# POLICY AS NARRATIVE: NEW LABOUR'S REFORM OF THE NATIONAL HEALTH SERVICE

KEVIN MORRELL

Beginning with a brief review of the governance literature, a definition of governance in the National Health Service of England and Wales (NHS) is offered. This introduces an analysis of NHS reform, as presented in the recent policy literature. Using narrative theory, I critique this literature with reference to three key actors: the new organizational form of the 'Foundation Trust', NHS staff, and NHS patients. For each actor, a motif is identified and examined: 'freedom' for Foundation Trusts, 'clinical governance' for staff, and 'choice' for patients. Each of these motifs is instrumental in the narrative on NHS reform, whose main themes are emancipation, progress and duty. These are common to other political projects. This critique makes the rhetoric underpinning the recent policy literature more explicit, and underlines the created, contingent nature of New Labour's account of NHS reform.

## INTRODUCTION

Since the phrase 'NHS reform' is almost a tautology, periodic evaluation of policy in this context can make a specific contribution, in terms of understanding NHS governance (see, for example, Kitchener 1998; Harrison and Wood 1999; Locock 2000). Analysis of the recent policy literature is perhaps timely, given: the creation in the UK of new organizational forms, such as Primary Care Trusts, and latterly Foundation Trusts; large increases in investment; the introduction of a new regime of payment by results; and an agenda of patient choice (DH 2002, 2003a, 2004a, b, c, d). The pace of recent healthcare reform has been described as both 'frenetic' and 'frantic' (Greener 2004), but the Wanless Report (2004) argues that future demographic and technological change, together with rising public expectations, mean that 'sustained action' is needed, otherwise, 'health care services will continue to run faster and faster and stand still' (Wanless 2004, p. 4).

There is also scope for such an analysis to make a more wide ranging contribution. The policy literature offers a rich opportunity to examine the way in which reform is presented. Since the inception of the NHS in 1948, there has been a firm and widespread commitment to it by the public (Marnoch *et al.* 2000; Syrett 2003). This legacy means that 'NHS reforms are a potential electoral liability' (Sheaff and West 1997, p. 189) and so analysing the way in which NHS reform is presented can inform understanding of the policy process.

Kevin Morrell is a Senior Research Fellow at Warwick Business School, The University of Warwick.

I begin by developing an account of what governance means in the NHS and this introduces discussion of recent policy. Using narrative theory, I analyse the recent policy literature with reference to three principal actors: the new organizational form of the Foundation Trust; NHS staff; and NHS patients. For each actor, a motif is identified and examined: 'freedom' for Foundation Trusts; 'clinical governance' for staff; and 'choice' for patients. Together, these constitute instrumental motifs in the narrative on NHS reform; the main themes of this reform are: emancipation; progress, or *telos*; and duty. These different elements constitute a reform narrative, a justificatory framework that is contingent and created. They furnish New Labour's programme of reform with credibility and novelty, and these are features of effective narrative (Barry and Elmes 1997). The narrative is told in such a way as to gloss over tensions and ambiguities implied by the likely outcomes of such reform.

## GOVERNANCE

Notwithstanding problems of definition (Jessop 1998; Lynn *et al.* 2001; Bache 2003), the term governance remains popular. It is at the heart of contemporary debates in many fields, including: business ethics (Daily *et al.* 2003); development studies (Leftwich 1994); economics (Campbell *et al.* 1991); globalization studies (Kooiman 1993); international relations (Smouts 1998); political science (Pierre and Peters 2000); and public administration (Rhodes 2000; Flinders 2004). More specifically, it is employed as an analytical concept in particular areas of interest, for example, in corporate governance (Sundaramurthy and Lewis 2003); in modelling the relations between boards, chief executives and directors (Farrell 2005); either in understanding the implementation and adoption of public policy in general (Gaudin 1998) or in terms of the effectiveness of particular policies and reforms (Newman 2001); in describing new forms of organization, two examples being networks (Jones *et al.* 1997) and partnerships (Pierre 1998); in describing new forms of service delivery, such as 'co-production', or 'co-management' (Gaudin 1998 p. 53); and, in the NHS, as 'clinical governance' (Scally and Donaldson 1998; McColl and Roland 2000) and 'research governance' (Clough 2002; DH 2001b).

A number of features of public sector work make it difficult to apply stable definitions of governance, one such being: 'objectives and outcomes of transactions are less transparent… power of direction and control is widely dispersed… goals of actors are multifarious and often in conflict' (Lynn *et al.* 2001, pp. 5–6). Differentiating between public and private sector organizations becomes harder if we acknowledge that private sector firms can subscribe to a doctrine of social responsibility and democratic principles (Jones and Goldberg 1982). It is also argued that one consequence of changes in the way society is governed mean that the distinction between the public and private becomes blurred (Teisman and Klijn 2002). However, certain features

of market-based systems engender greater clarity about goals and objectives. Markets have, 'a discovery process based on price signals, competition and choice. It is this process, rather than a planning or target-led system which informs, stimulates and sets the framework for actions by company executives' (Mather 2003 p. 487). This makes accountability requirements in the private sector more straightforward. Public sector organizations also operate within a political, 'authorizing' environment (Moore 1995), and are formally and practically accountable to elected representatives and citizens. At an organizational level, this is a more complex set of relationships than that which private sector firms have with their shareholders.

## GOVERNANCE AND ACCOUNTABILITY

An established notion in the writing on governance is that changes in society and in public sector service provision have made accountability more problematic (Rhodes 1997). This is expressed more so in the management of NHS organizations than perhaps any other sector. In recent years a large number of different bodies and mechanisms have been created to monitor different aspects of the NHS. For example, Flinders (2004 pp. 888–9) details the creation of 35 quasi-autonomous public bodies in the policy area of health since New Labour were elected. In tandem with these, various new mechanisms such as Clinical Governance reviews, National Patient and Staff Surveys, National Service Frameworks, the Performance Assessment Framework and the Performance Rating System evaluate performance. These coexist with numerous targets encapsulated in documents such as *The NHS Plan* (DH 2000, 2001a; Healthcare Commission 2004; McKay *et al.* 2004; McMaster 2004).

'Accountability' means more than simply being able to hold people to account for their actions. Even though this sense can be interpreted as core (Mulgan 2000), seeking a broader understanding of accountability in healthcare is not simply 'unnecessary complication' (Mulgan 2000, pp. 556–7). Rather, when considering the mission and purpose of a healthcare organization, it is also important to consider both representativeness and legitimacy (Griffith 1997). These are principles that influence the acceptability of claims to authority (King 2003); what Lipset (1959 p. 71) memorably refers to as, 'the peaceful "play" of power'. For example, the organization should be able to demonstrate that it serves the entire public in its domain, including those disadvantaged through health issues such as mental illness, and those in deprived areas (Briggs 1996). For NHS organizations, interpretations of accountability are closely linked to principles of autonomy. This can be expressed in terms of: freedom from central control, freedom to influence particular outcomes, and reflection of a local identity (Pratchett 2004).

The relationship between autonomy and accountability can be both reciprocal and additive. Ensuring accountability to a local constituency can be an expression of autonomy from the centre, enhance influence on outcomes and reflect identity. This is consistent with the legislation enacting NHS

Foundation Trusts (DH 2004b). However, to demonstrate effectiveness and efficiency, Trusts need to offer bases for comparison – in other words non-local accountability. This describes a tension between local autonomy and some form of centralized control (albeit via targets and monitoring rather than discrete interventions), but it is not a matter of a simple trade-off. Pollitt *et al.* (1998, p. 90) describe how Conservative health reforms, ostensibly intended to devolve power through the creation of NHS Trusts, actually resulted in greater control by the centre. This has implications for interpreting recent reforms and these are discussed below.

Relationships between organizational structure and accountability are also complex. For example, bureaucratic forms have clear structures that specify reporting arrangements. However, because they often address complex social problems, bureaucratic systems can produce, 'weak, misplaced and misguided accountability' (Barzelay 1992, p. xv). Even where hierarchical structures are discarded in favour of alternative modes of coordination, since healthcare is such an important issue for voters, there remains a political imperative to retain control through systems of measurement. As Farrell and Morris (2003, p. 129) state: although, 'new governance forms… may have reduced hierarchy, paradoxically, the changes have increased bureaucratic tendencies', resulting in a, 'bipolarized bureaucracy with an anarchic form at the decentralized level and a bloated centralized cadre desperately trying to control the anarchy' (Farrell and Morris 2003, p. 150).

## GOVERNANCE AND THE NHS

Pierre and Peters (2000, pp. 52–69) identify eight conditions that have pre-cipitated an interest in governance across different fields:

1. the financial crisis of the state;
2. the ideological shift towards the market;
3. globalization;
4. failure of the state;
5. emergence of the New Public Management;
6. social change and increasing complexities;
7. new sources of governance; and
8. the legacy of traditional political accountability.

All these are relevant in considering healthcare governance and reform in the NHS. The New Labour government has prioritized public sector reform and change, as signalled in influential policy documents, such as *The NHS Plan* (DH 2000), subtitled, 'A Plan for Investment, a Plan for Reform'. Governance processes in the NHS are defined most recently as:

> the 'rules' that govern the internal conduct of an organization by defining the roles and responsibilities of key offices/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements. (DH 2004d)

This refers specifically to Foundation Trusts, but is similar to other Department of Health (DH) definitions of corporate governance (DH 2003b, p. 3). Where these show limitations is that they are 'meso' or mid-level definitions, focused on the level of the organization and emphasizing internal accountability arrangements. As detailed above, accountability is a good deal more complex than considering due decision making since it involves consideration of different forms of accountability: hierarchical, legal, professional and political (Hughes 2003).

Having outlined some of the complexities in the wider literature, and in the more specific healthcare literature, I have suggested the following as a working definition. 'Governance in the NHS' refers to:

> (i) the way in which complex interactions between various constituencies (members of the public, etc.), the government, the NHS and other social forms are produced, patterned and regulated; (ii) the implications of these interactions for the provision of healthcare; (iii) the relationship between (i) and (ii). (Morrell 2006)

What this definition attempts to do is to describe the complex context for NHS governance succinctly. The first two elements address the impact of modes of coordination as well as activity within and between different constituencies; the third element signals the recursive relationship between reforms and their consequences. This relational complexity is partly a function of the multi-level nature of healthcare governance, the diversity among constituent groups and the cultural and political legacy of the NHS. More fundamentally, it is produced by the complexities inherent in the provision of healthcare as well as the difficulties in interpreting and implementing healthcare reform.

## GOVERNANCE AND NARRATIVE

Governance in the NHS is intended to be accomplished not just through rounds of inspections, surveys or targets, but also through the actual implementation of reform. I argue that the way in which recent reforms are presented can be thought of as a narrative told by the policy-makers to various constituencies (Bevir 2003). The term narrative is often used in the literature on public administration, though it is not often explicitly defined (Christensen 2003; Elgie 2003). Barry and Elmes define narratives as, 'thematic, sequenced accounts that convey meaning from implied author to implied reader' (1997, p. 431). Narrative approaches can be used to study 'talk' as well as 'texts'; Marnoch *et al.* (2000, pp. 977–8), for example, examine how legitimacy is created and managed in the NHS, in interviews with 40 clinical directors, using the framework of 'stories', 'plots', 'characters' and themes'. Rhodes (2005) studies 'everyday life in a ministry', identifying the central role of stories for his 'cast of characters' in three domestic service ministries. Using the aesthetic theory of the Russian Formalist Shklovsky, Barry and Elmes

(1997) argue that across various genres, effective narratives have two features: they establish credibility; and they create a sense of novelty or defamiliarization. This simple framework yields analytical benefits when studying texts that are intentionally factual or descriptive. Policy documents are authored and devised with an audience in mind. They also need to be both credible and novel in order to unite and mobilize different constituencies and to satisfy the demands of the electorate.

The narrative approach shares some features with discourse-analytic approaches: for example, a concern with the way in which texts or talk are produced and legitimized (Oswick et al. 2000). However, the term discourse is often used rather vaguely, sometimes as, 'a smokescreen for an unclear and ambivalent view on language' (Alvesson and Karreman 2000, p. 1145). There is more consensus as to what narrative analysis involves, partly because it is so clearly linked to everyday notions such as stories and story-telling. Stories are an important part of sense-making (Weick 1995), and Boje describes story-telling in organizations as, 'the preferred sense-making currency' (Boje 1991, p. 106). An important element within this analytical approach is that it calls attention to the role of rhetoric in producing credible narratives (Barry and Elmes 1997). Rather than the everyday sense of rhetoric as a pejorative label, signifying 'mere words' (Fairclough, p. viii), it is used here to analyse the way in which language is deployed as a resource. This approach can be traced to Aristotle, who describes rhetoric as 'the power of observing the means of persuasion on almost any subject presented to us' (Aristotle 350BCE, 1:i).

Recent reforms can be studied insofar as they concern three constituencies or actors in the system of NHS governance: Foundation Trusts, NHS staff and NHS patients. These actors are cited in the above definition of NHS governance. Taking recent DH policy documents into account, I argue that a motif is associated with each of these actors, respectively: 'freedom', 'clinical governance' and 'choice'. This offers fresh scope to analyse issues of healthcare governance and 'define and redefine problems in novel ways' (Rhodes 2000, p. 358). To claim an independent position of authority in this analysis would be inconsistent with the view that texts are fictions. Instead, as an operating metaphor to describe the purpose of this project, I suggest that just as the policy literature can be interpreted as narrative, this approach can be seen as a critical review. Rather than an exercise in 'forensic humiliation' Rhodes (2005, p. 19), or pedantry, the object of this review is to interpret recent policy as narrative. This does not presuppose or require an alternative narrative for reform; nor does it involve acting out, 'the role of *ersatz* public servant' (Rhodes 2000, p. 358), but it opens new possibilities for analysing policy.

Foundation Trusts are a new form of NHS organization, defined in recent legislation as 'public benefit corporations' (HMSO 2003). They are accountable to local communities, to staff, and to an independent regulator, by whom they are authorized. They have more scope to decide local priorities

than other NHS organizations, and additional borrowing and spending powers (DH 2004b). They exemplify a common idea in the governance literature, namely the changing role of the state, since Foundation Trusts are represented as, 'at the cutting edge of the Government's commitment to devolution and decentralisation in the public services' (DH 2003a, A:1). However, earlier NHS reforms, which were presented as devolving power, resulted in greater central control (Pollitt *et al.* 1998). This suggests that the frequent reference to Foundation Trusts' 'freedom' warrants examination.

Clinical governance for NHS staff was introduced in 1998 (DH 1998a). The term 'clinical governance' is explicitly defined as a 'framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DH 1998a, p. 3.2). Despite the presence of an established definition, understanding and implementation of the term vary (Freeman 2003). Since the term is presented as both empowering, and controlling quality, this suggests a potential governance dilemma, as expressed in Jessop's (1998) analysis of 'governability versus flexibility'.

'Choice' for patients is the cornerstone of the recent government White Paper (2004). It is clear that patient choice will create markets and market forms of governance, something which raises conflicts with the founding principles of the NHS. Choice is also used to signal the responsibility patients have to improve their own health, and to imply a liberating redistribution of power. These and other senses of choice suggest that examining the term is useful in understanding NHS governance, and examining whether it is simply a (market) governance mechanism, or signals new forms of engagement in the co-production of healthcare.

To examine how the complexities in healthcare governance are portrayed in the relevant policy literature, the following three sections explore particular arenas of policy reform. The narrative underlying recent reform is then critiqued.

### 'Freedom' for Foundation Trusts

The recent policy literature refers to 'freedom' for Foundation Trusts (see, for example, HMSO 2003, p. 6; DH 2004a, pp. 11, 64). Foundation Trusts are, 'free from the powers of direction of the Secretary of State for Health… free to decide their own local priorities' (DH 2004b, p. 1). These emancipatory promises are subject to considerable qualifications. Foundation Trusts, 'have a duty in law to co-operate with other local partners using their freedom in ways that fit with NHS principles and are consistent with the needs of other local NHS organizations' (DH 2003a, A:1); they must work 'within a common vision for their local health communities and a framework of national quality control' (DH 2004b, p. 1). Alongside this, 'lighter touch monitoring by the Regional Offices' (DH 2004a, p. 64), Foundation trusts are still, 'subject to

independent inspection and monitoring by the new Commission for Health-care Audit and Inspection, taking account of national quality standards [and] will also feature in the annual NHS performance ("star") rating system' (DH 2003a, 1:3).

In addition, Foundation Trusts have multiple accountability requirements: firstly, an 'Independent Regulator – accountable to Parliament – will issue an authorization; this is like a 'licence' to operate; to each NHS Foundation Trust'. Trusts are accountable to, 'local communities and front line NHS staff'; they also, 'sign legally binding agreements with NHS Foundation Trusts to provide agreed levels of service which accurately reflect local needs and which reward results' (DH 2004b, p. 2). The tensions implicit in the accountability requirements for Foundation Trusts can be described in terms of Jessop's (1998, pp. 41–2) four dilemmas of governance:

1. 'co-operation versus competition'. Foundation Trusts are subject to a mandated responsibility to co-operate with other Trusts, but this can be compromised where there is a regime of payment by results, and where competition ('choice') is more pronounced that at any stage in the history of the NHS (Kitchener 2004);
2. 'openness versus closure'. There is a need for Trust's decisions to be transparent, and open to scrutiny by different constituencies. This implies a degree of openness and transparency. However, this can run in conflict with the need for free and frank discussion, which is necessary to enable effective decision making, and an important factor in the running of public sector organizations (Mordaunt and Comforth 2004);
3. 'governability versus flexibility'. On the one hand there is a need for NHS Trusts to incorporate accountability structures and formal mechanisms to preserve the principle of representation on the board, as well as respond to inspection agencies and guidelines (NICE, CHAID, NSFs), and a regime of quality management ('clinical audit'); on the other hand a key principle within the practice of medicine is clinical autonomy, since the problems doctors face are complex and not amenable to bureaucratic solutions (Harrison 2003);
4. 'accountability versus efficiency'. Establishing clear lines of accountability is not always possible given the dual sources of authority and power in the administration of hospitals, which are archetypal professionalized bureaucracies (Minzberg 1990). This implies that seeking clarity of accountability can be inefficient in itself. Also, the drive to promote efficiency savings may result in compromises to the quality of care, and both these aspects have different, though sometimes overlapping lines of accountability (Marnoch *et al.* 2000).

An additional source of complexity is the obligation to collaborate with other organizations, partly to promote efficiency gains. This means that lines of accountability are even less clear. The scope of such collaboration is ambitious as indicated in the recent White Paper (DH 2004c, p. 3):

> Real progress depends on effective partnerships… including local government, the NHS, business, advertisers, retailers, the voluntary sector, communities, the media, faith organizations and many others. People look to Government to lead, coordinate and promote these partnerships.

Areas where collaboration is explicitly invoked include, 'marketing health' (p. 4) 'food labelling' (p. 5), on a 'food and health action plan' (p. 6), a 'social responsibility scheme with alcohol' (p. 7), and 'delivering local improvements in health' (p. 18). This introduces further complications in terms of accountability arrangements, further qualifying the notion of Trust 'freedom'. There is also evidence that current partnerships within the NHS make generally accepted principles of good governance (scrutiny, transparency and openness) hard to realize, the 'sheer complexity of many local arrangements means it is difficult for the Commission for Health Improvement (CHI) to assess the impact of the quality of local partnership working within the confines of a review' (CHI 2004b, p. 33).

### 'Clinical governance' for staff

A second arena of reform is 'clinical governance' for staff. There is considerable ambiguity relating to this term, despite, as has been mentioned, the prevalence of a clearly established definition of clinical governance as:

> a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Though this definition is widely cited and referred to (Scally and Donaldson 1998; DH 2001a; Clark and Smith 2002, p. 261), Freeman (2003, p. 235) describes it as, 'undoubtedly unwieldy', partly because it encapsulates a tension between internal quality improvement and external forms of control. A number of policy documents deal with aspects of clinical governance (DH 1998, 2002a, 2003; NHS 1999), but confusion remains. This is redolent of ambiguities in the wider literature on governance. Freeman suggests clinical governance suffers a 'lack of conceptual clarity' (Freeman 2003, p. 234); others support this, 'it is not clear to many what it entails' (Clark and Smith 2002, p. 261), 'primary care practitioners remain unsure about the meaning of clinical governance' (McColl and Roland 2000, p. 872). This has serious implications for practice. CHI, commenting on their series of reviews of different types of Trusts state, '[r]isk management systems across the investigated organizations are almost universally weak … generally indicative of a lack of progress in implementing sound and comprehensive clinical governance, often without clear accountability arrangements' (CHI 2004c, p. 9).

Part of the problem with understanding clinical governance is that the established definition (above) is extremely broad. It directly addresses ideas that loom large in the mainstream literature on organizational behaviour,

including: quality management, culture change, organizational and individual learning, change management, risk management, performance management and measurement (see, for example, DH 1998a, b, 1999, 2000b). In terms of the specific healthcare literature, it directly addresses existing ideas such as clinical risk management and audit, continuing professional development, adverse incident reporting, information systems and evidence-based practice (Ward *et al.* 2001; Clark and Smith 2002). Indirectly, it involves consideration of the sociological literature on the system of professions (Mahmood 2001), forms of public sector management (Newman 2001) and governance itself, 'Clinical governance will be part of an overall NHS governance framework' (DH 1998, p. 34).

A second complication may be that the espoused reasons for introducing clinical governance, to ensure quality and consistency of care (DH 1998a; Scally and Donaldson 1998), are not in line with the actual ones. Harpwood (2001, p. 229) argues that, 'there can be little doubt that dealing with the litigation problem was a major driving force behind the Health Act 1999, which gave statutory force to clinical governance'. If we accept that, at its genesis, clinical governance expressed a split between espoused values of providing quality care and ensuring equity, and pragmatic concerns with minimizing litigation, it is small wonder that there are differences in the way it has been interpreted and implemented. Some have identified clinical governance as part of a continuing trend to curb professional power; a form of neobureaucratic control (Harrison and Ahmad 2000), somewhat in contrast to claims by the Chief Medical Officer of the time that it was, 'empowering to health professionals' (Donaldson 1998).

Implementing a system of risk management across an organization as complex as the NHS is hugely problematic. NHS organizations face a diverse set of risks, express a multitude of different cultures and subcultures, and undertake widely different sets of activities. It is unlikely that any single definition, format, or series of metrics for risk assessment would be truly transferable across the whole service (Ireland *et al.* 2002). There is also a need to avoid being too prescriptive if a programme of clinical governance is to be empowering, and enhance accountability at a local level, 'guidance is not prescriptive as to the exact methods to be used. This is for health organizations and their staff to work out in the light of their knowledge of local services' (NHS 1999, p. 4). In these senses, there is a definite benefit to be gained by having a number of different interpretations and emphases of the term. However, there is evidence that clinical governance does not function as an organizing, umbrella-concept; 'audit [of clinical practice] is often patchy and not linked to the strategic priorities of the PCT… there is little evidence of linking audit and its findings to the design of future training or the development plans of the workforce' (CHI 2004b, p. 25).

Clough suggests that clinical governance is, 'above all about changing culture, about becoming a learning organization' (2002, p. 7), a view supported by Walsh and Small (2001). Cullen *et al.* (2001, p. 278) emphasize that

the, 'development of measurement systems is a key part of the development of clinical governance', whereas Wallace *et al.* (2004, p. 17) state that, 'a major plank of clinical governance is the personal accountability of the chief executive and board for the quality of clinical services'. Franks (2001a, p. 259) is more definitive, describing it as, 'no more, and no less than a process of focused and continuous quality improvement with explicit duties of accountability on behalf of NHS health care providers', but elsewhere identifies different emphases in the definitions of clinical governance from the DH and CHI (Franks 2001a, p. 222, b, p. 220), and in an analysis of 21 definitions of clinical governance reports a 'wide variation in style and approach, and even content'. This diversity in interpretation means that the implementation of clinical governance, 'is proving to be a significant challenge… there is no recognised ideal model or gold standard' (Lewis *et al.* 2002, p. 150). Som dramatically states that, despite 'a proliferation of definitions and models… *none* of these captures the essence of clinical governance' (Som 2004, p. 87, emphasis added). Unfortunately it seems that rhetorical flexibility is a disadvantage. It means, for example, that there are a number of competing interpretations of what clinical governance means in practice, and though these are frequently prescriptive, taken as a set, they are also contradictory.

**'Choice' for patients**

The motif of choice is core to the White Paper, 'Choosing Health: Making Healthier Choices Easier' (DH 2004c). The moral, political and organizational complexities inherent in making sense of healthcare governance and accountability are glossed over, as choice is used to signal seemingly straightforward causal processes:

> Patient choice will be a key driver of the system and resources will flow to those hospitals and healthcare providers that are able to provide patients with the high-quality and responsive services they expect. (DH 2004a, p. 12)

This implies that systemic improvement is conditioned by a simple relationship between choice (implicitly competition), quality and resources. One problem with choice is that it presupposes inequality (or choice would be redundant), which is antithetical to the founding values of the NHS. Informed choice also requires access to information, and, potentially, mobility (if it means travelling elsewhere for treatment). Both of these are forms of immaterial, or non-economic 'cultural capital' (Bourdieu 1986). Using Bourdieu's (1986) framework, they are 'embodied', directly incorporated within individuals and influencing what is in their power to do. Embodied capital cannot be transmitted instantaneously and inequalities in this type of capital are not immediately obvious. The costs of transferring this type of capital are also high. This can mean that inequalities are harder to address, and that patterns of inequity are reproduced (Bourdieu and Passeron 1977).

As the White Paper acknowledges, 'choice' is philosophically and practically difficult to unpick for certain disadvantaged groups. For example those:

> who are disabled or suffer from mental ill health, stretched for money, out of work, poorly qualified, or who live in inadequate or temporary accommodation or in an area of high crime… people in lower socioeconomic, socially excluded or black and minority ethnic groups. (DH 2004c, p. 13)

Though these groups are referenced, it is not clear that an alternative mechanism to choice is considered. Although Trust boards will need to ensure they have representatives from their community, it may be difficult to encourage those from disadvantaged groups to participate. This point is made more forcefully in the Wanless Report (2004):

> provision of untargeted health information will usually increase the state of the nation's health, but the generally better educated middle-classes are likely to benefit more, increasing health inequalities. (Wanless 2004, p. 168)

Evidence for believing that information poverty will be a factor in any new arrangements can be inferred from CHI's report into Primary Care Trusts (PCTs), 'the public are still generally very unfamiliar with PCTs and their functions' (CHI 2004b, p. 16). This undermines the extent to which choice is sensibly understood as one of several 'citizens empowerment mechanisms' (DH 2004a, p. 95), and qualifies some of the earlier, visionary, policy rhetoric, 'empowering patients to become informed and active partners in their care involving them in the design, delivery and development of local services… PCTs led by clinicians and local people' (DH 2002, p. 4). Implementing choice is also problematic for staff, 'more choice also means that primary care professionals will need to ensure patients are clear about the implications of choosing where they receive their treatment' (CHI 2004b, p. 29). It is also hard to differentiate between demands and needs, both of which may be expressed when patients exercise choice (Sheaff *et al.* 2002).

A confusing aspect to 'choice' is that not only is it used to describe choice of providers of healthcare, but it extends to lifestyle choices, such as eating sensibly, reducing smoking and taking exercise (DH 2004a). Choice is employed as a governance mechanism, a signal of emancipation, and to indicate the duty to exercise individual responsibility. Although in everyday language we use terms such as choice flexibly, it is confusing that the same term is used to reference such different ideas in policy reform. Introduction of the term choice can be seen as an instance of defamiliarization (Barry and Elmes 1997), which is needed to enhance the effectiveness of recent reform. Equivocation conflates political, economic and moral dimensions in a way that is analogous to uses of the contested term 'governance'. An obvious rhetorical advantage to choice is that as well as being a novel byword for reform, it is difficult to be 'anti' choice, particularly since it is so loosely defined. However, alternative phrases such as 'internal market' – part of the strategy underpinning earlier reform by the Conservative government –

would be even more controversial for much of the intended audience of the White Paper (Baggott 1997).

## DISCUSSION

The policy literature on NHS reform (DH 1998a, 2000, 2001a, 2002, 2004a, c) glosses over the inherent complexities in understanding accountability and governance in healthcare. A number of normative elements are evident in this literature and they can be located in a narrative which references three themes: the self-evident need for change, the promise of liberation, and the signalling of moral duties and responsibility.

### The *telos*

In the most recently published White Paper (DH 2004c), the case for reform is portrayed in teleological terms, as self-evident; a historic, democratic and technological necessity or *telos*.

> At the start of the twenty-first century England needs a new approach to health of the public, reflecting the rapid and radical transformation of English society in the latter half of the twentieth century, responding to the needs and wishes of its citizens as individuals harnessing the new opportunities open to it. (DH 2004c, p. 2)

This passage is underwritten by an influential New Labour theme, the 'teleological discourse' (Allen 2001, p. 288), an implicit trajectory of improvement which enhances the credibility of the policy narrative. NHS reform is represented as necessary to, 'sustain and build upon an historic track record of progress' (DH 2004c, p. 2). Claims to the inevitability of social progress can be contested from a number of different analytical stances (Lewis and Kelemen 2001, 256 ff.). Accepting them in the context of healthcare limits the scope for critical assessment. If, however, this is seen as one theme within a narrative, it is simpler to acknowledge that alternative accounts could be created. It also becomes easier to identify rhetorical devices that support the case for this particular narrative.

The introductory passage above glosses over complexities in healthcare governance by establishing relations of 'entailment' (Fairclough 2000), such that widespread societal change entails certain specific reforms in healthcare. The extract above also stands as a rich example of *enthymeme* (Hamilton and Redman 2003), what Aristotle describes as, 'the substance of rhetorical persuasion' (Aristotle 350BCE, 1: i). *Enthymemes* take the form of an argument that comprises two propositions: an antecedent (A), and the consequent that is deduced from it (C); but where an implicit premise (P) is suppressed. The extract above suggests that:

> a new age (A) '21st Century England'
> necessitates radical reform (C) 'a new approach'
> because current structures are inadequate (P)

> societal change (A) 'transformation of … society'
> necessitates response to citizens as individuals (C) 'responding to needs'
> because that is the best way to provide healthcare (P)

> technological change (A) 'new opportunities'
> necessitates changes to modes of organization (C) 'harnessing'
> because current working patterns are obsolete (P).

Each of the tacit premises could be challenged, but the case for change is rhetorically strengthened by finessing discussions about the appropriateness of reform; whether this relates to abilities to respond to societal change, to engage with consumers or use new technology.

## Emancipation

Another theme in the policy narrative is that of emancipation, 'local delivery of professional self-regulation… moving away from a culture of "blame" to one of learning… [h]arnessing the knowledge and expertise of staff … life-long learning will give NHS staff the tools of knowledge' (NHS 1999, 5ff.). '*Shifting the Balance of Power* is about putting patients and staff absolutely at the heart of the NHS', a vision with, 'the key elements being: empowering front line staff to use their skills and knowledge to develop innovative services with more say in how services are delivered and resources are allocated… devolving power and decision-making to frontline staff' (DH 2002, pp. 3–4). Part of the role of Strategic Health Authorities is to be, '*empowering* – seeking to devolve power to the frontline' (DH 2002, p. 11, original emphasis). The theme of emancipation is echoed in the language of reform as it relates to each actor discussed above (Trusts, staff, patients): 'Primary care trusts … embody the principle of devolving more control and decision making power to the frontline clinicians involved in delivering and arranging care for patients' (CHI 2004b, p. 6). The recent initiative of payment by results is also portrayed as liberating, '[u]sers of social care will be empowered through the expansion of direct payments' (DH 2004a, p. 6).

The notion of 'freeing up' is a problematic one, given that the scale of reform means there is likely to be diversity in the ways in which new freedoms and responsibilities are understood, whether it is in the implementation of clinical governance (Franks 2001b), in the lack of clear accountability among leaders of Trusts (CHI 2004c, p. 9), a disconnect between strategic and operational levels (CHI 2004a, p. 14) or uncertainties in the minds of the public as to the role of new organizational forms (CHI 2004b, p. 16). Hoque *et al.*'s (2004) study of senior managers at an acute Trust indicates managers, 'had freedom to do what they were *told* rather than freedom to do what they *wanted*' (Hoque *et al.* 2004, original emphasis).

## Moral duty

The moral theme in the policy narrative comprises different aspects. First, there is the need to demonstrate that public money is being spent wisely.

This is closely tied to political concerns, which are not simply because governments in general want to be perceived as efficient, but because the New Labour government is ideologically the party of the public sector. A second consideration is that administration of healthcare necessarily involves consideration of moral issues, both in terms of provision of care for patients, but also in terms of the effective regulation of staff (DH 2001). Clinical staff have a duty to maintain high professional standards, and are formally accountable for doing so; patients also have a responsibility for their own health (DH 2004c). Third, the theme of duty is wedded to one of progress, with the notion that the only response suitable for government at this time is to 'build on a track record of progress' (DH 2004c, p. 2). The case for reform is powerfully countenanced by an appeal to established norms relating to patient care, '[i]deological boundaries or institutional barriers should not stand in the way of better care for NHS patients' (DH 2000, p. 96), and '[t]he new NHS will be incentivized to deliver for patients more effectively' (DH 2004a, p. 64). 'This is a package of radical reform… redesigning the health service from the patient's point of view' (DH 2003a, 1:2).

Taken together, these different elements constitute a reform narrative, a justificatory framework that is contingent and created. This constitutes an effective narrative for NHS reform by referencing ideals common to other political projects, 'the progressive emancipation of freedom and reason, the progressive emancipation of labor, or the enrichment of humanity' (McKinlay 1998, p. 485). Three themes feature in this narrative: the *telos*, emancipation, and duty. *The NHS Plan* (2000a, p. 10) described how the NHS is, 'a 1940s system operating in a 21st century world [with] a lack of national standards; old-fashioned demarcations between staff and barriers between services; a lack of clear incentives and levers to improve performance; over-centralisation and disempowered patients' (DH 2000, p. 10). This states the self-evident need for change, the moral imperative to reform and the scope for liberation this brings to 'disempowered patients', in the process, justifying the introduction of 'incentives and levers'. More recent policy documents continue this rhetorical trend while introducing far-reaching reforms whose implications are both uncertain and are premised on poorly defined concepts that are likely to result in differences in interpretation and implementation.

Bevir (2003, p. 456) argues that the stories told about policy by New Labour seek, 'to tame the contingency of social life… to make social life governable'. However, 'the process of simplification distorts their understandings of social life in ways that contribute to the failures that plague their attempts to govern it'. Analysis of policy documents can offer suggestions as to why there are differences between policy rhetoric and its outcomes. Since these outcomes are experienced, as well as influenced, by an audience, 'who do not generally make up the policy elites' (Schofield and Sausman 2004, p. 245), identifying themes used by the authors of NHS reform offers an alternative basis for analysis.

## CONCLUSION

This paper began by introducing the term governance and showing how it is a contested term, with a number of possible senses (Rhodes 1997; Jessop 1998; Lynn *et al.* 2001; Bache 2003). Though definitions of governance share common elements, the emphases of each are different. This has implications for how governance is implemented in practice, something that is a particular concern in the NHS given the scale and scope of recent reforms (DH 2000, 2003a, 2004a, b, c, d). Recent reforms were examined in three arenas: patient choice, autonomy for NHS Trusts, clinical governance for staff. Analysis of these suggests that the policy literature invokes different strands that support the case for recent reforms: the necessity of change, or *telos*; the promise of emancipation; and moral duty. Though each is open to question, together they constitute a narrative for reform, a narrative that is self-supporting and loosely coupled to empirical realities (CHI 2004b, c).

Academics have a role to play both in critically examining policy reform and in refining and developing frameworks which can offer conceptual clarity. Where there is a lack of precision in use of key concepts and complexities in understanding accountability requirements, there is value in trying to identify the structures that underpin reform. Here, it is suggested that the case for NHS reform is premised on normative themes that gloss over such complexities. The stories told about these reforms in policy documents reference ideals common to other political projects (McKinlay 1998), reinforcing the point that these reforms are contingent and created.

## ACKNOWLEDGEMENT

## REFERENCES

Allen, C. 2003. 'Desperately Seeking Fusion: on 'Joined-up Thinking', 'Holistic Practice' and the New Economy of Welfare Professional Power', *British Journal of Sociology*, 54, 2, 287–306.

Alvesson, M. and D. Karreman. 2000. 'Varieties of Discourse: On the Study of Organizations through Discourse Analysis', *Human Relations*, 53, 9, 1125–49.

Aristotle, 350 BCE. *Rhetoric,* trans. W. Rhys Roberts, full text available online (http://classics.mit.edu/Aristotle/rhetoric.html).

Bache, I. 2003. 'Governing through Governance: Education Policy Control under New Labour', *Political Studies*, 5, 1, 300–14.

Barry, D. and M. Elmes. 1997. 'Strategy Retold: Toward a Narrative View of Strategic Discourse', *Academy of Management Review*, 22, 2, 429–52.

Bevir, M. 2003. 'Narrating the British State: an Interpretive Critique of New Labour's Institutionalism', *Review of International Political Economy*, 10, 3, 455–80.

Bevir, M., R.A.W. Rhodes and P. Weller. 2003. 'Traditions of Governance: Interpreting the Changing Role of the Public Sector', *Public Administration*, 81, 1, 1–17.

Boje, D.M. 1991. 'The Storytelling Organization: A Study of Story Performance', *Administrative Science Quarterly*, 36, 1, 106–26.

Bourdieu, P. 1986. *The Forms of Capital*, in J. Richardson (ed.), *Handbook of Theory and Research for the Sociology of Education*. London: Greenwood Press, pp. 241–58.

Bourdieu, P. and J. Passeron. 1977. *Reproduction in Education, Society, and Culture*. Beverly Hills, CA: Sage.

Briggs, H.E. 1996. 'Creating Independent Voices: The Emergence of Statewide Family Advocacy Network', *Journal of Mental Health Administration*, 23, 4, 447–57.

Campbell, J., R. Hollingsworth and L. Lindberg. 1991. *Governance of the American Economy*. Cambridge: Cambridge University Press.

Christensen, T. 2003. 'Narratives of Norwegian Governance: Elaborating the Strong State Tradition', *Public Administration*, 81, 1, 163–90.

Clark, C.E. and L.F.P. Smith. 2002. 'Clinical Governance and Education: The Views of Clinical Governance Heads in the South West of England', *British Journal of Clinical Governance*, 7, 4, 261–6.

Clough, E. 2002. 'Putting Governance into Research and Development', *British Journal of Clinical Governance*, 7, 1, 7–9.

CHI (Commission for Health Improvement). 2004a. 'What CHI Has Found In: Acute Services'. London: CHI.

CHI (Commission for Health Improvement). 2004b. 'What CHI Has Found In: Primary Care Trusts'. London: CHI.

CHI (Commission for Health Improvement). 2004c. 'Lessons from CHI Investigations 2000–2003', all CHI publications available on (http://www.healthcare-commission.org.uk/).

Cullen, R., S. Nicholls and A. Halligan. 2001. 'Measurement to Demonstrate Success', *British Journal of Clinical Governance*, 6, 4, 273–7.

Daily, C.M., D.R. Dalton and A.A. Cannella. 2003. 'Introduction To Special Topic Forum Corporate Governance: Decades of Dialogue and Data', *Academy of Management Review*, 28, 3, 371–82.

DH (Department of Health). 1998a. 'A First Class Service: Quality in the new NHS'. London: HMSO.

DH (Department of Health). 1998b. 'Working Together: Securing a Quality Workforce for the NHS'. London: HMSO.

DH (Department of Health). 1999. 'Continuing Professional Development: Quality in the New NHS'. London: HMSO.

DH (Department of Health). 2000. 'The NHS Plan: A Plan for Investment, a Plan for Reform'. London: HMSO.

DH (Department of Health). 2001a. 'Building a Safer NHS: Implementing an Organization with a Memory'. London: HMSO.

DH (Department of Health). 2001b. 'Research Governance Framework For Health and Social Care'. London: HMSO.

DH (Department of Health). 2002. 'Shifting the Balance of Power: The Next Steps'. London: HMSO.

DH (Department of Health). 2003a. 'NHS Foundation Trusts: A Guide to Developing Governance Arrangements', 3e. London: HMSO.

DH (Department of Health). 2003b. 'Corporate Governance Framework Manual for Strategic Health Authorities'. London: HMSO.

DH (Department of Health). 2004a. 'The NHS Improvement Plan: Putting People at the Heart of Public Services'. London: HMSO.

DH (Department of Health). 2004b. 'NHS Foundation Trusts Information Guide: Accountability and Regulation'. London: HMSO.

DH (Department of Health). 2004c. 'Choosing Health: Making Healthier Choices Easier'. London: HMSO.

DH (Department of Health). 2004d. 'Foundation Trusts'. London: HMSO.

Donaldson, L. 1998. 'Commentary: Clinical Governance and Service Failure in the NHS', *Public Money and Management*, October–December, 10–11.

Elgie, R. 2003. 'Governance Traditions and Narratives of Public Sector Reform in France', *Public Administration*, 81, 1, 141–62.

Fairclough, N. 2000. *New Labour, New Language?* Routledge: London.

Farrell, C.M. 2005. 'Governance in the UK Public Sector: The Involvement of the Governing Board', *Public Administration*, 83, 1, 89–110.

Ferguson, B. and J.N.W. Lim. 2001. 'Incentives and Clinical Governance: Money Following Quality?', *Journal of Management in Medicine*, 15, 6, 463–87.

Flinders, M. 2004. 'Distributed Public Governance In Britain', *Public Administration*, 82, 4, 883–909.

Franks, A.J. 2001a. 'Clinical Governance as a Restructuring of Quality Assurance Processes: Shifting the Focus from Corporate to Clinical Action', *British Journal of Clinical Governance*, 6, 4, 259–63.

Franks, A.J. 2001b. 'How Goes the Night, Watchman? An Overview of the First Annual Clinical Governance Reports (1999/2000) from Acute Trusts in an English NHS Region', *Journal of Management in Medicine*, 15, 3, 220–6.

Freeman, T. 2002. 'Using Performance Indicators to Improve Health Care Quality in the Public Sector: a Review of the Literature', *Health Services Management Research*, 15, 2, 126–37.

Gaudin, J. 1998. 'Modern Governance, Yesterday and Today: Some Clarifications to be Gained from French Government Policies', *International Social Science Journal*, 50, 1, 47–56.

Graham, H. 2004. 'Tackling Inequalities in Health in England: Remedying Health Disadvantages, Narrowing Health Gaps or Reducing Health Gradients?' *Journal of Social Policy*, 33, 1, 115–31.

Greener, I. 2004. 'Health Service Organization In The UK: A Political Economy Approach', *Public Administration*, 82, 3, 657–76.

Hamilton, P.M. and T. Redman. 2003. 'The Rhetoric of Modernization and the Labour Government's Pay Agenda', *Public Money and Management*, October, 223–8.

Harrison, S. 2003. 'Medical Autonomy and Managerial Authority in the National Health Service', Paper presented at the King's Fund seminar on Professionalism in Medicine, Leeds Castle, Kent, 23 March 2003, University of Manchester, available on (http://www.ipeg.org.uk/).

Harrison, S. and W.I.U. Ahmad. 2000. 'Medical Autonomy and the UK State, 1975 to 2025', *Sociology*, 34, 1, 129–46.

Harrison, S. and B. Wood. 1999. 'Designing Health Service Organization in the UK, 1968 to 1998: from Blueprint to Bright Idea and "Manipulated Emergence"', *Public Administration*, 77, 4, 751–68.

HMSO. 2003. 'Health and Social Care Community Health and Standards Act 2003: Explanatory Notes'. London: HMSO.

Hoque, K., S. Davis and M. Humphreys. 2004. 'Freedom to Do What You Are Told: Senior Management Team Autonomy in an Acute NHS Trust', *Public Administration*, 82, 2, 355–75.

Hughes, O.E. 2003. *Public Management and Administration: An Introduction*, 3rd edn. London: Macmillan.

Ireland, A., D.A., Tomalin, M. Renshaw and K. Rayment. 2002. 'A Clinical Risk Profiling Tool for Trusts', *International Journal of Health Care Quality Assurance*, 15, 2/3, 94–8.

Jessop, B. 1998. 'The Rise of Governance and the Risks of Failure: The Case of Economic Development', *International Social Science Journal*, 50, 1, 29–45.

Jones, T.M. and L.D. Goldberg. 1982. 'Governing the Large Corporation: More arguments for Public Directors', *Academy of Management Review*, 74, 603–11.

Jones, C., W.S. Hesterly and S.P. Borgatti. 1997. 'A General Theory of Network Governance: Exchange Conditions and Social Mechanisms', *Academy of Management Review*, 22, 4, 911–45.

King, L.A. 2003. 'Deliberation, Legitimacy and Multilevel Democracy', *Governance*, 16, 1, 23–50.

Kitchener, M. 1998. 'Quasi-market Transformation: An Institutionalist Approach to Change in UK Hospitals', *Public Administration*, 76, 1, 73–95.

Kooiman, J. 1993 (ed.), *Modern Governance: New Government-Society Interactions*. London: Sage.

Leftwich, A. 1994. 'Governance, the State and the Politics of Development', *Development and Change*, 25, 2, 363–86.

Lewis, S.A., N. Saunders and K. Fenton. 2002. 'The Magic Matrix of Clinical Governance', *British Journal of Clinical Governance*, 7, 3, 150–3.

Lipset, M. 1959. 'Some Social Requisites of Democracy: Economic Development and Political Legitimacy', *The American Political Science Review*, 53, 1, 69–105.

Locock, L. 2000. 'The Changing Nature of Rationing in the UK National Health Service', *Public Administration*, 78, 1, 91–109.

Marnoch, G., L. McKee and N. Dinnie. 2000. 'Between Organizations and Institutions: Legitimacy and Medical Managers', *Public Administration*, 78, 4, 967–87.

McColl, A. and M. Roland. 2000. 'Clinical Governance in Primary Care: Knowledge and Information for Clinical Governance', *British Medical Journal*, 32, 1, 871–4.

McKay, J., P. Bowie, L. Murray and M. Lough. 2004. 'Attitudes to the Identification and Reporting of Significant Events in General Practice', *Clinical Governance*, 9, 2, 96–100.

McKinlay, P.F. 1998. 'Postmodernism and Democracy: Learning from Lyotard and Lefort', *Journal of Politics*, 60, 2, 481–502.

McKinley, A. and K. Starkey. 1998. 'Managing Foucault: Foucault, Management and Organization Theory', in A. McKinley and K. Starkey (eds), *Foucault, Management and Organization Theory: From Panopticon to Technologies of the Self*. London: Sage, pp. 1–13.

McMaster, R. 2004. 'A Utilitarian Twist? Performance Measurement in the English National Health Service', *Journal of Economic Issues*, 38, 2, 429–37.

Mahmood, K. 2001. 'Clinical Governance and Professional Restratification in General Practice', *Journal of Management in Medicine*, 15, 3, 242–52.

Mather, G. 2003. 'Beyond Targets, Towards Choice', *Political Quarterly*, 74, 4, 481–92.

Minzberg, H. 1990. *Minzberg on Management*. London: The Free Press.

Moore, M. 1995. *Creating Public Value: Strategic Management in Government*. Cambridge, MA: Harvard Business School Press.

Mordaunt, J. and C. Cornforth. 2004. 'The Role of Boards in the Failure and Turnaround of Non-profit Organizations', *Public Money & Management*, 24, 4, 227–34.

Morrell, K. 2006. 'Governance, Ethics and the NHS', *Public Money & Management*, 26, 1, 55–62.

Mulgan, R. 2000. 'Accountability: An Ever-expanding Concept', *Public Administration*, 78, 3, 555–73.

Newman, J. 2001. *Modernising Governance: New Labour, Policy and Society*. London: Sage.

NHS (National Health Service). 1999. 'Clinical Governance: Quality in the New NHS', HSC 1999/065.

Pierre, J. 1998. *Partnerships in Urban Governance: European and American Experience*. Basingstoke: Macmillan.

Oswick, C., T.W. Keenoy and D. Grant. 2000. 'Discourse, Organizations and Organizing: Concepts, Objects and Subjects', *Human Relations*, 53, 9, 1115–23.

Pierre, J. and B.G. Peters. 2000. *Governance, Politics and the State*. Basingstoke: Macmillan.

Pollitt, C., J. Birchall and K. Putnam. 1998. *Decentralising Public Service Management*. London: Macmillan.

Preston, D. and J. Loan-Clarke. 2000. 'The NHS Manager: A View from the Bridge', *Journal of Management in Medicine*, 14, 2, 100–8.

Rhodes, R.A.W. 1997. *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability*. Buckingham: Open University Press.

Rhodes, R. 2000. 'The Governance Narrative: Key Findings and Lessons from the ESRC's Whitehall Programme', *Public Administration*, 78, 2, 345–63.

Rhodes, R.A.W. 2005. 'Everyday Life in a Ministry: Public Administration as Anthropology', *American Review of Public Administration*, XX, 1, 1–23.

Scally, G. and L.J. Donaldson. 1998. 'Looking Forward: Clinical Governance and the Drive for Quality Improvement in the New NHS in England', *British Medical Journal*, 31, 7, 61–5.

Schofield, J. and C. Sausman. 2004. 'Symposium on Implementing Public Policy: Learning from Theory and Practice', *Public Administration*, 82, 2, 235–48.

Sheaff, R. and M. West. 1997. 'Marketization, Managers and Moral Strain: Chairmen, Directors and Public Service Ethos in the National Health Service', *Public Administration*, 75, 2, 189–206.

Sheaff, R., S. Pickard and K. Smith. 2002. 'Public Service Responsiveness to Users' Demands and Needs: Theory, Practice and Primary Healthcare in England', *Public Administration*, 80, 3, 435 –52.

Smouts, M. 1998. 'The Proper Use of Governance in International Relations', *International Social Science Journal*, 50, 1, 81–90.

Sundaramurthy, C. and M. Lewis. 2003. 'Control and Collaboration: Paradoxes Of Governance', *Academy of Management Review*, 28, 3, 397–415.

Syrett, K. 2003. 'A Technocratic Fix to the "Legitimacy Problem"? The Blair Government and Health Care Rationing in the United Kingdom', *Journal of Health Politics, Policy and Law*, 28, 4, 715–46.

Telford, R., C.A. Beverley, C.L. Cooper and J.D. Boote. 2002. 'Consumer Involvement in Health Research: Fact or Fiction?' *British Journal of Clinical Governance*, 7, 2, 92–103.

Timmins, N. 1995. *The Five Giants – a Biography of the Welfare State*. London: HarperCollins.

Walsh, M.J. and N. Small. 2001. 'Clinical Governance in Primary Care: Early Impressions Based on Bradford South and West Primary Care Group's Experience', *British Journal of Clinical Governance*, 6, 2, 109–18.

Wanless, D. 2004. '*Securing Good Health for the Whole Population*'. London: HMSO (http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/).

Ward, L.M., C.J. Honeybourne and J. Harrison. 2001. 'A Clinical Librarian can support Clinical Governance', *British Journal of Clinical Governance*, 6, 4, 248–51.

Weick, K.E. 1995. *Sensemaking in Organizations*. London: Sage.