The General Managers believed that performance management was a strong control mechanism on their Organisation that appeared to make freedoms very restricted. Orders from the "centre" continued to deluge the organisations and all action seems to have short-term political objectives. It was felt those that some managers had the ability to influence healthcare in present environment, but that finance, contracting processes, Charter standards, the demands of GPs, Purchasers and clinical considerations had the potential to impose constraints on the managers' abilities to influence.	PROVIDER
	The General Managers from the Purchaser organisations indicated that the range of freedoms to make decisions varied according to context, and where they "sat" in the organisational hierarchy. The constraints of the managers' contract and DoH organisational policies, the HAs strategic framework and policies, and resource constraints would heavily influence their freedoms to manage.	PURCHASER
	The General Managers from the Regional Executive organisations felt that the freedoms of the manager to make decisions had to be seen at the micro level of healthcare provision and that they did not influence the Macro healthcare policies.	REGIONAL EXECUTIVE

Appendix IV. Table of Results

Ques. No	Question: What phrase (below) fits closely to your understanding of consumerism?	Yes	No	% Yes	% No
1a	Looking after the Purchaser/patient	3	9	25%	75%
1b	A financial philosophy within the organisation	1	11	8%	92%
1c	A philosophy that satisfies the Purchaser/patient	5	7	42%	58%
1d	Protection of the interests of the Purchaser/patient	8	4	67%	33%
1e	A philosophy based on a sound economy	2	10	17%	83%

Ques No	Questions (below):	Yes	No	% Yes	% No
2	Is the NHS operating in a consumer environment?	6	6	50%	50%
3	Has consumerism helped the patient?	7	5	58%	42%
4	Should the NHS operate in a consumer environment?	11	1	92%	8%
5	Has consumerism directed the Purchaser?	7	5	58%	42%

Ques No	Question: Who knows best about healthcare needs?	Yes	No	% Yes	% No
6a	The patient	5	7	42%	58%
6b	The Provider	6	6	50%	50%
6c	The Purchaser	6	6	50%	50%

Ques No	Questions (below):	Yes	No	% Yes	% No
7	Should the Provider involve the customer in the type of service provided?	12	0	100%	0%
8	Has the Provider any social responsibilities in relation to service provision?	11	1	92%	8%

Ques No	Question: How would you describe the role of the local community in the provision of healthcare?	Yes	No	% Yes	% No
9a	Ensuring Survival	4	8	33%	67%
9b	Financial	1	11	8%	92%
9c	Increasing local competition	0	12	0%	100%
9d	Providing direction for local services	11	1	92%	8%

Ques No	Questions (below):	Yes	No	% Yes	% No
11	Does your organisation have a business code of practice?	5	7	42%	58%
12a	Is the code enshrined in each General Managers' contract?	3	9	25%	75%
12b	Is adherence to the code monitored?	2	10	17%	83%
12c	Is the code applicable to senior managers only?	1	11	8%	92%
12d	Is the code applicable to all staff?	3	9	25%	75%

Ques No	Question: Is your management culture one of the following?	Yes	No	% Yes	% No
13a	Authoritarian management	2	10	17%	83%
13b	Consensus management	6	6	50%	50%
13c	Democratic management	5	7	42%	58%

Ques No	Questions (below):	Yes	No	% Yes	% No
14a	Has this cultural attitude (q13) affected your organisation?	7	5	58%	42%

Ques No	Question: How would you describe your organisation?	Yes	No	% Yes	% No
14b	Defensive	3	9	25%	75%
14c	Entrepreneurial	4	8	33%	67%
14d	Analytical	8	4	67%	33%
14e	Centralist	1	11	8%	92%
14f	Devolutionist	11	1	92%	8%
14g	Controlling	0	12	0%	100%
14h	Collaboration	10	2	83%	17%
14i	Competition	4	8	33%	67%
14j	Conform to beliefs	2	10	17%	83%
14k	Challenge beliefs	10	2	83%	17%

Ques No	Questions (below):	Yes	No	% Yes	% No
15a	Do you meet with clinicians?	10	2	83%	17%

Ques No	Question: If yes to Q15a tick the subject matter discussed as a regular issue.	Yes	No	% Yes	% No
15b	Medical Audit	7	5	58%	42%
15c	Clinical management	6	6	50%	50%
15d	patient care planning	5	7	42%	58%
15e	Clinical protocols	5	7	42%	58%
15f	Contract performance	8	4	67%	33%
15g	Trust financial performance	8	4	67%	33%
15h	Trust management	8	4	67%	33%
15I	Communications	7	5	58%	42%

Ques No	Questions (below):	yes	No	% yes	% No
16a	Do you meet with GPs?	10	2	83%	17%

Ques No	Question: If yes to Q16a please tick subject matter discussed as a regular issue.	Yes	No	% Yes	% No
16b	Trust (Provider organisations) clinical performance	6	6	50%	50%
16c	Access to Trust (Provider organisations) facilities	9	3	75%	25%
16d	Access to beds	6	6	50%	50%
16e	Cost of services provided	6	6	50%	50%
16f	Contribution of GPs to the management of the organisation	8	4	67%	33%
16g	Services provided for the local community	9	3	75%	25%
16h	Support for GPs	7	5	58%	42%
16i	Communications	9	3	75%	25%
16j	Contracting issues	9	3	75%	25%

Ques No	Questions (below):	yes	No	% yes	% No
17a	Do you meet with patients or their representatives?	9	3	75%	25%

Ques No	Question: If yes to Q17a please tick subject matter discussed as a regular issue.	Yes	No	% Yes	% No
17b	Available facilities	5	7	42%	58%
17c	Hotel services	2	10	17%	83%
17d	Access to Clinicians	2	10	17%	83%
17e	Fund raising	3	9	25%	75%
17f	Complaints	7	5	58%	42%
17g	Waiting times in A&E /OPD	3	9	25%	75%
17h	Waiting lists	4	8	33%	67%
17i	Effectiveness of treatment	2	10	17%	83%
17j	Communications	7	5	58%	42%
17k	patient Charter standards	5	7	42%	58%

Ques No	Questions (below):	Yes	No	% Yes	% No
18a	Has DoH healthcare policy changed your organisation?	11	1	92%	8%

Ques No	Question: If yes to Q18a please tick as many of the boxes as appropriate.	Yes	No	% Yes	% No
18b	In the area of contracting	9	3	75%	25%
18c	In the area of primary health care.	10	2	83%	17%
18d	In the area of management	12	0	100%	0%
18e	In the area of strategy	11	1	92%	8%
18f	Size of organisation	5	7	42%	58%
18g	In the area of services offered	2	10	17%	83%
18h	The patient care environment	1	11	8%	92%
18I	In the area of clinical practice	3	9	25%	75%
18j	In the area of marketing	4	8	33%	67%
18k	In the area of financial control	12	0	100%	0%
18l	In the area of human resources	7	5	58%	42%

Ques No	Questions (below):	yes	No	% yes	% No
19a	Is your organisational environment responsive to changes in DoH healthcare policy?	10	2	83%	17%

Ques No	Question: If yes to Q19a, indicate in which areas your organisation is responsive.	Yes	No	% Yes	% No
19b	Is the organisation in a state of change	9	3	75%	25%
19c	Is your organisation dynamic	10	2	83%	17%
19d	Is your organisation static	0	12	0%	100%
19e	Is health policy a threat	1	11	8%	92%
19f	Is health policy an opportunity	11	1	92%	8%
19g	Has the environment improved	6	6	50%	50%
19h	Has your organisation coped with the changes	9	3	75%	25%
19I	Is your organisation very sensitive to health policy	6	6	50%	50%
19j	Is your organisation sensitive to health policy	5	7	42%	58%
19k	Is your organisation cautious to health policy	2	10	17%	83%
19l	Has strategy changed	9	3	75%	25%
19m	Has the environment remained unchanged	0	12	0%	100%

Ques No	Question: How do you cope with environmental change?...by;	Yes	No	% Yes	% No
20a	Scenario planning	10	2	83%	17%
20b	Contingency planning	9	3	75%	25%
20c	Sensitivity testing	3	9	25%	75%
20d	Model building	6	6	50%	50%
20e	Specialist attention to elements of the change	5	7	42%	58%

Ques No	Questions (below):	yes	No	% yes	% No
21a	Have managerial values changed because of health policy?	12	0	100%	0%

Ques No	Question: If yes to Q21a please indicate in which areas	Yes	No	% Yes	% No
21b	Attitudes to staff	4	8	33%	67%
21c	Aims and objectives	10	2	83%	17%
21d	Style of leadership	5	7	42%	58%
21e	Decision making	7	5	58%	42%
21f	Behaviour towards the organisation	2	10	17%	83%
21g	Training & development	6	6	50%	50%
21h	Sensitivity to customer demand	8	4	67%	33%
21I	Management style	4	8	33%	67%
21j	Problem solving	2	10	17%	83%

Ques No	Questions (below):	Yes	No	% Yes	% No
22a	Should General Managers work by a code of practice (behaviour)?	12	0	100%	0%

Ques No	Question: if yes to Q22a indicate areas that should be covered in the code of practice.	Yes	No	% Yes	% No
22b	Quality of decision making	6	6	50%	50%
22c	Bribery	7	5	58%	42%
22d	Social responsibilities	7	5	58%	42%
22e	Personnel and resource management	7	5	58%	42%
22f	Rules of the organisation	8	4	67%	33%
22g	Honesty and trustworthiness	10	2	83%	17%
22h	Confidentiality and privacy	10	2	83%	17%
22i	Conflicts of interest	10	2	83%	17%
22j	The principles of the code	7	5	58%	42%
22k	Quality, effectiveness and dignity	7	5	58%	42%
22l	Rules of the profession	5	7	42%	58%
22m	The Organisations well being	5	7	42%	58%
22n	Discrimination	7	5	58%	42%
22o	Contracts, agreements & responsibilities	8	4	67%	33%

Ques No	Question: Are the external policies of your organisation.	Yes	No	% Yes	% No
23a	Financially driven	11	1	92%	8%
23b	Clinically driven	11	1	92%	8%
23c	Political in nature	6	6	50%	50%
23d	Other policies	1	11	8%	92%

Ques No	Questions (below):	Yes	No	% Yes	% No
24	Do you have a media policy?	7	5	58%	42%
25	Is your organisation sensitive to publicity?	11	1	92%	8%

Ques No	Questions (below):	Yes	No	% Yes	% No
26a	Is your organisation sensitive to media influence?	12	0	100%	0%

Ques No	Question: If yes to Q26a please indicate how sensitive your organisation is.	Yes	No	% Yes	% No
26b	Has it got a reactionary stance to the media?	2	10	17%	83%
26c	Has it got a defensive stance to the media?	0	12	0%	100%
26d	Has it formed partnerships with the media?	9	3	75%	25%
26e	Has it got a media/communications policy?	7	5	58%	42%
26f	Has it got an open access policy to the media?	4	8	33%	67%

Ques No	Question: What information did you need to do your job successfully in 1991?	Yes	No	% Yes	% No
27a	Clinical information	5	7	42%	58%
27b	Media information	2	10	17%	83%
27c	Financial information	10	2	83%	17%
27d	Corporate Information	6	6	50%	50%
27e	Statistical Information	11	1	92%	8%
27f	Textual information	5	7	42%	58%
27g	Business information	1	11	8%	92%

Ques No	Question: What information do you need to do your job successfully now?	Yes	No	% Yes	% No
28a	Clinical information	9	3	75%	25%
28b	Media information	7	5	58%	42%
28c	Financial information	12	0	100%	0%
28d	Corporate Information	11	1	92%	8%
28e	Statistical Information	11	1	92%	8%
28f	Textual information	7	5	58%	42%
28g	Business information	10	2	83%	17%

Ques No	Question: What do you believe being successful today entails?	Yes	No	% Yes	% No
30a	Meeting contract targets	7	5	58%	42%
30b	Meeting financial targets	8	4	67%	33%
30c	High approval rate from users	8	4	67%	33%
30d	Meeting all DoH targets	6	6	50%	50%
30e	Being uncontroversial	1	11	8%	92%
30f	High number of five star ratings	2	10	17%	83%

Ques No	Question: What information do you need for monitoring progress in the organisation?	Yes	No	% Yes	% No
31a	Formal reports	10	2	83%	17%
31b	Informal reports	9	3	75%	25%
31c	Benchmarking comparisons	9	3	75%	25%
31d	Treatment costs	7	5	58%	42%
31e	Income vs expenditure	10	2	83%	17%
31f	Charter standards	7	5	58%	42%
31g	Business plan monitoring	9	3	75%	25%
31h	Contract performance	10	2	83%	17%
31I	Human resource performance	6	6	50%	50%
31j	Accuracy of communications	8	4	67%	33%

Ques No	Question: What information do you frequently need to hand when making decisions?	Yes	No	% Yes	% No
32a	Contract performance	8	4	67%	33%
32b	Income & Expenditure	9	3	75%	25%
32c	Return on Investment	1	11	8%	92%
32d	Return on capital	1	11	8%	92%
32e	Local Purchaser demands	7	5	58%	42%
32f	Service planning programme	5	7	42%	58%
32g	Costs of provision of services	3	9	25%	75%
32h	Health of the Nation targets	3	9	25%	75%
32i	patient Charter performance	4	8	33%	67%
32j	Local population health needs	7	5	58%	42%
32k	Healthcare outcome data	6	6	50%	50%
32l	Competitor performance	1	11	8%	92%

Ques No	Question: Does the information you receive.....	Yes	No	% Yes	% No
33a	Meet your needs?	6	6	50%	50%
33b	Not meet your needs?	5	7	42%	58%

Ques No	Question: When receiving information, how do you treat it, especially if it does not appear to meet your immediate needs?	Yes	No	% Yes	% No
34a	Positively	7	5	58%	42%
34b	Indifferently	3	9	25%	75%
34c	Negatively	0	12	0%	100%

Ques No	Question: Do you believe that your decision-making has a direct effect on the following;	Yes	No	% Yes	% No
35a	Potential patients	9	3	75%	25%
35b	The Purchaser	7	5	58%	42%
35c	The health of patients	6	6	50%	50%
35d	Actual patients	10	2	83%	17%
35e	Other Providers	8	4	67%	33%
35f	Others	4	8	33%	67%

Ques No	Question: Do you believe that your decision-making has a direct effect on the following;	Yes	No	% Yes	% No
37a	Empowerment of patients	0	12	0%	100%
37b	Empowerment of future patients	8	4	67%	33%
37c	Empowerment of present patients	8	4	67%	33%

Ques No	Question: Who or what decides what healthcare the patients really need.	Yes	No	% Yes	% No
38a	The patient	6	6	50%	50%
38b	The Clinician	11	1	92%	8%
38c	Pressure of demand	3	9	25%	75%
38d	He who shouts loudest	0	12	0%	100%
38e	The Purchaser	7	5	58%	42%
38f	The GP	5	7	42%	58%
38g	The General Managers of the organisations	1	11	8%	92%
38h	Nurses, PAMs	3	9	25%	75%
38i	Availability of facilities	5	7	42%	58%
38j	Resource limits	6	6	50%	50%
38k	Area that patient lives in	4	8	33%	67%

Ques No	Question: Before 1986 who had influence over healthcare provision?	Yes	No	% Yes	% No
39a	The Clinicians	12	0	100%	0%
39b	The patients	2	10	17%	83%
39c	The Government	9	3	75%	25%
39d	The local community	3	9	25%	75%

Ques No	Questions (below):	Yes	No	% Yes	% No
40	Has the influence changed since 1986?	11	1	92%	8%

Ques No	Question:Who has benefited from the changes in influence?	Yes	No	% Yes	% No
41a	The Purchaser as an organisation	5	7	42%	58%
41b	The Government	5	7	42%	58%
41c	Local Government	0	12	0%	100%
41d	Local people (community)	4	8	33%	67%
41e	Other healthcare providers	1	11	8%	92%
41f	The Provider as an organisation	4	8	33%	67%
41g	The patients	9	3	75%	25%
41h	The Provider employees	1	11	8%	92%
41i	Clinicians	2	10	17%	83%
41j	GPs	5	7	42%	58%

Ques No	Question: How would you describe the relationship pre 1986 between doctors and General Managers?	Yes	No	% Yes	% No
42a	Cooperative	4	8	33%	67%
42b	A hierarchical relationship	2	10	17%	83%
42c	Dictatorial	3	9	25%	75%
42d	Authoritarian (doctor dominant)	4	8	33%	67%
42e	Patronising	1	11	8%	92%
42f	Unco-operative	2	10	17%	83%
42g	No relationship to speak of	1	11	8%	92%
42h	A partnership	1	11	8%	92%
42i	Isolated	3	9	25%	75%
42j	Single relationship, different agendas	2	10	17%	83%
42k	Aggressive	1	11	8%	92%
42l	Authoritarian (General Manager dominant)	0	12	0%	100%
42m	Functional	3	9	25%	75%

Ques No	Question: How would you describe the relationship pre 1986 between patients and General Managers?	Yes	No	% Yes	% No
43a	Cooperative	2	10	17%	83%
43b	A hierarchical relationship	1	11	8%	92%
43c	Dictatorial	0	12	0%	100%
43d	Authoritarian (patient dominant)	1	11	8%	92%
43e	Patronising	1	11	8%	92%
43f	Unco-operative	0	12	0%	100%
43g	No relationship to speak of	7	5	58%	42%
43h	A partnership	0	12	0%	100%
43I	Isolated	3	9	25%	75%
43j	Single relationship, different agendas	2	10	17%	83%
43k	Aggressive	0	12	0%	100%
43l	Authoritarian (General Manager dominant)	1	11	8%	92%
43m	Functional	2	10	17%	83%

Ques No	Question: How would you describe the relationship pre 1986 between patients and doctors?	Yes	No	% Yes	% No
44a	Co-operative	3	9	25%	75%
44b	A hierarchical relationship	7	5	58%	42%
44c	Dictatorial	3	9	25%	75%
44d	Authoritarian (doctor dominant)	5	7	42%	58%
44e	Patronising	7	5	58%	42%
44f	Unco-operative	0	12	0%	100%
44g	No relationship to speak of	0	12	0%	100%
44h	A partnership	1	11	8%	92%
44i	Isolated	0	12	0%	100%
44j	Single relationship, different agendas	0	12	0%	100%
44k	Aggressive	0	12	0%	100%
44l	Authoritarian (patient dominant)	0	12	0%	100%
44m	Functional	4	8	33%	67%

Ques No	Question: How would you describe the relationship during the period 1986-1991 between doctors and General Managers?	Yes	No	% Yes	% No
45a	Co-operative	7	5	58%	42%
45b	A hierarchical relationship	2	10	17%	83%
45c	Dictatorial	1	11	8%	92%
45d	Authoritarian (doctor dominant)	3	9	25%	75%
45e	Patronising	1	11	8%	92%
45f	Unco-operative	1	11	8%	92%
45g	No relationship to speak of	0	12	0%	100%
45h	A partnership	2	10	17%	83%
45I	Isolated	0	12	0%	100%
45j	Single relationship, different agendas	4	8	33%	67%
45k	Aggressive	2	10	17%	83%
45l	Authoritarian (General Manager dominant)	1	11	8%	92%
45m	Functional	6	6	50%	50%

Ques No	Question: How would you describe the relationship during the period 1986-1991 between patients and General Managers?	Yes	No	% Yes	% No
46a	Co-operative	4	8	33%	67%
46b	A hierarchical relationship	1	11	8%	92%
46c	Dictatorial	1	11	8%	92%
46d	Authoritarian (patient dominant)	0	12	0%	100%
46e	Patronising	2	10	17%	83%
46f	Unco-operative	0	12	0%	100%
46g	No relationship to speak of	6	6	50%	50%
46h	A partnership	2	10	17%	83%
46i	Isolated	1	11	8%	92%
46j	Single relationship, different agendas	2	10	17%	83%
46k	Aggressive	0	12	0%	100%
46l	Authoritarian (General Manager dominant)	3	9	25%	75%
46m	Functional	3	9	25%	75%

Ques No	Question: How would you describe the relationship during the period 1986-1991 between patients and doctors?	Yes	No	% Yes	% No
47a	Co-operative	6	6	50%	50%
47b	A hierarchical relationship	3	9	25%	75%
47c	Dictatorial	2	10	17%	83%
47d	Authoritarian (doctor dominant)	4	8	33%	67%
47e	Patronising	4	8	33%	67%
47f	Unco-operative	0	12	0%	100%
47g	No relationship to speak of	1	11	8%	92%
47h	A partnership	2	10	17%	83%
47I	Isolated	0	12	0%	100%
47j	Single relationship, different agendas	0	12	0%	100%
47k	Aggressive	0	12	0%	100%
47l	Authoritarian (patient dominant)	0	12	0%	100%
47m	Functional	5	7	42%	58%

Ques No	Question: How would you describe the relationship now between doctors and General Managers?	Yes	No	% Yes	% No
48a	Co-operative	9	3	75%	25%
48b	A hierarchical relationship	0	12	0%	100%
48c	Dictatorial	0	12	0%	100%
48d	Authoritarian (doctor dominant)	1	11	8%	92%
48e	Patronising	0	12	0%	100%
48f	Unco-operative	0	12	0%	100%
48g	No relationship to speak of	0	12	0%	100%
48h	A partnership	9	3	75%	25%
48i	Isolated	0	12	0%	100%
48j	Single relationship, different agendas	2	10	17%	83%
48k	Aggressive	0	12	0%	100%
48l	Authoritarian (General Manager dominant)	0	12	0%	100%
48m	Functional	5	7	42%	58%

Ques No	Question: How would you describe the relationship now between patients and General Managers?	Yes	No	% Yes	% No
49a	Co-operative	7	5	58%	42%
49b	A hierarchical relationship	0	12	0%	100%
49c	Dictatorial	0	12	0%	100%
49d	Authoritarian (patient dominant)	1	11	8%	92%
49e	Patronising	1	11	8%	92%
49f	Unco-operative	0	12	0%	100%
49g	No relationship to speak of	1	11	8%	92%
49h	A partnership	4	8	33%	67%
49I	Isolated	2	10	17%	83%
49j	Single relationship, different agendas	1	11	8%	92%
49k	Aggressive	0	12	0%	100%
49l	Authoritarian (General Manager dominant)	1	11	8%	92%
49m	Functional	4	8	33%	67%

Ques No	Question: How would you describe the relationship now between patients and doctors?	Yes	No	% Yes	% No
50a	Co-operative	8	4	67%	33%
50b	A hierarchical relationship	2	10	17%	83%
50c	Dictatorial	0	12	0%	100%
50d	Authoritarian (doctor dominant)	2	10	17%	83%
50e	Patronising	1	11	8%	92%
50f	Unco-operative	0	12	0%	100%
50g	No relationship to speak of	0	12	0%	100%
50h	A partnership	7	5	58%	42%
50i	Isolated	0	12	0%	100%
50j	Single relationship, different agendas	0	12	0%	100%
50k	Aggressive	0	12	0%	100%
50l	Authoritarian (patient dominant)	0	12	0%	100%
50m	Functional	6	6	50%	50%

Ques No	Questions (below):	Yes	No	% Yes	% No
52	Is this influence likely to change in the near future?	7	5	58%	42%

Ques No	Questions (below):	Yes	No	% Yes	% No
54a	Have your information needs been influenced by any change in the balance of power over the last few years?	9	3	75%	25%

Ques No	Question: If yes to Q54a indicate in what areas your information needs have been influenced.	Yes	No	% Yes	% No
54b	Contract performance	9	3	75%	25%
54c	Income & Expenditure	6	6	50%	50%
54d	Return on Investment	2	10	17%	83%
54e	Return on Capital	2	10	17%	83%
54f	Local Purchaser demands	7	5	58%	42%
54g	Service planning programme	4	8	33%	67%
54h	Management structures	3	9	25%	75%
54i	Health of the Nation targets	4	8	33%	67%
54j	patient Charter performance	6	6	50%	50%
54k	Local population health needs	3	9	25%	75%
54l	Healthcare outcome data	4	8	33%	67%
54m	Competitor performance	5	7	42%	58%

Ques No	Question: How your information needs moved in response to the changes in the healthcare environment?	Yes	No	% Yes	% No
56a	Become more complex	9	3	75%	25%
56b	Become simpler	0	12	0%	100%
56c	Become more sensitive to the aims & objectives of the organisation	5	7	42%	58%
56d	More focused	7	5	58%	42%
56e	Improved accuracy	6	6	50%	50%
56f	More flexibility	3	9	25%	75%
56g	More specialised	3	9	25%	75%
56h	More generic	1	11	8%	92%
56i	Less focused	0	12	0%	100%

Ques No	Questions (below):	Yes	No	% Yes	% No
57	Will the healthcare environment continue to change?	11	1	92%	8%

Ques No	Questions (below):	Yes	No	% Yes	% No
58a	Will you be able to adapt as information needs move to meet changes in the healthcare environment?	9	3	75%	25%

Ques No	Questions (below):	Yes	No	% Yes	% No
60a	Is the NHS a "managed" market?	9	3	75%	25%

Ques No	If the NHS is a "managed" market, what areas of information needs are affected?	Yes	No	% Yes	% No
60b	Contract performance	9	3	75%	25%
60c	Income & Expenditure	8	4	67%	33%
60d	Return on Investment	2	10	17%	83%
60e	Return on Capital	3	9	25%	75%
60f	Local Purchaser demands	8	4	67%	33%
60g	Service planning programme	7	5	58%	42%
60h	Management structures	1	11	8%	92%
60i	Health of the Nation targets	6	6	50%	50%
60j	patient Charter performance	8	4	67%	33%
60k	Local population health needs	6	6	50%	50%
60l	Healthcare outcome data	4	8	33%	67%
60m	Competitor performance	4	8	33%	67%

Ques No	Questions (below):	Yes	No	% Yes	% No
61a	Should the NHS be in the "market place" for healthcare?	7	5	58%	42%
64a	Is the healthcare market a mechanism for change?	8	4	67%	33%
66a	Healthcare free at the point of access and income generation appear to be opposing philosophies, do you agree?	3	9	25%	75%

Ques No	Questions (below):	Yes	No	% Yes	% No
68a	Does the healthcare market provide empowerment to individuals?	2	10	17%	83%
68b	If yes to 68a, should it continue to do so?	1	11	8%	92%

Ques No	Is the Clinician's views towards empowerment of the individual, one of:	Yes	No	% Yes	% No
69a	Passive support	6	6	50%	50%
69b	Disenchantment	0	12	0%	100%
69c	Disregard	2	10	17%	83%
69d	No opinion	1	11	8%	92%
69e	Disagreement	0	12	0%	100%
69f	Active support	1	11	8%	92%

Appendix V. Table of results for Questions 51, 53, 62

Question 51: Which Groups had the Ability to Influence, (Present Day),expressed as a % of the total Number of General Managers voting and as the number of General Managers "voting" for Each of the Groups

Group	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
Clinicians	42% **5**	25% **3**	8% **1**	8% **1**	0%	0%	0%	0%	0%	0%
DoH	17% **2**	8% **1**	8% **1**	17% **2**	17% **2**	8% **1**	8% **1**	0%	0%	0%
GPs	17% **2**	8% **1**	25% **3**	8% **1**	17% **2**	0%	8% **1**	0%	0%	0%
Local community	0%	0%	8% **1**	0%	0%	0%	8% **1**	17% **2**	17% **2**	25% **3**
Management	17% **2**	33% **4**	8% **1**	8% **1**	8% **1**	0%	8% **1**	0%	0%	0%
Media	0%	0%	0%	0%	8% **1**	17% **2**	0%	8% **1**	17% **2**	25% **3**
Pams/Nurses	0%	0%	0%	8% **1**	25% **3**	8% **1**	25% **3**	0%	8% **1**	0%
patients/patient representative groups	0%	0%	17% **2**	25% **3**	0%	17% **2**	8% **1**	8% **1**	8% **1**	0%
Purchasers	8% **1**	25% **3**	25% **3**	0%	0%	17% **2**	0%	0%	0%	0%
Unions/Professional bodies	0%	0%	0%	0%	8%	0%	0%	33%	17%	17%

Question 53: Which Groups had the Ability to Influence, (Future),expressed as a % of the total Number of General Managers voting and as the number of General Managers "voting" for Each of the Groups

Group	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
Clinicians	8% *1*	25% *3*	8% *1*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*
DoH	8% *1*	0% *0*	17% *2*	8% *1*	0% *0*	0% *0*	0% *0*	8% *1*	0% *0*	0% *0*
GPs	8% *1*	8% *1*	0% *0*	17% *2*	8% *1*	0% *0*	8% *1*	0% *0*	0% *0*	0% *0*
Local community	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	8% *1*	8% *1*	8% *1*	17% *2*	0% *0*
Management	17% *2*	8% *1*	8% *1*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	8% *1*
Media	0% *0*	8% *1*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	17% *2*	17% *2*	8% *1*
Pams/ Nurses	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*	25% *3*	0% *0*	0% *0*	0% *0*	17% *2*
patients/patients representative groups	8% *1*	0% *0*	0% *0*	17% *2*	25% *3*	0% *0*	0% *0*	0% *0*	0% *0*	0% *0*
Purchasers	8% *1*	0% *0*	8% *1*	0% *0*	8% *1*	8% *1*	8% *1*	0% *0*	0% *0*	0% *0*
Unions/Professional bodies	0%	0%	0%	0%	0%	0%	17%	8%	8%	8%

Question 62: The General Managers' Resource allocation priorities expressed as a % of all the group and as the number of General Managers that "voted".

With finite resources available, specify in order of priority how resources should be spent	1st	2nd	3rd	4th	5th	6th	Total
Evidence based decisions	58% **7**	8% **1**	8% **1**	0% **0**	0% **0**	0% **0**	75% **9**
Information structures	0% **0**	0% **0**	8% **1**	33% **4**	17% **2**	8% **1**	67% **8**
The clinical demands of doctors	0% **0**	8% **1**	8% **1**	17% **2**	25% **3**	8% **1**	67% **8**
The clinical demands of patients	33% **4**	0% **0**	42% **5**	8% **1**	0% **0**	0% **0**	83% **10**
The expansion of services.	0% **0**	8% **1**	0% **0**	8% **1**	8% **1**	42% **5**	67% **8**
The rationalisation of services.	0%	50%	0%	0%	17%	8%	75%

Appendix VI. The White Paper 1997

INTRODUCTION

The Government's White Paper on the NHS "The New NHS - Modern, Dependable- was published on 10 December 1997.

This summary identifies the likely effect of its principal proposals upon Private Finance Initiative (PFI) in general. The White Paper on its publication received a broadly positive response throughout the NHS and many of its main themes: re-integration, evidence based medicine, and locality commissioning, continued directions already set, not only in the present Government's manifesto but also by the last Government. The transfer of policy initiatives from other sectors was also apparent. The threat of intervention in under-performing hospitals, for example, clearly echoed the task force approach to failing schools. The main surprises included the abrupt end to GP Fundholding (from April 1999), the effective merging of primary care, hospital and drugs budgets and the introduction of "Clinical governance" responsibilities for Trust (Provider) Chief Executive Officers (CE0s).
A near unanimous response to the White Paper has resulted in little knowledge about how changes are to be implemented. This was effectively acknowledged by the series of Working Papers, which were to follow. Consequently, the likely pace and longer-term impact of the proposals was uncertain, particularly for a relatively young Government, which had still to demonstrate its ability to face down powerful interest groups. This uncertainty was reflected in commentators' differing interpretations of how, and to whom power was to be redistributed by the White Paper. The assessment below therefore represents a judgement made at a particular point in time.

The White Paper contained few specific references to PFI other than to note how the "inherited log-jam had been broken" and to reaffirm that future prioritisation for capital investment, whether, public or privately funded, would be firmly based upon health need. It also noted exploration of the potential to extend "public private partnerships" into "non-acute areas" - IT, community health.

Key Principles of the White Paper are:

A national service - with consistent access to, and quality of, services

- Local responsibility - particularly for doctors and nurses for delivering healthcare (but to national standards).
- Partnerships - strengthening relationships, within hitherto separate parts of the NHS, and between the NHS and local authorities.
- Efficiency - including national monitoring of performance and continued pressure on management costs.
- Excellence in the quality of clinical care.
- Public confidence - built upon openness and accountability and responsiveness to public opinion.

The White Paper's principal proposals are as follows:

1. Quality and Efficiency

National Service Frameworks - based upon evidence of clinical effectiveness to ensure consistent access and quality of care for particular services. The White paper refers to the existing Calman Hine proposals for Cancer services as an example.

National institute for Clinical Excellence (NICE) - to disseminate good practice on clinical and cost effectiveness.

Commission for Health Improvement (CHI) - to monitor local performance against clinical quality standards, with powers of intervention in cases of under-performance.

New Performance Framework - replacing the current (and much discredited) "Efficiency Index", seeks to promote more rounded performance targets. These will incorporate national reference costs.

Health Improvement Programme (HImP) - to be agreed between Health Authorities (HAs), Trusts (Providers) and Primary Care Groups (PCGs) will set the local framework for health targets.

Impact

Generally, a further top down impetus to service reviews already underway, viz Pan Manchester reviews of renal, neurology, cardiology and children's services. The Calman Hine model for National-Service Frameworks is likely to increase pressure to concentrate services where evidence suggests that outcomes are volume related. This is likely further to promote

Trust (Provider) mergers (acute to acute) inter Trust collaboration and hub and spoke relationships.

Given that membership of both NICE and CHI will be drawn from similar constituencies (health Professions, Academics, patient representatives) there is some uncertainty as to their relative responsibilities. It is clear however, that CHI, which will have powers of intervention and, in extreme cases, may recommend replacement of Trust Chairs and non-Executives. This provision has clearly been influenced by concern over recent failures in breast and cervical screening. Since the Secretary of State already has such "step in rights", the White Paper, in this respect, does not post any new threat to PFI projects although the threshold for intervention may be lower than hitherto.

2. Health Authorities:

- Will retain continued responsibility for assessing health need (a function which has been discharged variably to date).
- Will have "stronger, clearer strategy roles" as over time they relinquish direct commissioning to primary care groups.
- Will develop 3 year Health Improvement Programmes (HIMP), the framework within which local services are to be delivered.
- Will lead the move to closer working between the health service and local authorities (local authority CEOs are to attend HA meetings).
- Will have a key role in the establishment, transition and management of PCGs.

Impact

Whether HAs can eventually relinquish their purchasing/commissioning role seems doubtful, given the formidable challenge of widespread devolution to PCGs. This is an area of the White Paper, which has been greeted with the greatest scepticism given the different perspectives of GPs and GP Fundholders and the GPs' variable readiness and willingness to coalesce. The emphasis upon HAs strategic leadership role may shift the balance of power, in their favour, in their relationship with Trusts. If so, this may allow HAs to become more assertive over the issues of inter trust collaboration. Widespread HA mergers are anticipated but these will follow local discussion rather than national edict such that the future pattern cannot yet be predicted. The combination of newly empowered HAs managing a larger

geographical area may be expected to accelerate service rationalisation and address inappropriate outflows.

3. Primary Care Groups (PCGs)

- PCGs to replace GP Fundholding - in all its forms by 1999.
- PCGs to consist of GPs and community nurses, typically serving 100,000 patients.
- A four stage "spectrum of opportunities" for PCGs such as:
  1. Advising the HA on commissioning.
  2. Devolved budgets within the HA.
  3. A Free-standing commissioning body.
  4. A move to Trust status providing primary and community services plus free standing commissioning responsibility.
- Devolved to PCGs (in stages 2-4) will be the Unified PCG Budgets, for their population. This will combine previously separate and ring fenced hospital and Community budgets.
- Community, primary infrastructure and prescribing elements within a "single, cost limited envelope".

Impact

The commissioning aspects of PCGs are as proposed in Labour's election manifesto for "locality commissioning groups" and our earlier comments regarding the potential impact of shifts of service by such groups upon the project apply. In Stage 4, PCGs with Trust status as providers of services currently managed by Community Trusts (but not mental health) will take this potential a stage further. With some similarities to US Health Maintenance Organisations, will have the incentive, resources and power to substitute their own services for some of those currently provided by hospitals. Such substitution need not be limited to the more obviously transferable services such as outpatients, day cases and physiotherapy that were the subject of similar shifts under GP Fundholding. Some PCGs may choose to manage local community hospitals, an option explicitly noted in the White Paper, using this as a base from which to provide alternatives to acute hospital care for elderly people, convalescence, or post operative rehabilitation.

Unified primary care budgets will allow other forms of substitution, and pharmaceutical companies have already recognised the opportunity to promote disease management solutions in which earlier use of drug therapies may be an alternative to hospital care. The

impact upon the project will depend upon the pace at which PCGs develop locally and this is likely to vary across Manchester as it is across the country as a whole. While some embryonic primary groups already exist, coalitions between GPs elsewhere are seen as a long-term prospect, with doubts that some may never materialise.

HAs' accountability for PCGs performance, within an agreed HImP is likely to minimise the risk of short-term de-stabilisation of the local healthcare system and is presumably intended to ensure smooth management of longer-term shifts. However, the provision for PCGs to "signal a change, to their local service agreements where ... Trusts are failing to deliver" is noteworthy.

4. Trusts (Providers)

- While retaining operational autonomy, Trusts are to be formally integrated in the development of HImP through a statutory duty to work in partnership with health authority and PCGs.
- HAs will have reserve powers to ensure that Trusts' major investment decisions, including capital developments and consultant appointments, are consistent with the agreed HImP.
- Under Clinical governance provisions, Trust CEOs' existing accountability for proper use of resources will be extended to quality of care.
- Strengthened arrangements for monitoring Trust performance are largely a formalisation of current practice but with the addition of CHI.
- Further mergers between acute and community Trusts (vertical integration) will be discouraged. Other mergers (e.g. horizontal integration between acute Trusts) will be considered "on their merits".

Impact

The clear intention is to bring health authorities and Trusts closer together. Nevertheless, there are clear signals regarding management styles, which some Trust General Managers may need to unlearn. Clinical governance places a heavy responsibility on Trust CEOs and will require clear procedures and protocols to define clinically acceptable practice, which in time should strengthen management control over clinical practice.

5. Resources

- Reassertion of the manifesto commitment to annual real terms increases in NHS spending between Trusts and HAs.
- Existing annual contracts to be replaced by (typically) three-year "service agreements". These will be increasingly focused upon packages of care, possibly embracing community and hospital stages, rather than discrete hospital based episode.
- Abolition of extra contractual referrals and cost per case contracts (the "spot market").
- £1 billion to be released from unnecessary bureaucracy for improved patient care.
- Trusts to publish and benchmark costs against national "reference costs".
- Resources will continue to flow via the HAs, within a further revised allocation formula to meet local population's need.

Impact

A key determinant of how White Paper proposals take effect will be the resources available to the NHS. Many commentators view the commitment to real term growth pessimistically and are withholding judgement on the likely pace and direction of many changes pending the outcome of the government's comprehensive spending review. Continued downward pressure on management costs and pursuit of the targeted £1bn saving is likely to encourage further Trust mergers. The intention to establish "reference costs" in time to inform long-term agreements for 1999-2000 is regarded as extremely challenging and may absorb significant management time. How the costs of 171 projects are to be reported in subsequent versions of those benchmarks is unclear. The new contracting arrangements are intended to create greater stability than hitherto and to allow transition that is more graceful where service change occurs.

Appendix VII. Facts and Figures

- The total UK population is approximately 57,000,000.
- The NHS employs 500,000 Nurses, 55,000 doctors, 36,000 General Practitioners, 100,000 Professional Technicians and 170,000 Ancillary Staff. The number of managers in the NHS was 140,000 in 1990 but is generally considered to be rather more than that now, following the recent restructuring.
- The NHS cost £30,000,000,000 in 1990, which was £520 per capita or 5.85% of Gross National Product (GNP). Private Health Care accounted for another £1,750,000,000 or 1.02% GNP. 58% of all health expenditure was spent on hospitals, of which half was nursing salaries.
- The country is divided into managerial districts, and each such District Health Authority (DHA) provides hospital and community based health care for a population of around 250,000 people, though the range is 50,000 to 1.5M.
- General Practitioners (GPs) have an average list size of about 1,800 to 2,200 people for whom they are contracted to provide a core Primary Health Care service, and usually a range of additional services as well. Practices have on average 5 partners, but 10% of practices are still single-handed whilst 20% have more than 6 partners.
- A typical DHA, serving a population of 250,000, will receive almost all of its referrals for treatment from some 125 GPs working in the same district, based in some 30 separate Partnerships.
- On average, every UK citizen sees his or her GP 4 times a year. In any one year around 14% of the population will be admitted to hospital, 23% will be seen at Accident and Emergency and 18% will be referred de novo to Out patients.
- Infant Mortality, Maternal Mortality, Male and Female Life Expectancy figures are essentially the same as for the USA and all other developed countries.