

Framing in policy processes

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**Framing in policy processes: A case study from hospital planning in the National Health Service
in England.**

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1 **Framing in policy processes: A case study from hospital planning in the National Health Service**
2 **in England.**

3

4 **Abstract**

5

6 This paper reports from an ethnographic study of hospital planning in England undertaken between
7 2006 and 2009. We explored how a policy to centralise hospital services was espoused in national
8 policy documents, how this shifted over time and how it was translated in practice. We found that
9 policy texts defined hospital planning as a clinical issue and framed decisions to close hospitals or
10 hospital departments as based on the evidence and necessary to ensure safety. We interpreted this
11 framing as a rhetorical strategy for implementing organisational change in the context of community
12 resistance to service closure and a concomitant policy emphasising the importance of public and
13 patient involvement in planning. Although the persuasive power of the framing was limited, a more
14 insidious form of power was identified in the way the framing disguised the political nature of the
15 issue by defining it as a clinical problem. We conclude by discussing how the clinical rationale
16 constrains public participation in decisions about the delivery and organisation of healthcare and
17 restricts the extent to which alternative courses of action can be considered.

18

19

20 **Keywords**

21 England, NHS, Healthcare policy, Ethnography, Rhetoric, Discourse.

22

1 Hospital planning is an enduring and seemingly intractable issue on the agenda of local health
2 services managers. Efforts on the part of regional planners to rationalise hospital services have been in
3 place since the publication of the Hospital Plan for England in 1962 (Ministry of Health, 1962). Since
4 the 1990s this agenda has coincided with that of national professional associations representing
5 doctors which have sought to centralise acute services (i.e. concentrate in fewer, larger departments)
6 in order to facilitate medical staffing and training (Joint Working Party of the British Medical
7 Association, Royal College of Physicians of London and the Royal College of Surgeons of England,
8 1998; Senate of Surgery, 1997, 2004; Royal College of Obstetricians and Gynaecologists 2012;
9 Academy of Medical Royal Colleges, 2012).

10

11 In both managerial and professional narratives policy arguments are couched in the language of
12 rational analysis whereby the centralisation of hospital services is presented as the means to some
13 desired ends ('efficiency' say or 'effectiveness'). These claims are highly contested in the research
14 community. Criticisms have concerned the methods of studies investigating the relationship between
15 volume and outcome, the interpretation of findings and, of particular relevance to this paper, *the*
16 *choice of policy response* (Nuffield Institute of Health, 1996; Shahian and Normand, 2003; Bryne and
17 Yang, 2008; Shapiro, 2008; Harrison, 2012).

18

19 Plans to close hospitals or hospital departments also face significant community resistance. One of the
20 best known examples of community resistance to hospital closure in England is that of Kidderminster,
21 where in 2001 a Member of Parliament lost his seat in a general election to a single-issue candidate on
22 a platform to save the local hospital. At the same time national policy rhetoric emphasises the
23 importance of involving the public in decisions about healthcare delivery (Secretary of State for
24 Health, 2010, 2006).

25

26 We understand politics to involve a conflict in *meanings* as well as *interests* (Fischer, 2003). Insight
27 into the differences in meaning ascribed to health services by different social groups has come from
28 the field of cultural geography. Brown (2003), for example, has argued that proponents of hospital

1 closure from a rational planning perspective ‘neglect to locate the hospital, and in particular the
2 district general hospital, within its broader context’ (p. 489). He draws on the work of Kearns and
3 Joseph (1993) and Pred (1983) to show how health services are important to people’s ideas about
4 local identity and 'sense of place'. Here ‘sense of place’ refers to the consciousness of a locality from
5 the ‘insider perspective’. It is based on the understanding that a place is more than the sum of its
6 material characteristics, it is the centre of meanings, values, significance and emotional attachment.

7
8 Thus the political contest over hospital planning can be understood as a conflict in frameworks of
9 meaning, between the instrumental rationality instantiated in both management and medicine
10 (Rhodes, 2013; Good, 1994) and the perspective of community groups for whom health services are
11 not just health services but are replete with social and emotional attachments. Our concern in this
12 paper is not with how services should be provided but with exploring the role of policy in political
13 contests. Following Shore and Wright (1997) we ask how, in this instance, does policy ‘work’ as an
14 instrument of power?

15
16 Drawing from an ethnographic study of hospital planning in England we consider how policy is
17 espoused in national policy documents, how this shifts over time and how it is articulated and enacted
18 in practice. Following Wright and Reinhold (2011) our approach is one of ‘studying through’, that is
19 following a policy through relations between actors, institutions and discourses across space and time.
20 We found that power operated through policy texts and in the practices of policy implementation in
21 ways that were often difficult to see. Central to these processes were medical knowledge and expertise
22 which served to frame the debate and undermine public involvement in decision-making.

23

24

25 **Frames and framing in policy processes**

26

27 Our approach is informed by the anthropology and sociology of policy (Shore, Wright and Pero 2011;
28 Wedel and Feldman, 2005; Shore and Wright, 1997; Ball, 1990; Donnan and McFarlane, 1989). This

1 approach views policy as a social practice that is essentially linguistic. It presupposes that policy is a
2 site of political contestation and uses discourse theory to illuminate the operation of power. A central
3 concern is with unsettling the ‘certainties and orthodoxies that govern the present’ (Shore and Wright
4 1997, p.17) so as to create room for alternative policy options.

5
6 From this stance, one way to view policy texts is as rhetorical strategies intended to convince other
7 actors of the legitimacy of a course of action by using language to connect it to broader social values
8 (Suddabury and Greenwood, 2005). Beyond the often quite obvious attempts at persuasion, there are
9 the less visible discursive acts of ‘naming and framing’ that have the effect of making a certain course
10 of action appear inevitable whilst marginalising alternatives (Shore and Wright, 1997). Much of the
11 literature on naming and framing draws on Foucault’s (1979, 1980) insights on the exercise of power
12 in modern societies. Specifically, his observations on the way that language constructs the social
13 world, the immanence of knowledge and power and how the operation of power becomes hidden from
14 view. So, for example, Edelman (1988) acknowledges a debt to Foucault in his analysis of how policy
15 problems are constructed in discourse. In contrast to the rational approach to policy, which sees
16 governments responding to policy problems that exist ‘out there’, Edelman argues that policy
17 problems are created in the policy proposals that are offered as solutions. Similarly Stone (1988)
18 argues that policy texts are a political process of establishing definitions. The classifications and
19 categories used in policy not only reflect a particular view of the world, they have consequences for
20 people’s lives. They ‘confer advantages and disadvantages, rewards and penalties, permissions and
21 restrictions, or power and powerlessness’ (p.309).

22
23 Ball (1990) has described policies as ‘power/knowledge configurations par excellence’. Policies,
24 according to Ball ‘embody claims to speak with authority, they legitimate and initiate practices in the
25 world, and they privilege certain visions and interests’ (p.22). Similarly, Shore and Wright draw on
26 Foucault when they argue that:

27

1 Policies are most obviously political phenomena, yet it is a feature of policies that their political
2 nature is disguised by the objective, neutral, legal-rational idioms in which they are portrayed.
3 In this guise policies appear to be mere instruments for promoting efficiency and effectiveness
4 (1997, p.8).

5
6 Scholars differ on the extent to which they see the operation of power in policy texts as intentional.
7 Some focus on the *uses* of discourse, emphasising the intentional mobilization of discourses for
8 political purposes. Bacchi (2000), for example, attempts to capture this in her notion of ‘category
9 politics’. Others focus more on the *effects* of discourse, emphasising the way underlying assumptions
10 and presuppositions of policies constrain what can be said or done. Ball, for example, sees the
11 constraints imposed by discourse as arising from institutional practices and power relations and insists
12 that the effects of discourse ‘cannot simply be reduced to the intentions and ambitions of a few key
13 actors’ (1990, p.155). Similarly, Shapiro (1992) speaks of the operation of discourse as *exceeding* the
14 intentions of individuals. According to Shapiro, when people speak they participate, often
15 unreflectingly, in an existing discursive practice that ‘constructs worlds of submission and
16 domination’ (1981, p.38). So for example, doctors dominate patients not so much through the
17 strategic use of language but through the fact that discursive practices construct ‘doctors’ and
18 ‘patients’.

19
20 To explore the operation of power in policy processes we employed, as a point of departure, Rein and
21 Schön’s (1993) concepts of ‘frames’ and ‘framing’. The concept of interpretive frames stems from the
22 work of Goffman (1974) who defined frames as organizing principles that govern the meaning we
23 assign to social events (p.10). Rein and Schön have applied the notion of frames to the study of
24 public policy, using the term to refer to ‘a perspective from which an amorphous, ill-defined,
25 problematic situation can be made sense of and acted on’ (1993, p.146). Rein and Schön argue that
26 policy actors have different frames that lead them to see things differently and support different
27 courses of action concerning ‘what is to be done, by whom, and how to do it’ (1993, p.147).

28

1 Hospital planning exemplifies what Schön and Rein call ‘intractable policy controversies’. Intractable
2 policy controversies are ‘marked by contention, more or less acrimonious, more or less enduring’
3 (1994, p.3). A feature of policy controversies is that they are resistant to resolution by appeals to
4 evidence or reasoned argument. This is because opposing parties hold different frames which lead
5 them to differ in their view of what facts are important or to give the same facts different
6 interpretations.

7
8 Schön and Rein distinguish between action frames and rhetorical frames. Action frames are those
9 implicit in the content of policies while rhetorical frames are those that underlie the persuasive use of
10 argument. Sometimes the same frame serves both functions but more often they are different. A
11 rhetorical frame may obscure the underlying action frame:

12
13 Frames are about action, and the desire to do something usually leads to a commitment to make
14 the action we seek realizable. We often do so by ‘hitching on’ to a dominant frame and its
15 conventional metaphors, hoping to purchase legitimacy for a course of action actually inspired
16 by different intentions (Rein and Schön 1993, p.151).

17
18 The concepts of ‘frames’ and ‘framing’ allow for the consideration of the operation of power both
19 with and without intention. Rein and Schön describe ‘frames’ as ‘part of the natural, taken-for-granted
20 world’ so that ‘we are often unaware of their role in organizing our perceptions, thoughts and actions’
21 (1993, p.151). Elsewhere they speak of the strategic act of ‘framing’. We apply these concepts to the
22 case of hospital planning in England, looking at how a policy to centralise hospital services is framed
23 in policy texts and in the processes of policy implementation.

24
25
26 **Methods**

27

1 The topic of this study emerged during ethnographic fieldwork conducted for a larger project
2 (Eworthy et al, 2010). Whilst attending board meetings of a variety of local healthcare organisations
3 we noticed repeated appeals to the ‘clinical case for change’ when managers presented plans to close
4 hospital departments. This rationale contradicted earlier planning documents that contained a financial
5 rationale. We were struck by the rhetorical force of these appeals which felt, to us, to have the effect
6 of shutting down debate. This seemed significant given the stated policy objective of involving
7 patients and the public in decision-making. The extent and implications of this observation then
8 became the focus of data collection and analysis.

9
10 In attempting to produce an account that made sense of this initial observation we tested our ideas
11 against data collected from a range of sources including documents, observations of meetings (n=12),
12 formal interviews (n=52) and informal conversations with national policy makers, local National
13 Health Service (NHS) managers and senior hospital doctors (known in the NHS as ‘consultants’). In
14 this study we have sought to capture the dynamics of policy framing through time and across national
15 and local domains. Fieldwork thus consisted of time spent in a local health economy (an English
16 county) as well as studying developments in national policy over the same period (November 2006 –
17 March 2009). Ethical approval was obtained from the local research ethics committee. Participants in
18 formal interviews provided written consent. Interviews were recorded, transcribed and imported into
19 NVIVO to aid analysis.

20
21 In line with our use of discourse theory, our analysis presupposed that text and talk are social
22 practices and focused on the resources (interpretive repertoires, identities and category systems)
23 drawn on by actors in those practices (Potter, 1997). Interview transcripts, fieldnotes and planning
24 documents were examined for regularities in the form of assumptions, categories, logics, claims and
25 modes of articulation (Miller, 1997). We drew on this data to construct an account of the way a policy
26 of centralising hospital services was framed in national policy texts and how this was translated in
27 practice. Our analysis is based on the entire dataset. Pseudonyms are used for individuals and
28 organisations.

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In the following section we present our findings. We describe first how a policy to centralise hospital services became reframed in national policy documents. We then show how this same framing was deployed by local health services managers seeking to implement the policy in one locality in England.

Framing in national policy

When we began fieldwork national policy on the distribution of hospital services was contained in the White Paper *Our health, our care, our say* (Secretary of State for Health, 2006). This document set out as a key objective the relocation of services from hospital to non-hospital settings. This policy was called ‘Care closer to home’ and throughout the document reference was made to providing care ‘closer to home’, ‘in the community’ and ‘in more local settings’. The White Paper presented the policy as a rational response to technological developments that enable health care to be delivered in more local settings, an increase in long-term conditions and patient expectations for health care that is convenient. In this technological and social context, ‘reconfiguration’ of health services was presented as a means of improving patient access and responsiveness. The emphasis was on providing hospital services ‘in more local settings’. Significantly less attention was given to the corollary, closing, or downgrading district general hospitals. This is mentioned directly only once, in a section of the document where the findings from a public consultation are being used to indicate public support for the policy:

Participants in the ‘Your health, your care, your say’ consultation said they wanted more care provided in community settings. The majority favoured increased investment in the latter, *even if this meant changing the type and scale of services provided by their local hospital* (2006, p. 140, emphasis added).

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The White Paper signalled an intention to consult the medical profession on how to provide services:

To ensure a stronger evidence base and a real clinical engagement, the Department of Health is working with the specialty associations and the Royal Colleges to define clinically safe pathways that provide the right care in the right setting, with the right equipment, performed by the appropriate skilled persons (2006, p.132).

In the above excerpt medical experts are identified as the appropriate party to be defining how and where services are provided. The aim of consulting the Royal Colleges is to ‘define appropriate models of care that can be used nationwide’ (2006, p.132). Over time the emphasis of national policy discourse shifted to the clinical necessity of centralising some acute care. Using Rein and Schön’s concept, there was a shift in the ‘framing’ of the issue. The new framing emphasised the ‘clinical case for change’. In this framing the decision to close hospitals or hospital departments was said to be based on the evidence and necessary to ensure safety.

The Department of Health followed the publication of the White Paper with a series of policy papers written by the national clinical directors. The national clinical directors were doctors who were appointed by the Department of Health to develop proposals for how services should be delivered for each specialty. Thus a paper authored by a doctor and outlining ‘the clinical case for change’ was published for heart disease and stroke (Boyle, 2006), emergency care (Alberti, 2006), mental health (Appleby, 2007), primary care (Colin-Thome, 2007), surgery (Darzi, 2007a), geriatrics (Philp, 2007), cancer (Richards, 2007), diabetes (Roberts, 2007), maternity and paediatrics (Shribman, 2007a; 2007b). The recurring theme of these documents was that while some services can be provided locally, other care needs to be centralised to ensure the best health outcomes.

1 One way of understanding the appearance of ‘the clinical case for change’ in national policy
2 documents is as a rhetorical strategy deployed to persuade other stakeholders of the need for
3 change. This rationale draws on the cultural authority of the medical profession and its association
4 with truth (Zola 1999). It presents the plans as technical and thus politically neutral and gives a
5 sense of importance, urgency and necessity. The clinical rationale was reinforced by the
6 involvement of doctors in policy development. These doctors were medico-politicians or in
7 management roles in the Department of Health, what Waring (2014) terms political elites. For
8 example, Professor Sir George Alberti, the national clinical director for emergency care, was
9 previously the President of the Royal College of Physicians, whilst Professor David Colin-Thomé,
10 the national clinical director for primary care, was previously Director of Public Health for the
11 London Strategic Health Authority, a regional office of the Department of Health.

12
13 In June 2007 a new health minister was appointed. Sir Ara Darzi was a consultant surgeon and
14 previously a national clinical director and author of ‘The clinical case for change’ for surgical
15 services. Darzi published a series of reports (Darzi, 2007b, 2007c, Secretary of State for Health,
16 2008) in which he positions himself as ‘a doctor not a politician’ (Darzi 2007c) despite the fact that
17 the reports had the status of government policy and were published by the Department of Health. The
18 reports concluded that for a number of acute services the quality of care is improved when provided in
19 specialist centres. However they maintained that decisions on service design and location should be
20 taken by local health service managers in consultation with stakeholders (Secretary of State for
21 Health, 2008).

22
23 The Darzi reports presented government policy as ‘the product of the work of more than 2000
24 clinicians’ (Secretary of State for Health 2008, p.17). At the same time the policy was described as
25 ‘developed in discussion with patients, carers and members of the public’ (p.8). In this way,
26 government policy is depicted as reflecting a consensus between national policy makers and local
27 actors on one hand and between clinical staff and the public on the other. As will be shown below,

1 this picture is contradicted by our account from ethnographic fieldwork in which local plans for
2 hospital services were highly contested.

3
4 The proposals contained in the above policy documents are described as ‘evidence-based’. For
5 example, the proposals in the first Darzi report are described as ‘rooted in the evidence’ and ‘from
6 reviews of the literature and data’ (Darzi, 2007b, p.4). In some cases there were references to studies
7 of the relationship between hospital volume and outcomes. In other cases references were to standards
8 published by the Royal Colleges. These specify catchment populations, staffing patterns, workload
9 and inter-professional linkages. When these were retrieved as part of analysis they were found to be
10 predominantly based on expert opinion. In some instances the basis of recommendations were
11 surprisingly arbitrary. This is illustrated in the following recommendation from the first Darzi report:

12
13 Obstetric units should have a consultant presence for at least 98 hours a week.¹⁰ This will
14 require fewer obstetric units than now in order to ensure there is an adequate workforce, that
15 staff gain sufficient experience and that the units are affordable.(Darzi, 2007b, p.46)

16
17 The superscript notation is in the original document. It is standard scientific notation to indicate a
18 citation. We assumed that the citation would be to research-based evidence in support of this
19 recommendation. Instead we found a footnote that read as follows:

20
21 The Royal College of Obstetricians and Gynaecologists have suggested that units should be
22 moving towards having consultant presence 24/7. We are not convinced that this is essential for
23 a high quality service, so we have set a more conservative requirement of a consultant presence
24 of 98 hours a week, which would be a significant increase in some units. (Darzi, 2007b, p.83)

25
26 In appealing to ‘the evidence’ this discourse assumes an unproblematic progression from research
27 findings to decisions about a course of action. However research findings are contested and decisions
28 about ‘what should be done’ are complicated by the need to balance competing objectives, such as

1 effectiveness and access (Russell et al, 2008). In the policy discourse for hospital planning the
2 evidence for clinical effectiveness is emphasised to the exclusion of other considerations. This,
3 together with the sometimes tenuous links to empirical research, suggests that these appeals were in
4 large part rhetorical. Here the use of scientific vocabulary serves to establish plans for changing how
5 services are provided as based on objective knowledge and independent of political interests.

6
7 The other recurring motif was an appeal to 'safety'. The following is an excerpt from field notes. It is
8 a quote from a national politician speaking at a think tank seminar:

9
10 In Manchester they were facing resistance to changes to maternity services, but once we could
11 make the argument that the way we are doing things is killing you and killing your babies it
12 was easier to make these decisions. (Field notes, January 2008)

13
14 An appeal to 'safety' is among the most powerful rhetorical motifs because it is seemingly
15 unanswerable - who would argue against safety? An appeal to the safety of babies is the 'trump card'
16 (Green, 2000).

17
18 That this is an instance of strategic reframing is also suggested by national guidance issued to regional
19 offices. At this time it was the role of regional offices to ensure that national policy was incorporated
20 into local plans. The guidance, sent out in February 2007, consisted of recommendations for how
21 local plans to close services should be implemented. The guidance recommended 'involving clinical
22 staff at every stage of the process, from developing proposals and the case for change to
23 implementation' (Carruthers, 2007, p.6):

24
25 Where clinical leaders genuinely develop and support proposals, they play a vital role in
26 building public and patient confidence. In the best examples, medical directors have written
27 forewords to consultation documents, clinicians have supported proposals at public meetings,

1 articles have been written by the heads of relevant clinical disciplines and letters to correct local
2 media stories have been sent from GPs [General Practitioners]. (p.6)

3
4 In the next section we consider how the framing of clinical necessity travelled from the national level
5 of government policy to the level of practice. Hughes (1996) has described local health service
6 managers as essentially 'rhetoricians'. He argues that local managers must act in a political context of
7 competing interest groups and that this process can be understood as an interplay of rhetorics, rather
8 than the more familiar conception of negotiation and bargaining. The tendency since the 1980s to
9 devolve responsibility for hard decisions downwards has made it necessary for local managers to
10 explain and to justify. They must persuade other players that one course of action is better than others.
11 This is not to say that the use of rhetoric is necessarily about manipulation or deception, as Hughes
12 demonstrates, it may be a way by which local actors make sense of changes in policy over which they
13 have no control. In the context of our study, we consider how local managers introduced changes to
14 hospital services. We look at how managers sought to persuade other stakeholders of the nature of the
15 problem and enrol them in the process of implementation.

17 **Framing in local policy implementation**

18
19 'The Shire' is an English county. It has five acute care providers. Two of these (Forest hospital and
20 Shire General hospital) consist of a single hospital. The remaining three (South Shire, Wildbridge and
21 Smithton, and Warton and Judford) have services across multiple sites, a legacy of earlier mergers
22 between organisations. At the time we started fieldwork (November 2006) organisations in the Shire,
23 as in other areas of England, were involved in plans to centralise hospital services. These plans had a
24 long and complicated history whereby the rationale for change, the organisations involved and the
25 details of the plans had all changed over time and continued to change whilst we were in the field.

26
27 The plans were being led by the local commissioner, at this time the 'Primary Care Trust' (PCT). 'Fit
28 for the future', as the plans were known, had been instigated by regional planners (the Strategic

1 Health Authority) on the recommendation of management consultants who had been brought in to
2 advise on responding to a financial deficit. The original plan was to close one of the District General
3 Hospitals in the Shire. This plan had faced considerable public resistance and, as a result, by spring
4 2007 the plans had changed to a proposal to close an Accident and Emergency department in one of
5 the hospitals. Subsequent iterations included plans to centralise a range of acute services across the
6 region and various proposals to merge organisations.

7
8 On the first day in the field it was immediately apparent that the plans were facing community
9 resistance. At the entrance of Shire General Hospital, for example, hung a large banner which read
10 'Save our Shire General'. The 'Save the Shire General campaign' involved local politicians from all
11 parties, the local newspaper, local charities, Shire General staff and members of the public. A national
12 leader of a political party also lent support to the campaign. The campaign had arranged a petition
13 against the closure of the hospital and had organised a number of public meetings and rallies,
14 including a candle-lit vigil at Westminster. The situation in the Shire was very different to the picture
15 of consensus presented in national policy. While interviews revealed that some local clinicians
16 supported some form of change in some service areas, there was considerable disagreement over who
17 should provide what, where and how. Some doctors also rejected what they saw to be the imposition
18 of a national 'blueprint' for hospital services irrespective of local circumstances.

19
20 Over the period of fieldwork we observed a reframing of the issue, from a financial to a clinical
21 rationale for change. The clinical rationale mirrored the framing which we have described above as
22 emerging in national policy documents at this time. The features and impact of this framing will be
23 illustrated with two events: a 'co-design' workshop and a provider Board meeting.

24 25 *The co-design workshop*

26
27 Echoing the enrolment of political elites in the formulation of national policy, the commissioner had
28 contracted a firm of management consultants to run a two-day 'clinical workshop' with local doctors.

1 That this workshop constituted the *strategic* use of medical expertise to secure legitimacy for the
2 commissioner's plans becomes apparent when 'front stage' talk is compared to 'back stage' talk.
3 Whilst talk on the front stage can be expected to display deference to values such as rationality,
4 objectivity, and public involvement, talk on the backstage gives more recognition to the political
5 dimensions of planning (Degeling, 1996). An example of 'front stage talk' can be found in the report
6 of the workshop published by the firm of management consultants and which describes the process as
7 follows:

8
9 [The workshop] enabled clinical leaders from across the three Trusts and from primary care to
10 come together and use their experience and judgement to help guide the future investment and
11 disinvestment decisions being faced by [the Shire] health economy. The clinical leaders worked
12 in three groups – one for each clinical area. They were asked to use their expert opinion and
13 judgement to develop sustainable service models that showed the levels of care and appropriate
14 settings for them. They then considered these clinical models and discussed them with regard to
15 options for service reconfiguration.

16
17 In contrast, in subsequent interviews with a range of local actors, the purpose of the workshop was
18 referred to in terms of 'presentation' and 'marketing' of the commissioner's plans. Local doctors who
19 had participated in the workshop expressed resentment at what they saw to be the superficial and
20 strategic nature of their involvement:

21
22 We were all very, very cross about that because it was only a short workshop, when you think
23 of the scale of what's discussed, to achieve some sort of meaningful outcome after two half
24 days is pretty ambitious. It was one afternoon and the next morning and the first session was
25 supposedly fairly broad discussion without any specifics and then the next was more focussed
26 on what would happen if you reduced sites or services at sites. But, the participants from here
27 felt that our input was effectively ignored and certainly we said quite a lot of things and almost
28 none of it were recorded. You felt that whoever wrote it had decided it all beforehand and the

1 consultation was not really intended to accurately reflect what the consultants felt. (Senior
2 doctor, Shire General Hospital)

3
4 Closing a hospital in this kind of area is not going to be easy, that's why they tried to sort of
5 shift it towards us clinicians having all these meetings, so we would show that we could do it
6 without affecting clinical services so trying to make it look like the clinicians were suggesting it
7 which was quite a crafty move and caused a lot of resentment among- a lot of my colleagues
8 were saying 'no, no don't take part in the process because otherwise you'll be blamed when it
9 happens'. (Senior doctor, Forest Hospital)

10
11 The co-design workshop was one of a number of ways the commissioner had involved doctors in the
12 process of implementation. It had also enrolled doctors to defend the plans during public consultation.
13 As one PCT manager explained:

14
15 I think in terms of the medical directors who are the key ones and especially (the medical
16 director) at Forest Hospital who was very helpful and because he can stand up and – and that's
17 what [the public] want – they don't want to hear people like me or even our Chief Executive,
18 what they want to see is an actual consultant saying 'this only makes sense – why wouldn't we
19 want to do it?' and so that's why it was always essential that we had their engagement.

20
21 In this way the commissioner can be seen to be following the guidance issued by the Department of
22 Health on how local plans to close services should be implemented. Thus local managers were not just
23 implementing national policy but adopting the recommended strategy to 'sell' the plans to the public.
24 The doctors enrolled in implementation were without exception doctors occupying management roles.
25 The findings of our study accord with similar studies that have interpreted these practices as the co-
26 optation of local managerial elites to effect service change in 'hard to reach' areas (Waring 2014,
27 Martin and Learmonth 2012, Coburn, Rappolt and Bourgeault 1997).

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The provider Board meeting

The following is an account of a Board meeting of Wildbridge and Smithton NHS Trust. It illustrates the mobilisation of the framing of clinical necessity to ‘sell’ plans to close the maternity unit at Wildbridge hospital to the public and resistance to that framing. The Board meeting was held in the summer of 2007. The Trust had brought its plans to the Board in order to secure agreement from the Board prior to commencing public consultation. The meeting was attended by what we estimated to be about 200 members of the public, many mothers with babies in pushchairs. The members of the public who attended the meeting opposed the plans to close the maternity unit.

The plans for closing the maternity unit were set out in a meeting paper, again with the title ‘The clinical case for change’. A verbal presentation was given by the clinical lead (a medical manager). Although she was speaking in her capacity as a manager, she began her presentation by listing her clinical credentials (‘a consultant paediatrician, an elected member of the Royal College of Paediatrics’). The reason for closing the maternity ward she said was ‘clinical viability’. This was based on Royal College standards for consultant staffing, as well as the European Working Time Directive (legislation that limits doctors’ working hours).

During the meeting vocal opposition to the plans came from the local MP, medical staff, a trade union leader and members of the public. For the most part the rationale for closing the maternity unit was challenged ‘on its own terms’. For example, the local MP argued that Wildbridge hospital met the Royal College standards for consultant staffing, it was Smithton hospital (where maternity services were to be centralised) that failed to meet the standard, and even so, the standard only applied to high risk populations, while Wildbridge had a low risk population. Similarly, a senior hospital doctor contested the Trusts’ claims that the changes were necessary to improve safety. The doctor presented mortality statistics to show that the outcomes for Wildbridge hospital were better than for Smithton, and lower than the national average. Submissions from members of the public drew on personal

1 experience and an assessment of local needs (such as no other hospital in reasonable distance and a
2 growing population of families who will require maternity services) to argue that the plans reduced
3 local access to services.

4
5 The Board then voted with the majority of the Board voting in favour so that the plans to close
6 maternity services at the hospital were agreed. It was clear that the members of the public who
7 attended the meeting were dissatisfied, especially with what they saw to be the weakness of the
8 rationale and that a decision had been made *prior* to public consultation.

9
10 Policy elites have argued that, among the public, there is a lack of understanding of the ‘technical
11 patient safety arguments’ for closing hospitals (Farrington-Douglas and Brooks 2007). However it is
12 apparent from this board meeting that it was not that the public did not understand the technical
13 arguments, it was that they did not *accept* them. Similar findings have been reported elsewhere
14 (Haycock et al, 1999). Stakeholders were confident in arguing against the plans, both ‘on their own
15 terms’ with regard to the weakness of the evidence for improvements in safety, and in drawing
16 attention to other considerations, such as access. They also mobilised alternative measures of ‘safety’.
17 In this case a particular and concrete understanding of safety was set against the universal and
18 abstract.

19
20 Thus, as rhetorical strategy, the clinical rationale was not successful in that other stakeholders were
21 unconvinced of the need for change. Public opposition, including organised rallies and
22 demonstrations, continued throughout the summer. Toward the end of fieldwork, in September 2008,
23 the commissioner decided to continue to commission maternity services from this hospital. Beyond
24 the Shire there were a number of other high profile cases of plans to close services being abandoned
25 in response to public opposition or rejected by the Independent Reconfiguration Panel (Torjesen,
26 2008; Moore, 2008). For example, in rejecting the plans of one NHS trust to close a maternity
27 department, the panel questioned the safety of long transfer times, emphasised the importance of
28 accessibility and choice and said that alternative models of staffing could provide better consultant

1 cover (Moore, 2008). As one national policy maker said during an informal conversation, ‘the public
2 aren’t buying it’ (Fieldnotes, March 2008).

3
4 Discursive power, however, goes beyond rhetorical force. It takes the form of the power to define the
5 nature of a problem and who should be involved in decision-making. The new framing defined the
6 nature of the problem as ‘clinical’ and thus the proper business of the medical profession. One of the
7 more tangible consequences of this framing in the Shire was that it enabled NHS organisations to
8 avoid public consultation. In the following excerpt LJ is talking to a PCT manager. This time it is
9 December 2007, and the manager is talking about the commissioner’s plans:

10

11 So we went through a whole load of hoops really, to get to where we are which is basically that
12 there are a number of Royal College clinical best practice requirements that have gone out as
13 commissioning intentions to the providers and they’ve come back with proposals, some of
14 which are about greater networking, or indeed moving services to one hospital site, rather than
15 having them spread across all three and it was agreed by the [health overview and scrutiny
16 committee] that we could effectively go out...through engagement rather than formal
17 consultation. So we were all set to do formal consultation and then at the end it looked like we
18 could say effectively well this is just about good practice and why would anyone disagree with
19 us following Royal College guidance?

20

21 The assumption, in this excerpt, is that planning health services is a technical exercise, a rational
22 process of applying scientific evidence. However, as Lasswell (1936) observed, questions of who gets
23 what, where and how are political. In Foucauldian terms, the new framing is a political technology
24 that takes what is essentially a political problem and recasts it in the neutral language of science
25 (Dreyfus and Rabinow, 1982, p.196).

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28 **Discussion**

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We have looked at how a policy of centralising hospital services was presented in national policy documents, how this shifted over time and how it was articulated and enacted in practice. At the national level we identified a shift in the framing of the issue, from a rationale of improving access and responsiveness to one of clinical necessity. We have interpreted this shift in framing as a rhetorical strategy, deployed at both national and local levels, with the aim of realising change in the face of community resistance to closing local hospitals and a concomitant policy rhetoric emphasising the need to involve the public in decisions about how services are provided.

A key dimension of this strategy was the co-optation of political and managerial elites from the medical profession (Waring 2014). At the national level this involved appointing medico-politicians to produce Department of Health policy documents. Until the 1980s the influence of the profession on national policy was such that Dunleavy described it as an example of ‘the professionalised state’ (Dunleavy, 1981). However since then the influence of the profession on national policy has declined as that of management has increased (Salter, 2003; Harrison and Ahmad, 2000). We argue that the involvement of political elites in the formulation of national policy on hospital planning can best be understood as co-optation in the interests of policy makers, rather than a resurgence of professional influence. While political elites were invited to participate in the seemingly intractable issue of hospital planning, the profession continued to be excluded from decisions in other areas of healthcare policy, such as when the New Labour government introduced a raft of policies designed to increase choice and competition in the NHS. A similar assessment has been made by Coburn et al (1997) in the case of state-profession relations in Ontario.

The strategic use of medical knowledge and expertise by managers as part of the micropolitics of local planning is not new. Milewa et al (1999), for example, describe how local managers made appeals to ‘clinical effectiveness’ when introducing changes to services. Learmonth and Harding (2006) consider the way that a discourse of ‘evidence-based’ practice serves elite interests, although they note that this is not necessarily intentional on the part of individual managers:

1 Given the taken-for-grantedness of dominant beliefs about evidence in health services, most
2 managers no doubt understand the incorporation of evidence into their practices as a politically
3 innocent way to deal with effectiveness problems (2006, p. 254).

4
5 Nor was the clinical rationale the only framing in play. We found that appeals to clinical leadership
6 were often coupled with an appeal to public involvement. We interpret this as reflecting the fact that
7 policy makers and local managers must attend to the concomitant policy imperative of public
8 involvement in decisions about service delivery. Martin and Learmonth (2012) go further,
9 highlighting how health service staff and members of the public 'are increasingly represented not just
10 as the objects of policy interventions, but as subjects implicated in policy design' (p.282). They argue
11 that claims about engaging clinicians and the public in policy formulation can best be understood as a
12 co-optive means of 'governing at a distance' (Rose and Miller 1992).

13
14 We found that the clinical rationale did not persuade other stakeholders of the need for change. But it
15 is not simply that the rhetoric is unconvincing, the tactics themselves, in so far as they are recognised
16 by other actors, engender distrust. This is likely to produce the opposite of what is intended, for as
17 Hajer (1995) has shown in relation to environmental policy, it is trust, rather than simply empirical
18 evidence, that is key to the acceptance of change in intractable controversies.

19
20 Beyond the more obvious use of rhetoric, the policy 'worked' through the discursive act of framing.
21 Frames present an interpretation of the way things are, of what should be done and who should do it.
22 Through the use of framing, policy texts channel thinking in a particular direction and make a
23 particular course of action appear self-evident. In this case centralisation is framed as a means of
24 improving clinical effectiveness. However, if the goal is improving health outcomes, there are
25 alternative courses of action. In maternity care, for example, outcomes may be improved by action to
26 reduce obesity and diabetes in the population, by improving uptake of antenatal care, improving
27 identification of 'at risk' women in the third trimester and so forth. Even taking a more narrow
28 concern with medical staffing and training, for any given objective, such as training doctors,

1 maintaining practitioner skills or ensuring sufficient input from a senior doctor, there are alternative
2 courses of action. These might include, for example, employing additional staff, improving teamwork,
3 using clinical networks or exploiting burgeoning innovations in telehealth. The framing of one course
4 of action as a 'clinical necessity' restricts the extent to which alternative responses can be considered.

5
6 The way an issue is framed can also make some elements appear fixed and proper while others are
7 open to change (Fischer 2003, p.85). Why, for example, are Royal College standards assumed to be
8 fixed and not open to debate? Given the limited evidence for these standards why not organise
9 staffing and training of doctors around other objectives, such as patient access? Lewis (2007) has
10 emphasised the need for creativity in finding solutions to difficult healthcare issues. The planning of
11 health services is just such an issue, involving a complex interrelation of service and training. Health
12 services are also not just health services but play important instrumental and symbolic roles in
13 communities. Framing the problem as an issue of 'clinical viability' elides this complexity and
14 hinders the development of effective policy.

15
16 The recasting of political decisions as clinical decisions has significant implications for the national
17 policy objective of involving the public in decisions about healthcare delivery. The government has
18 introduced a number of mechanisms aimed at strengthening public and patient participation in
19 decisions about how health services are provided. The power of the clinical rationale is that it does not
20 matter how effective the democratic mechanisms are if the definition of hospital planning as a clinical
21 decision means that it is kept off the agenda.

22
23 Fieldwork for this study was undertaken between 2006 and 2009. Our intention was to use
24 hospital planning during this period as a case study to explore the use and effects of framing in
25 policy and practice. We therefore sought to make a more general contribution to the understanding
26 of the role of policy in political contests. Moreover, in the current economic climate the issue of
27 hospital planning has become more acute as local managers are facing pressure to reduce costs.
28 Hence, our findings remain relevant to the present day. Since this study was undertaken policy

1 framings have continued to shift and in recent years there has been more emphasis in policy texts
2 on the need to close facilities in the face of austerity and to move spending from acute to
3 community services. There has also been an increasing emphasis on ‘co-producing’ plans for
4 service change with the public, suggesting a continuing reliance on a form of governmentality as
5 described by Martin and Learmonth (2012). Nonetheless, the framing that we have explicated in
6 this paper remains in play (Academy of Medical Royal Colleges, National Voices and NHS
7 Confederation 2013; NHS Northwest London 2012). For example, in justifying his decision to
8 downgrade the Accident and Emergency department at Lewisham Hospital (a decision taken in
9 response to the financial failure of a neighbouring provider) the Secretary of State for Health
10 claimed the decision ‘would save 100 lives a year’ (BBC News 31 January 2013). Indeed what
11 can be seen in current policy is a ‘layering’ of discourses -financial, clinical and public-that
12 reflects the layering of forms of governance in contemporary healthcare policy (Jones, Exworthy
13 and Frosini 2012 and Greener 2004).

14
15 Since fieldwork was completed the co-optation of medical elites to facilitate service change can be
16 seen to have continued and extended in continued growth of hybrid clinical-managers and models
17 of distributed leadership in organisational change. For example, Primary Care Trusts, staffed
18 largely by managers, have been replaced by ‘clinical commissioning groups’, staffed by clinicians.
19 According to central guidance distributed to these organisations, the value of having clinicians as
20 commissioners includes:

21
22 Better involvement and engagement of local people to adopt improved services and move from
23 familiar but out-dated services based on the focus on quality and outcomes and the trusted
24 positions held in communities. (NHS Commissioning Board Authority 2012, p8).

25
26 As Perkins et al (2014) observe, this suggests that the rationale for establishing clinical
27 commissioning groups was in part the ability of General Practitioners to persuade local community
28 groups to accept proposals to close hospital services.

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Conclusion

In this study we explored how a policy to centralise hospital services was presented in national policy documents and implemented in one locality in England. We identified a shift in the framing of the policy, from one that presented the policy as a means of improving access and making services more responsive to patients, to one of clinical necessity. In the latter framing plans to close hospital departments or entire hospitals were presented as clinical decisions that were based on the evidence and necessary to ensure safety. We have interpreted this framing as a rhetorical strategy employed to convince other stakeholders of the need for change. Although the persuasive power of a rationale of clinical necessity is limited, a more insidious form of power operates in the way it shapes how the problem is understood, which solutions are considered (and which are not) and who is included in decision-making.

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ACCEPTED MANUSCRIPT

Highlights

Explores the dynamics of framing in policy texts, over time and space

Shows how professional elites are co-opted to support service change

Finds that a framing of clinical necessity undermines democratic participation

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