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Sedimented governance in the English NHS

Lorelei Jones

Narratives of governance emphasise a shift in modes of organisation and action from public sector bureaucracies towards markets and networks. The extent and nature of this shift is the subject of debate, with some arguing that it has been overstated, that public-sector bureaucracies remain widespread, and others asking 'do governments do less, or have they merely changed the way they do things?' (Bevir 2013). Adopting an historical lens, Bevir accounts for the shift towards markets and networks as originating in the twin trends of modernist social science - neoliberalism and rational economics on the one hand, and modernist sociology on the other. Neoliberalism and rational economics have produced policies based on a critique of bureaucracies and a perceived superiority of the market and the management practices of the private sector. Modernist sociology has produced a critique of markets, in terms of coordination and steering, and a belief that efficiency and effectiveness derive from stable relationships characterised by trust. From the viewpoint of modernist sociology both bureaucracies and markets have failed to address 'wicked problems', those complex and contested social problems that require networks of individuals and organisations across sectors. Significantly for this chapter, both sets of reforms - markets and networks - continue the bureaucratic faith in modernist expertise which continues to play a key role in governance.

In this chapter I develop an account of contemporary healthcare governance that combines insights from the governance and governmentality literatures (Bevir 2011). I approach this task by, firstly, exploring the interaction of markets, networks and hierarchies. Drawing on a decentred theory of governance (Bevir 2013) I locate this interaction in a context of situated agency and local traditions. Secondly, I consider how, in this contemporary context of 'sedimented' governance, governing is accomplished through inscription practices that align local action with government ambitions.

My analysis draws on a study of local efforts to implement a national policy for 'integrated care'. This policy required local agencies to work collaboratively in networks to deliver services. Networks were, initially, granted autonomy from central control and promised the

'freedom to innovate'. What became evident, over the course of the research, was the resurgence of hierarchy, despite much of the pre-existing bureaucratic architecture of the NHS being dismantled by recent NHS reforms. The result was a hybrid form of governance whereby hierarchical control was exerted *through* networks. While in some localities hierarchical forms of control were contested and resisted, in others the perceived need to respond to this regime came to dominate the activities of local actors. In addition to hierarchical forms of control, governmental ambitions were also realised through a less visible assemblage of expert knowledges, procedures, calculations and documents. Looking specifically at two elements of this assemblage - data collection and analysis undertaken by NHS England (the 'Pioneer stocktake') and a policy evaluation commissioned from an academic team - I show how these analytical methodologies worked as indirect control technologies, constituting a particular version of integrated care and shaping local action.

Sedimented governance and governmentality

The last 20 years has seen English health care policy zig-zag between different governance mechanisms (hierarchy, markets and networks). Under New Labour, for example, there were three distinct policy streams based, in turn, on networks (e.g. national service frameworks), hierarchy (e.g. targets) and markets (choice and competition). Policy under the coalition government initially continued in the direction of 'more market' (Paton 2014), however, the current integrated care agenda marks a shift in direction once again toward networks. These policy streams have not simply replaced each other but have accumulated over time, or 'sedimented', producing a complex mix. By this I mean, each mode of governance has not, nor cannot, erase the history of previous governance regimes, but instead each period of reform can be seen as building on the past, where elements of the past continue to provide the 'bedrock' and 'contours' of the present, or they result in periodic protrusion and distortions into the contemporary form. Different governance mechanisms interact, with each other, and with local practices, so that resultant action is both interactional and contingent.

For example, looking at the implementation of market-based policies under New Labour, Jones et al (2014) found that local health service managers worked in a context of multiple and often conflicting policies. One response of local managers was to prioritise central targets, particularly those to do with waiting times, financial control and infection rates. This

response could be explained, in part, by the severity of the sanctions associated with failing to meet central targets, but it had the consequence of stymieing implementation of market-based policies. The implementation of market-based policies was also stymied by local social networks, between clinicians and, to a lesser extent, managers. Thus, contra to the goal of market-based policies, referral patterns remained largely unaltered as clinicians continued to use relationships and trust to manage uncertainty and coordinate action. However, while in some instances local social networks persisted, in others they were disrupted by market-based policies, leading to more adversarial relations, eroding trust, and preventing collaboration. Local action was also shaped by shared norms and beliefs, for example, a shared belief that patients want to attend the local hospital, resulting, again, in 'sticky' referral patterns. A sedimented governance framework is thus attuned to the interaction of policies, with each other, and with features of the local context, seeing resultant action as mediated by local (informal) social networks and shared values and traditions.

Newman (2005) adopts a Foucauldian lens to illuminate power dynamics and explain social action in the context of sedimented governance. From this perspective contradictions and tensions are created from the interaction of different discourses, associated with different governance regimes. These discourses construct subjectivities and political objects in different, often conflicting, ways. This creates tensions, for example, between constructs of 'consumers' (market discourses) and 'stakeholders' (network discourses) or between the neutral administrator who is guided by routines (bureaucratic hierarchies), the entrepreneurial manager (markets), and the value driven leader (networks). Each discourse guides behaviour by channelling thinking, and through the very constitution of political subjects and objects. Their interaction, however, creates contradictions for local actors. These contradictions must be resolved, in some way, for local actors to 'get on with the job' (Newman 2005, p730).

I similarly adopt a Foucauldian lens, but while Newman's focus is on the agential strategies employed by local actors in response to multiple and conflicting discourses, I look instead at the role of expert knowledge and practices in governing. To do this I draw on governmentality scholarship to consider the assemblage of 'programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to government ambitions' (Rose and Miller 1992, p175). Scholars such as Miller and Rose (1993, 2008) and Johnson (1993) have extended Foucault's theory of governmentality by developing the role of professionals in governing. This work argues that

expertise, the practical activities of professionals, and the perceived neutrality and social authority of professionals, are essential to rendering realms of social life knowable and amenable to governing (Johnson 1993, Miller and Rose 1993, 2008). One focus of this work are the seemingly mundane practices of notation and calculation - written reports, graphs, tables, statistics, etc. – that nonetheless play an important role in aligning local action with central policy imperatives.

Ferlie et al (2012, 2013), argue that governmentality is a particularly potent theoretical resource for conceptualising 'post bureaucratic' forms of governance. They have applied this approach to the field of health care policy to explore the way the knowledge and techniques of 'Evidence Based Medicine' constitute subjectivities and reshape modes of thought and professional work practices. Empirical research, however, has been largely restricted to analysis of policy documents, with few studies observing governmental practices and the response of individuals in different contexts. As a consequence, scholarship has neglected the role of agency and the influence of alternative guides for action (such as local traditions).

Taking a case study from the NHS in England, I consider the way governing is accomplished in sedimented contexts. Firstly, I describe the persistence of hierarchy, albeit in a networked form (a networked hierarchy hybrid). Secondly, I show how 'action at a distance' (Rose and Miller 1993) occurs through an assemblage of rationalities, knowledges and practices. I look in particular at two elements of this assemblage, data collection and analysis undertaken by NHS England (the NHS 'stocktake'), and a policy evaluation commissioned from an academic team. I argue that these analytical methodologies work as an indirect control technology constituting a particular version of health care and shaping activities of local actors. I then show how the response to these practices varied in different contexts, resulting in action that was both variegated and contingent.

The case of integrated care

In England current health care policies emphasise the need for greater integration and continuity in the organisation and delivery of patient care. Integrated care policies illustrate a form of governance based on local networks of inter-connected organisations cooperating together on the basis of trust and reciprocity to realise greater coordination. Such networks

have the perceived benefits of engendering local flexibility, innovation and pace of change, and including more opportunities for public and stakeholder involvement in decision-making. In England the increasing use of networks as a form of organisation has been viewed as part of a broader shift involving the dispersal of power to a range of dynamic organisational actors, both public and private, that has accompanied the 'hollowing out' of the state (Rhodes 2007). Ostensibly the NHS in England is exemplary of this shift. The Health and Social Care Act abolished the existing architecture of NHS hierarchy, removing layers of management at the local and regional levels and dispersing the functions of the centre among a range of 'partner' organisations.

In 2013, the coalition government selected 14 localities to be 'pioneers' in whole-system health and social care integration and to share learning with other localities (Department of Health 2013). This programme emanated from a network of 'national partners' made up of newly created single purpose arms-length bodies and other national organisations (Department of Health, NHS England, Monitor, Care Quality Commission, NHS Improving quality, NHS Health Education England, Public Health England, National Institute for Health and Care Excellence, Local Government Association, Association of Directors of Adult Social Service, Association of Directors of Children's Services, Social Care Institute for Excellence, Think Local Act Personal). Bids to be part of the Pioneer programme were invited from networks of local organisations working in partnership to provide integrated health and social care. These networks typically comprised health and social care commissioners (Clinical Commissioning Groups and the Local Authority respectively), health and social care providers (acute care trusts, community care trusts, and mental health care trusts) and, in some cases, voluntary or independent sector organisations.

The successful localities varied in complexity, with some characterised by a single, coterminous, healthcare commissioner (Clinical Commissioning Group), social care commissioner (Local Authority) and acute care provider, while others had multiple commissioners and providers. Thus, the 'Integrated Care and Support Pioneers' were not small scale, or single pilots, but rather entire local health and social care systems that were expected to drive change 'at scale and pace' (Department of Health 2013). There was no accompanying funding (apart from £90,000 for each Pioneer) instead localities were offered 'support' from the national partners. This support consisted of advice, expertise and resources

(websites, webinars, workshops etc) to share learning between localities and from international experts.

The stated aim of national policy promoting integrated care is to improve services from the perspective of the patient (National Collaboration for Integrated Care and Support 2013). The Integrated Care and Support Pioneers programme defined integration as 'person-centred coordinated care' but did not prescribe how this should be achieved. Rather, the intention was to support and encourage localities to develop innovative models of service integration that had emerged through networks of health and social care organisations working in collaboration. The centrality of the patient perspective was underscored by the commissioning of National Voices, a coalition of health and social care charities in England, to produce a patient narrative for the integrated care. National Voices provided the following definition of integrated care from the patient perspective:

> *My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes*. (National Voices 2013)

I developed this account from fieldwork in four localities in England undertaken as part of a national evaluation of the Pioneer programme commissioned by the Department of Health (Erens et al 2015). The evaluation followed the first two years of the Pioneer programme. Fieldwork involved observation of planning meetings, interviews with key officers and front-line staff, informal conversations, visiting facilities and initiatives, and reading planning documents and meeting papers.

The reification of national policy and the standardisation of local activities

Initially there was considerable diversity in the plans of the 14 local networks, both in terms of planned activities and espoused goals and values. In many instances localities had long-term strategies aimed at preventing ill health by addressing 'upstream' factors that influence health and wellbeing, such as housing and early-years education. Most also had goals that extended beyond health service outputs to include, for example, reductions in health inequalities, social inclusion, increased democratic participation, community capacity

development, urban regeneration and restorative justice. Over time, however, there was a shift in the focus and activities of local actors, to implementing an increasingly narrow set of concrete healthcare initiatives, in particular, a community-based multidisciplinary team and 'care navigator' (Erens et al 2015). A particular 'programme logic' also emerged, whereby concrete initiatives such as a multi-disciplinary team, were seen primarily in instrumental terms, as means of reducing emergency admissions to hospitals, and 'rebalancing the system' so that more health care was provided in community, rather than acute, settings. The ultimate aim was to reduce costs. In this way a national policy to provide 'more integrated care' became reified as a particular set of practices with particular intended outcomes. This reification of integrated care was reflected in the slippage in the vocabulary among local actors from 'being a Pioneer', to 'the Pioneer' when referring to these concrete initiatives. In the remainder of this chapter I consider the ways this reification of integrated care, and an accompanying standardisation of local activities, was accomplished through a combination of hierarchical and other, less visible, forms of control.

The resurgence of hierarchy

When I started fieldwork a key question in my mind was 'how would a policy to provide more integrated care interact with existing market-based polices?'. Market-based policies were re-introduced to the NHS in England under New Labour (having previously been introduced in the 1990s by the conservative government) and continued under the coalition government. The underlying assumption was that competition between a wider-range of providers would improve the quality and efficiency of services (Jones et al 2014). The Health and Social Care Act (2012) sought to embed a provider market in the NHS by setting out an expectation that health care commissioners would, with some exceptions, use competitive tendering to commission services.

A key critique of market-based policies in the NHS is that they prevent the collaboration between individuals and organisations that is necessary in health and social care (Flynn et al 1996). Therefore, one a priori hypothesis for this study was that there would be a conflict between integrated care policy and existing market-based policies and the structures that had been put in place to promote local markets in health care. This conflict was not as apparent as expected. Some acute care providers claimed that the local practice of competitive tendering

promoted secrecy, rather than the openness and transparency required for collaboration. And interviewees claimed that the practice of competitive tendering in community services was a barrier for integrated care because providers were required to compete against each other for contracts. The condition-specific approach to contracting was also seen to inhibit integrated care for people with multiple long-term conditions. Yet the claims made by local actors with regard to the influence of pre-existing market structures varied widely between contexts. In some instances, such as where a single commissioner and a single acute provider were interdependent, market incentives were seen by local actors as irrelevant. In other localities, the commissioner chose simply not to use them. These findings reflect the fact that implementation of market-based reforms across England was varied, contingent on features of the local context, including the approach taken by different NHS regional managers (Peckham et al 2012). The findings may also reflect a decline in the uptake of market-based incentives by commissioners following the announcement in November 2014 by the Health Secretary, Jeremy Hunt, of a shift in direction in national policy, from choice and competition, to integrated care (West 2014). These findings highlight the fact that in England the market has always been a 'top down' market (Paton 2014) so that national pressure could be reduced at will, with a corresponding response from localities.

The more conspicuous development was the resurgence of hierarchy. This occurred despite the coalition government having dismantled much of the pre-existing bureaucratic architecture of the NHS, so that what emerged over the course of the study was a 'networked hierarchy'. One manifestation of hierarchy was the use, by NHS England, of budget allocation combined with setting, and monitoring, targets. This took the form of the 'Better Care Fund', a proportion of which was conditional on meeting a target for reducing 'avoidable' emergency admissions (Department of Health and Department for Communities and Local Government 2014). The Better Care Fund required that funds would be held in a local pooled budget under joint governance between health and social care commissioners and used to fund joint integration plans. These plans were required to be submitted, and approved, via a nationally prescribed template. In addition to meeting a target for reducing avoidable emergency admissions, localities were also required to report against other metrics covering admissions to residential and care homes, delayed transfers of care, effectiveness of reablement initiatives and a measure of patient experience. The Better Care Fund thus embodied an explicit managerial objective of moving care out of hospitals so as to reduce costs. In one instance, local performance against the Better Care Fund metrics was shared

with front line staff during a multidisciplinary team meeting, suggesting that it was not just local managers, but front line staff, who were expected to understand their work in these terms. In this way the Better Care Fund, and the accompanying targets, introduced a bureaucratic infrastructure which enabled the regulation of the activities of local networks.

Some local organisations also received the 'Monday morning call', a personal telephone call from the Health Secretary, Jeremy Hunt, to CEOs of acute trusts which had failed to meet the target for reducing emergency admissions (Campbell 2013). The resurgence of hierarchy was also evident in the practice of personal visits by the CEO of NHS England, Simon Stevens, to localities. As illustrated in the following extract, during these visits the CEO of NHS England communicated an expectation (contra to assurances of local autonomy given in national policy documents) that localities would pursue particular objectives, namely reducing emergency admissions:

> I can still hear Simon Stevens in my ear, 'how quickly are you going to reduce emergency admissions?' (CCG Chair, Board meeting June 2015)

Responses from localities to the resurgence of hierarchy varied. In some cases these manifestations of hierarchy were resisted, in others the perceived need to respond to this regime came to dominate the activities of local actors. So, for example, in one case study initial plans were aimed at improving the wellbeing of residents (conceived broadly in social and economic terms) and a long-term focus on prevention of the harmful consequences of social deprivation through early intervention (i.e. targeting the under fives). This locality had a system-wide alignment of strategies among relevant agencies and the overall plan remained unchanged despite considerable top-down pressure. In the following extract from an interview transcript the local programme lead is describing how he sees the relationship between national policy and local strategy:

> So Pioneer to us, the reason that we signed up for that as [locality], was essentially to say 'Well could this help us to do what we wanted to do further and faster?', and where that is able to do that, well that's great, and where it isn't, well we won't do it, whereas I know lots of others, well most of the other sites across the country have used Pioneer to be their transformation

programme and they describe their transformation programme as their Pioneer programme; well we don't do that.

In the following excerpt, from another manager in this locality, there is a sense of 'push back' in response to central pressure to demonstrate progress in quantifiable terms:

Interviewer: You said you needed a period of uncertainty or exploration before you could get your concrete building blocks in place. Did you feel that the centre gave you that space? You didn't feel anyone breathing down your neck wanting fast results? Or were you able to talk to them about that?

Respondent: I would say there was a bit of both really. I think there was a bit of, 'when are we going to see something, when are we going to see some impact'? But I think equally people understood that our model in [locality], we wanted to ensure that it was co-produced, there was good buy-in from clinician stakeholders, that it was something that was developed from the grass roots through the bottom-up approach, and so I think people accepted that if we were going to be true to that, it wasn't going to be a quick fix, it wasn't going out with a 'this is how it's going to be'. There was a need to be far more organic in approach. And so I think that did balance out some of the, 'well, when are we going to see results?' type of comments that we did get as well, but people sort of came round to understanding where we were coming from.

Interviewer: You say people came around, does that include the centre?

Respondent: We've had numerous visits from the centre, and I think everybody has accepted the approach we have taken.

Features of the local context that might have influenced this approach include leadership of the network by the Local Authority (rather than the NHS) and strong leadership of the Health and Wellbeing Board by a local councillor. For example, during one meeting of the Health and Wellbeing Board, attended by a representative of NHS England, the chair was observed robustly challenging the authority of NHS England, and the accuracy and legitimacy of their

analysis, and defending locally defined priorities. Interview accounts, planning documents, observations and informal conversations also exuded a sense of strong shared geographical identity and a culture of local pride and autonomy.

In contrast, in another case study local plans changed over the course of the evaluation. This locality initially had radical plans aimed at achieving a more broadly conceived notion of citizen wellbeing through an 'asset based' approach to community development, and a long-term focus on prevention by targeting children and young people. However, by the end of the evaluation, local plans were for a primary care multidisciplinary team and a care navigator. Observing a meeting of the governing board toward the end of the study it was apparent that the board were consumed by a perceived imperative to meet the Better Care Fund targets. This meeting was dominated by discussion of performance against the Better Care Fund metrics. At one point the health commissioner's Director of Strategy suggested that improvement on one of the targets might be achieved by better cleaning of the data. This particular meeting was chaired by the Director of Adult Services (an agency which has traditionally sat outside of the NHS hierarchy, accountable horizontally to locally elected councillors). She concluded the discussion of performance against the Better Care Fund metrics by saying 'this puts us in an uncomfortable position in relation to NHS England' (fieldnotes May 2015). The content of this meeting contrasted with that of early meetings where more time was devoted to collaborative planning to achieve locally defined objectives.

Unlike the first case study, in this second case study the network was led by the healthcare commissioner so that the idea of an NHS hierarchy may have held more legitimacy. The locality also occupied a newly created geographical footprint that brought together previously distinct geographical cultures and where a shared identity was in its infancy. It also faced severe financial challenges. Indeed, one reading of the data is that it suggests a strategic reframing on the part of local actors in order to garner external resources (financial and other support from NHS England).

The resurgence of hierarchy is interpreted here as resulting from the *realpolitik* of growing demand and reduced budgets. Between 2010 and 2013 spending on adult social care decreased by 12% in real terms (LGA/ADASS 2014). Whilst spending over this same period on the NHS increased on average by 0.8% per year, this is below the estimated 4% needed to meet increases in demand for health care (Appleby et al 2015). And at the time data was

being collected the government was facing a general election (held in May 2015). In this context ministers and senior civil servants sought to control policy implementation, to ensure that local activities were aligned with national imperatives to reduce spending, and to demonstrate progress in quantifiable terms. As an informant from one of the national regulators noted, 'there is no money so everyone at the centre wants grip' (fieldnotes, May 2015).

The resurgence of hierarchy might also be interpreted as resulting from the persistence of hierarchy as a tradition and cultural template within the NHS, so that it has become, for many who work in the NHS 'the way things are done around here' (Exworthy et al 2011, Exworthy and Frosini 2008). As a consequence, patterns of behaviour, conditioned by previous bureaucratic processes, remain unaltered despite shifts in national policy direction. Local managers, especially those who have worked in the NHS for a long time, may have become inured to hierarchy, habitually responding to its remnants and anticipating its return.

Governing in the networked hierarchy

My research also suggests that local action was shaped, not just by the coercive measures described above, but also by less direct, and less visible, means of regulation and persuasion. Here, I draw on the work of Foucault (1979, 1990, 1991) to consider the operation and effect of micro technologies of power. I focus on the analytical methodologies of the Pioneer 'stocktake' undertaken by NHS England, and the national evaluation of the Pioneer programme. These analytical methodologies are here viewed as indirect control technologies that shape local action in line with government objectives.

NHS England 'stocktake'

In April 2015 the 'support' function of the Integrated Care and Support Pioneers programme was transferred from a separate arms-length body known as 'NHS Improving Quality' (NHS IQ) to NHS England where it was redesigned and relaunched. This function continued to be framed as 'support' (rather than 'performance management') offering localities assistance in form of 'facilitation', 'development', 'coaching' and so forth. Shortly afterwards, NHS

England announced a Pioneer 'stocktake'. The stocktake collected information from a range of sources of published statistics which was then collated in a 'Data Pack', a Power Point slide pack given to each locality. The Data Pack presented the data that had been collected in graphs and tables so as to compare each locality with other Pioneer sites against a selection of metrics. According to this document the aim of the stocktake was to 'create a single 'one stop shop' information resource which provides an overview of the Integrated Care programme using a consistent narrative and library of data'.

Initial slides in the Data Pack include a section on 'demographics' - comprising graphs and maps for the locality showing the distribution of the population in terms of age and ethnicity, followed by a section on finance, showing in tabular form the healthcare commissioner's allocations and key areas of spend. The next section focused on the 'Ambitions of the Pioneer Better Care Fund Plans', and included the following table which gives expenditure against 'benefits':

Table 1. Plan-specific view – benefits (Source NHS England. Pioneer Stocktake. Data Pack).

	Reduction in non-elective stays	Reduction in non-elective activity (%)	Saving (£m)	Reduction in delayed transfers of care (days)	Reduction in delayed transfers of care (%)	Saving (£m)	Reduction in permanent residential admissions (%)	Saving (£m)	Increase in reablement	Increased reablement (%)	Saving (£)	Other savings – from local metrics (£m)	Total savings (£m).
Name of locality													

The above metrics embody a managerial imperative for health services concerned with cost savings. In the Data Pack these metrics are also presented in bar graphs that compare all Pioneer localities. In this way localities can view their own performance against these metrics with other localities. In Foucauldian terms the NHS England Stocktake inscribes information about a locality and transports it to the centre. In doing so it makes the multitude of diverse activities of professionals at the periphery visible and knowable to the centre, but it also regulates activity at the periphery by defining, privileging and constituting a particular version of integrated care, one where the primary objective is to reduce emergency admissions to hospitals and thereby reduce costs. 'Taking stock' as Foucault observed, is not just about examination but about correction. Whilst Foucault was referring to the individual as the 'stocktaking administrator' (1988, p 33) the Pioneer Stocktake acts in a similar way on collectivities. Localities are encouraged to compare themselves with others and correct. The Stocktake normalises both the means and the ends of health care, shaping thinking and subsequent action. Whilst the subsequent decisions by local actors are apparently free from visible coercion, they are shaped by a particular understanding of integrated care, constituted in a shared vocabulary, theory and explanation. This influence is largely invisible, hidden in the seemingly neutral and objective practices of data collection and analysis. The influence of the NHS England Stocktake on local action was not, however, complete. In some areas, the relevance of the measures were contested and the process was resisted by local actors. For example, at one local planning meeting where a representative from NHS England was introducing the Data Pack, the public and patient involvement representative commented that the metrics did not capture the patient experience. In another example, during conversation with managers from NHS England they reported that the Stocktake had 'a cool reception in some places' with local actors concerned by the administrative burden and 'feeling like they are being performance managed' (fieldnotes July 2015).

Policy evaluation

Like other national policies, the Pioneer programme included an independent evaluation commissioned from an academic team. Evaluation refers to the activities of applied social scientists who collect and analyse data to provide information on program results (Browne and Wildavsky 1984). Evaluation of national policy became routine under New Labour as part of a 'modernisation' programme underpinned by a philosophy of developing sustainable

policies based on ‘what works’ (Newman 2001). In institutional theory, evaluation plays an important role in establishing the legitimacy of policy processes, demonstrating that the process is rational and procedurally correct (Feldman and March 1981). Like audit, evaluation has become increasingly important in ‘post bureaucratic’ governance contexts where direct bureaucratic accountability has declined (Power 1997). In this section I consider how the inscription practices and analytical methodologies of evaluation align local action with governmental objectives.

The evaluation of the Pioneer programme employed an interview topic guide, a list of questions which reflected ‘what the funder wanted to know’. One of the questions was ‘how many patients/service users had experienced changes in service delivery?’. This question reflects a political rationality concerned with quantifying progress. It also constructs a particular version of integrated care. The question only makes sense if integrated care is understood as a concrete intervention (rather than say a dimension of quality). The number of patients or service users who receive the intervention can then be counted. Thus the only way localities can comply with this seemingly neutral process of data collection is through this particular understanding of integrated care. Another question was ‘what are they doing?’. To answer this question data was collected using a spreadsheet that displayed, in rows, the localities, and, in columns, pre-determined categories of initiative (multidisciplinary team, care navigator, single point of access and so forth). In this way a procedure for classifying and comparing localities reinforced the reification of integrated care as a narrow set of concrete initiatives.

The evaluation of the Integrated Care and Support Pioneers included plans to conduct a cost-effectiveness analysis (Policy Innovation Research Unit 2015). Although the procedure for the analysis had not been finalised at the time of fieldwork, there had been discussions within the team about suitable initiatives that could be used for the analysis. Like the interview topic guide, and the spreadsheets used to classify and compare sites, the methodology of the cost-effectiveness analysis contributes to the reification of integrated care as a concrete initiative, and the standardisation of network activities. In order to assign a value to the ‘cost’ part of the analysis integrated care must become something that can be costed, and in order to compare across sites, it must be standardised. In the process the policy objective of ‘integrated care’ becomes elided with a concrete initiative such as a multidisciplinary team.

Just as organisations have to change to make them auditable (Power 1997) so to health care has to change to make it evaluable.

Evaluation inheres an objective instrumental ideal. One assumption of this mode of analysis is that the methods themselves are neutral. However, as Tribe (1972) has argued, scientific language, like any language, constrains the way we think about the world. Take, for instance, the cost-effectiveness analysis, one of the key analytical methodologies of policy evaluation. Cost-effectiveness analysis embodies means-end rationality and (by definition) a managerial ideology concerned primarily with cost and operational effectiveness. Moreover, the focus on the *end result* of care processes, and a restricted focus on what can be readily measured, excludes many dimensions of care that are less tangible but may be important to patients and professionals, such as the quality of interaction between patients and staff and emotional support (Brown 2008). Indeed, for patients with a long-term condition it is often the process of care, rather than the end-result, that matters most to patients (Mol 2008). It is not just that these values are excluded from analyses, but that the analysis constructs a particular version of health care. The discursive effects of these analytical methodologies have implications in the material world in the way that they influence managerial practice and, in turn, the behaviour of health care staff.

Discussion

The findings from this study illustrate the sedimentation of governance in the NHS in England. A sedimented governance framework is attuned to the interaction of governance mechanisms in local contexts. In this instance a policy based on networks of local organisations working in partnership to provide integrated health and social care was introduced into a context of pre-existing market structures. What was observed was a largely discretionary market, as local actors responded to national signals of a change in policy direction. Then, over the period of the study, there was an observable resurgence of hierarchy, manifested in the use by NHS England of the top-down tools of budget allocation and central targets, and coercive forms of influence through positions of formal political authority. The interaction of networks and hierarchy produced a network-hierarchy hybrid. In the networked hierarchy the practices of data collection, analysis and evaluation are key resources for governing. Through these analytical methodologies a particular version of

integrated care is constructed and the actions of local agents are regulated. These practices channel the action of local managers and professionals in a way that focuses attention on measures of service efficiency and cost savings, but are poorly aligned with the aim of improving the patient experience.

Sedimented governance is produced by the combination of neoliberal regimes, committed to decentred forms of coordination and control, and the persistence of hierarchy in contexts where citizens and their representatives 'will, in one way or another, sooner or later, insist on accountability on the part of those who act in their name using resources appropriated from them' (Lynn 2011, p231). This study highlights the top-down nature of markets and (formal) networks in the NHS, their use by the centre and their political role as statements of ideology, rhetorical devices and discursive strategies to conceal and bolster central control.

The findings from this study have implications for policy in the way they illustrate what happens when different instruments of government interact. In government programmes, networks are used where problems lie beyond the reach of any single agency and thus can only be addressed by professionals and organisations working together across sectors (Bevir 2013). Networks have the perceived benefits of engendering local flexibility, innovation and pace of change. The effect of hierarchies on networks, however, is to reduce their autonomy, distinctiveness and effectiveness (Rhodes 2007). The findings from this study are consistent with the 'corruption' of networks by hierarchy observed by Addicott et al (2007) in relation to cancer networks. They found that central targets dominated the activities of local networks and displaced alternative objectives such as sharing learning. The findings from my research show how networked governance can reinforce central control, illustrating the way that a single purpose agency (in this case NHS England) can achieve a greater focus on policy implementation than could ever be realised by a multi-purpose bureaucracy.

I have combined insights from the governance and governmentality literature to show *how* governing is accomplished in sedimented contexts. In this study central control was bolstered by an assemblage of procedures, analyses, calculations and documents. One element of this assemblage was the 'support' provided by NHS England to Pioneer sites. Consisting of numerous 'soft' forms of control (facilitation, coaching, expertise) the support provided by NHS England mimics the role of private management consulting firms, and like private management consulting firms, has the effect of homogenising forms of organisation

(DiMaggio and Powell 1983). My focus was on the inscription practices of data collection, analysis and evaluation and how these worked as indirect control technologies, constituting political objects and shaping action. This analysis attends to the role of expert knowledge and practices in governing, in this case those of health service research. The analytical methodologies of health services research transport information about localities to the centre, classifying and comparing localities to make them knowable and thus governable. At the same time these inscription practices constitute the political object, enhance central control through standardisation of activities and regulate the behaviour of local actors.

I also challenge Foucaudian scholarship that has made theoretical assumptions of control without empirical data from the observation of local practices. I show not just how governmentality combines with more sovereign forms of power in empirical contexts, but also how different forms of power interact with situated agency. In one locality both sovereign and governmental forms of power were rejected by local actors who were instead guided by local meanings including a local culture of pride and autonomy. In another locality the local actors responded with a strategic reframing aligned with national objectives in order to garner external resources. The combined picture is one of governing practices that are contingent, variegated and sedimented.

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