22 PLANNING IN THE FACE OF POLITICS: RESHAPING CHILDREN'S HEALTH SERVICES IN INNER LONDON

Mike Cushman[1] and Jonathan Rosenhead[2]

[1] Department of Information Systems
London School of Economics and Political Science
London WC2A 2AE, United Kingdom

[2] Department of Operational Research
London School of Economics and Political Science
London WC2A 2AE, United Kingdom

SUMMARY

There was a broad measure of convergence among health care professionals in a central London Health Authority that changes in patterns of care delivery and specialist staffing required a reduction in the number of inpatient units, a substitution of ambulatory care units, and an extension of community care provision. Strategic Choice was used in a series of workshops with intervening analysis to convert this 'in principle' agreement into a specific proposal that achieved consensus among stakeholders. This process is analysed in terms of the opportunities provided by sequential workshops and the difficulties presented by inter-organizational working and absent stakeholders.

KEY WORDS

22.1 INTRODUCTION

This chapter describes an engagement in which the Strategic Choice Approach was used with multiple stakeholders to redesign children's health care provision for an inner city area covering two boroughs with a total population of some 375,000 people. Section 22.2 describes the genesis of the work, and the relevant context. In Section 22.3 the intervention itself is described. Section 22.4 covers the process of reporting outputs to the work's sponsors, and a summary of feedback received from key actors one year later. A concluding section considers some lessons that can be learnt from the experience.

22.2 BACKGROUND

Planning children's health services for an area with a substantial population has some features in common with other medical specialties, and others that are distinct. Common features, in the UK, include:

- the necessary participation of a number of service providers, as well as an agency charged with representing the health needs of the population – at the time of the study on which this chapter is based, the relevant Health Authority;

- a degree of interaction of the services under consideration with other specialties, with primary care provision and also with teaching arrangements;

- uncertainties as to current utilisation patterns, future tendencies, decisions in related areas and political priorities;

- the involvement of the public in the ratification of any proposals.

The principal distinctive feature of planning for children's health care provision is that the specialty is based not on the health condition of its patients, but on their age. There are evident reasons for this, including the need for segregated treatment environments for such vulnerable and impressionable patients. However, it does mean that children's health care has to deal with patients who, if they were adults, would fall within a wide range of different specialties. Among the resulting complications are the provision of Children's Accident and Emergency facilities, and the need to ensure continuity of care from children's through to adult services for those with life-long conditions (perhaps taking in along the way treatment in an adolescent unit).

22.2.1 The nature of the problem

This chapter reports and comments on a study to effect a significant re-orientation of children's health services in the inner London district of Camden and Islington. However, the conditions that provoked the review are by no means limited to those geographic boundaries.

Both patterns of childhood illness and clinical practice have been changing, resulting in a striking and sustained move away from hospitalisation. For example, over the last 20-30 years there has been a marked reduction in acute illnesses such as serious infections that used to be a common reason for admission to hospital. Improvements in practice and new treatments and technologies mean that many conditions can now be treated on a day-case basis [1]. Avoiding the trauma of inpatient stays is an undoubted benefit for the children concerned and their families – and now fewer children are being admitted, and for shorter stays. Furthermore, more children with chronic illnesses are surviving, and they and their families need to be supported at home, necessitating more services in the community.

The downside of all these advances is that historically located services need re-orientation to meet the new situation. There has been an increase in the need for day-case, outpatient, community-based and home care services. And there has been a reduction in use of hospital beds. In Camden and Islington it was policy that ill children should whenever safely possible be treated at home, in familiar surroundings and close to family and friends [1].

There were other related pressures on the Health Authority to reduce the concentration of resources in hospital-based pediatric services. Guidance from professional bodies, and the corresponding quality standards, are based on there being a 'critical mass' at any children's unit, in terms of both quantity and mix of clinical cases. The three secondary inpatient units in Camden and Islington were each well below an appropriate level. These caseloads were regarded by local pediatricians as inadequate to provide a satisfactory clinical experience to all trainees. The available child inpatient cases were being spread over too many units. Furthermore, the number of local pediatric training posts was due to be reduced in line with national medical manpower plans. Each of the three units was expected to lose one specialist registrar per year for three years. This put in question the ability of the existing units to cover adequately the full spectrum of children's conditions. To compound these difficulties, the reduction in hours worked by junior doctors had cut the amount of service provided by doctors in training.

It was against this background that the Camden and Islington Health Authority (C&IHA) encouraged the Director of Public Health to use her

1999 Annual Report [1] to initiate a process, involving the main providers of children's health services, to secure as much agreement as possible on how these difficulties should be addressed. By September 2000 this process, building on discussions over a period of years, had produced a strong consensus among those most involved that a reduction in the number of secondary inpatient units was both desirable and necessary.

A discussion document was drafted by a broad-based Children's Strategy Working Group, and published under the imprint of 12 local health care agencies [2]; a summary leaflet was then circulated widely as part of a three-month discussion process. A wide range of stakeholder groups were involved in different ways. Presentations were made to Trust and Primary Care Group Boards and to local government sub-committees. A conference was called for relevant voluntary organizations and a series of workshops was held with health care professionals (in children's emergency services, pediatric surgery, tertiary pediatrics, neonatal intensive care and maternity, primary care and community pediatrics, and workforce education and training) Each of these looked at the strengths and weaknesses of current arrangements, and considered how the service might provide a better fit for the future.

The discussion document stated that "we believe that there should be only one secondary pediatric and surgical inpatient unit" [2]. However, this was an input to the discussion process rather than a committed position. What was certainly not agreed was where closures would fall, the specification of the non-inpatient services which would complement the remaining unit(s), and where these services would be located. Indeed the entire September to November discussion process was conducted 'in the abstract', not linking any element of the possible new service to any particular real location. It is probable that without this self-denying ordinance, constructive discussion of principles would have proved impossible.

It was in the resolution of these issues, and their ramifications for other parts of the local health service, that the authors were invited to be involved. It was realised by all those involved that agreement in principle to closures was one thing, and agreement in practice was quite another. Building on the outputs of the discussion period there would need to be "a process of synthesis, consolidation, analysis and negotiation … to draw together the various strands towards producing a set of concrete options for change and criteria for discriminating between them" [3]. A consensual outcome where major institutional interests were involved was likely to be hard to reach, yet without agreement among the institutions a suspicious public would be still more likely to react vigorously to any talk of closures and to exercise an effective veto.

This touches on a key aspect of the decision process. Health services issues around the world tend to be politically sensitive (see, for example, [4]). This is perhaps particularly true of Britain, where the National Health Service as an institution is highly regarded by the public. The legacy of bed and hospital closures by the Thatcher and successor administrations in the 1980s and 1990s had led to considerable popular mobilisation. There was a widespread presumption that proposals for closures were cost-driven, and possibly a preparation for privatisation.

### 22.2.2 *Organizing the problem structuring workshop process*

It was evident to the Director of Public Health and her team that the situation with which they were grappling was characterised by high levels of complexity and uncertainty, compounded by the need for the involvement, participation and commitment of multiple stakeholders. Her enquiries as to methods which could be effective in helping in such situations led her to consult with the authors about the possible use of problem structuring methods.

Initial meetings and documentation led us to propose the Strategic Choice Approach (SCA) [5] as, in principle, the most appropriate method to employ, though we wished to retain the freedom to adopt other methods depending on the evolution of the engagement. In particular, if the question of sequential implementation of service configurations were to be reached (which would be well down the road) then robustness analysis [6] was thought likely to be a valuable complement. (In fact, this option did not materialise.) A very rough scoping of the exercise led to a proposal for three whole-day workshops at monthly intervals. In the event this time-scale proved appropriate.

SCA is a participative method for working with groups facing a joint problem situation characterised by complexity and uncertainty which requires strategic thinking. Either complexity or uncertainty can undermine the clarity of thought and understanding necessary for confidence in decision-making. Together they can be a lethal combination. SCA offers a format and a procedural framework for eliciting information from the group and its members, and then iteratively growing a picture of the interacting issues by further elicitation and structuring. This shared representation, and the tools used to develop it and to explore its implications, enables the group to establish what commitments can and should be made, and in what areas additional information is needed to better inform decisions. (For an accessible introduction to SCA, see [7].)

The SCA process rests on four modes of decision making, as shown in Figure 22.1. Though an engagement using SCA will generally start with *shaping* and conclude with *choosing*, there is no necessarily linear path through the modes. Understanding gained, or obstacles encountered, may indicate the advantage of returning to an earlier stage of analysis for reformulation. In each mode there are tools to assist in the elicitation and structuring of information. These tools are low-tech and capable of being understood intuitively by lay participants.

Figure 22.1 The Strategic Choice Approach
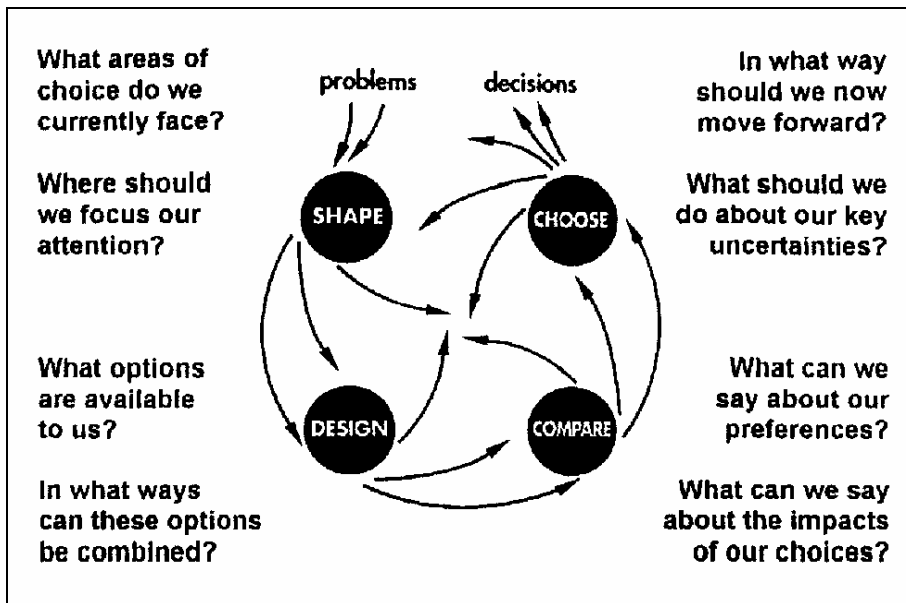
The key concept in SCA is the 'decision area', and in *shaping* mode the group identifies the set of interconnecting decision areas that constitutes their problem, and prioritises a manageable number of them as a 'problem focus'. In a *designing* phase, the options for choice in each decision area in the problem focus are identified, and incompatible combinations are weeded out to establish a list of feasible 'decision schemes', each of which consists of one option from each decision area. In *comparing*, decision schemes are rated against each other on a range of criteria generated by the group. This may eliminate some schemes, or even identify one which is clearly preferred. More commonly it highlights what uncertainties obstruct commitment to any scheme in its entirety. In *choosing* mode this information is consolidated into a 'progress package' consisting of agreed commitments, explorations to reduce key uncertainties, and contingency plans.

There were various aspects of the problem of re-designing Camden and Islington's children's health services that seemed to make Strategic Choice a good choice. There were evidently a considerable number of inter-linked decision areas, each with alternative options – for example, numbers of units of different kinds, and locations of those units. And there were numerous and varied uncertainties.

Maternity provides a double example of the inherent uncertainties. There was a link between maternity and pediatric provision, through the practice of providing shared staff rotas between neonatal intensive care units and pediatrics in smaller units. But it was unclear whether this was a firm constraint. Furthermore, there was an ongoing review of neonatal services provision across London. As the maternity review was being conducted by a different sponsor, C&IHA could not require that it be postponed and was unwilling to delay the pediatric review for an unspecified period to allow the maternity review to be completed. In any case our problem was more than complicated enough, and to merge it with another one of comparable intricacy would render it still more intractable.

Another factor speaking in favour of SCA was the political sensitivity of the issues under consideration. Unusually among analytic methods, SCA can incorporate political factors, or the unpredictable reception of proposals in the wider world, by representing them as uncertainties. It has already been mentioned that health service changes or shortcomings, and closure proposals in particular, are capable of generating quite intense political disturbances. Both the population affected and their political representatives take these matters very seriously. The high-profile organizational participants and central London location of this study guaranteed that it would not be the exception to this particular rule. Indeed there were aggravating factors. A long-serving Camden Member of Parliament had only recently ended a well-regarded tenure as Secretary of State for Health; and the Hampstead and Highgate Express, covering much of Camden, was regularly garlanded as among the highest quality local papers in the country. It was an effective campaigner, and had a strong readership among the concentration of national movers, shakers and opinion formers living locally. Therefore the capacity of SCA to accommodate the political dimension of the issues under discussion was a valuable bonus.

It was agreed that SCA should be the method for use at the workshops. Membership of the 'core group' to take part in these workshops was given a great deal of detailed consideration. The participants needed, between them, to represent both the main stakeholder institutions, and the principal relevant professional and disciplinary groupings. As consultants, we explained the importance of keeping the group size small to facilitate constructive

conversation, and argued for ten members as the upper limit. However, our C&IHA collaborators came to the conclusion that a feasible design could not be achieved within that constraint, and we accommodated ourselves to a group size of 12. Ten were members of the Children's Strategy Working Group and so were broadly familiar with the issues that would need to be addressed, and in addition there were representatives of the two local Community Health Councils who had been closely monitoring the process on behalf of users.

To make this account of the workshop process understandable, it is necessary to sketch in the roles of the key institutional players in relation to children's health services in Camden and Islington. We should start with C&IHA itself, as the Health Authority has a particular role in the UK health service which is not precisely replicated elsewhere.

At the time of this work, any Health Authority was responsible for ensuring that the health needs of the population in its area were met, and it received from central government the bulk of the funds made available for this purpose. (Changes in these arrangements have occurred since the project was carried out.) However, the actual delivery of health services was and is provided by a number of autonomous health care trusts, comprising a variety of types of hospitals and hospital groupings, as well as trusts dedicated to the provision of community-based or specialised services. The bulk of patients are treated by trusts in or geographically close to the Health Authority area in which they live.

C&IHA's area consisted of the two inner London local government boroughs of Camden and Islington with a total population of about 375,000 people, of which some 65,000 are under 16 (a lower proportion than the inner London or UK average). The maximum East-West distance is about 10 km, and the North-South span is around 6 km (see Figure 22.2).

Both boroughs, but in particular Islington, are characterised by areas of intense deprivation and large public housing estates. The population is both ethnically and linguistically highly diverse. Both boroughs, but in particular Camden, have very affluent districts. This mixture of rich and poor is characteristic of many London boroughs.

The institutions represented at the workshops, in addition to C&IHA itself, were:

Camden and Islington Community Health Services NHS Trust The trust covers the same area as the Health Authority and was responsible for all community-based services including health visitors, children's health clinics,

Figure 22.2 Map of Camden and Islington showing locations of main hospitals

district nurses, midwives and domiciliary care. It has major responsibilities for preventative medicine as well as for medical care.

Great Ormond Street Hospital Great Ormond Street is regarded as the preeminent children's hospital in the UK, with an international reputation for both care and research. Located near the southern tip of Camden, it currently took only tertiary patients. However, it was expressing interest in developing a secondary inpatient pediatric service, which would require the acquisition of additional premises. Great Ormond Street is relatively close to University College Hospital, with whom it has been developing cooperative arrangements.

University College London Hospitals (UCLH) UCLH was formed from the merger of two major teaching hospitals, University College and Middlesex. Their services (and those of a number of other units) were shortly to be brought together in a major new hospital building currently under construction through a public finance initiative (PFI) arrangement. UCLH is certainly one of the most prestigious and powerful teaching and research hospitals in the country with an international reputation. It is well located for a range of public transport services.

Royal Free Hospital   The Royal Free is another distinguished London teaching hospital, located rather to the north of the borough of Camden. It is linked to UCLH through a joint medical school. Far more than UCLH it draws patients not only from Camden and Islington, but also from Barnet, Enfield and Haringey, the Health Authority (just being merged out of two predecessor authorities) immediately to the north of Camden and Islington.

Whittington Hospital   The Whittington is a large hospital located at the northern edge of Islington. It functions broadly as a district general hospital, and services an area spanning across the boundary into Barnet, Enfield and Haringey with a high population and population density.

Moorfields Eye Hospital   The country's leading specialist eye hospital, Moorfields provides a mix of secondary and tertiary care. It was directly, if somewhat tangentially, involved in the redesign of pediatric services through its inpatient provision for children.

Community Health Councils   Community Health Councils (CHCs) were bodies charged with representing the interests of the public in their areas. (They have since been abolished by the national government.) Both Camden and Islington CHCs were represented at the workshops by their Chief Officers and/or Chairs.

Primary Care Groups were represented by a long established and well-respected local general practitioner (GP) who also voiced the viewpoint of GPs.

At the Workshops, senior representatives of these groups were confronted with a problem which could be summarised as:

- Which of Great Ormond Street, Royal Free, UCLH and Whittington should have secondary inpatient units?

- How many non-inpatient 'ambulatory care centers' should complement these, and where should they be located?

- How and to what extent should community services be strengthened?

22.3 THE WORKSHOP PROCESS

Our preparation for the workshop had not only consisted of discussion with the Director of Public Health and her team. One of us attended a meeting of the Children's Strategy Working Group which occurred between the commissioning and the start of our project; and we both read the distributed discussion document, reports from consultation meetings and relevant

background materials. From these we distilled what seemed to us to be some principal areas of choice in the situation, and pre-prepared a set of a dozen or so ovals (large oval 'Post-it' notes with particularly convenient adhesive properties) each conveying concisely one of these candidate *decision areas*.

22.3.1 Workshop 1, January

These ovals formed the starting point of the first all-day Workshop, held in January 2001 at a well-appointed location away from any of the participants' places of work. They were displayed on an end wall papered with A1 flip charts. An initial discussion confirmed that these were broadly the issues that mattered, though the group made some alterations to the way they were formulated. This discussion also demonstrated the interconnection of the issues; only a very few of them could be set aside as separable or secondary. When one decision area was raised, other factors were at once identified as needing to be taken into consideration with it, and these led on to others in a similar fashion. It seemed both that no decision could be taken in isolation, but that the ensemble of decisions was too complex to be comprehended simultaneously.

This experience, demonstrating in effect the need for some analytic assistance, provided a persuasive motivation for the use of Strategic Choice. The first pass through the approach addressed the remaining decision areas, and the group was asked to agree preferably no more than three of them as an initial, priority, *problem focus*. The remaining ovals were 'parked' to one side, and discussion was centered on:

- the location of the first inpatient unit;

- location of the second such unit (if any);

- whether neonatal intensive care units must always be co-located with inpatient pediatrics.

This last question was a technical one, based on the argued need to share staff rotas for the two activities to provide sufficient coverage 24 hours per day, seven days per week. It had provoked lively debate in the initial discussion, but of course had not then been resolved as the argument cascaded on. The provisional reduction in complexity provided by the problem focus allowed the matter to be resolved decisively. An *option graph* was developed of the problem focus, looking at the options available within each of the three decision areas, and identifying which combinations were infeasible (see Figure 22.3). It was then realised that to say 'yes' to the proposition would in fact rule out one of the strong organizational

contenders to house an inpatient unit. When it was clear that no one in the group was willing to do this, it became evident that the answer was 'no': co-location was certainly desirable, but not an absolute requirement. This problem focus was taken no further – it had served its purpose by resolving a troublesome issue, thereby simplifying the remaining problems. In fact the achievement was startling – the perceived link between pediatric and maternity beds had always been seen as a complication that made the problem almost insoluble.

Figure 22.3 Option Graph showing the infeasibilities between the requirement for collocation with neonatal intensive care, and the locations of the proposed pediatric inpatient unit, and the second unit (if any)
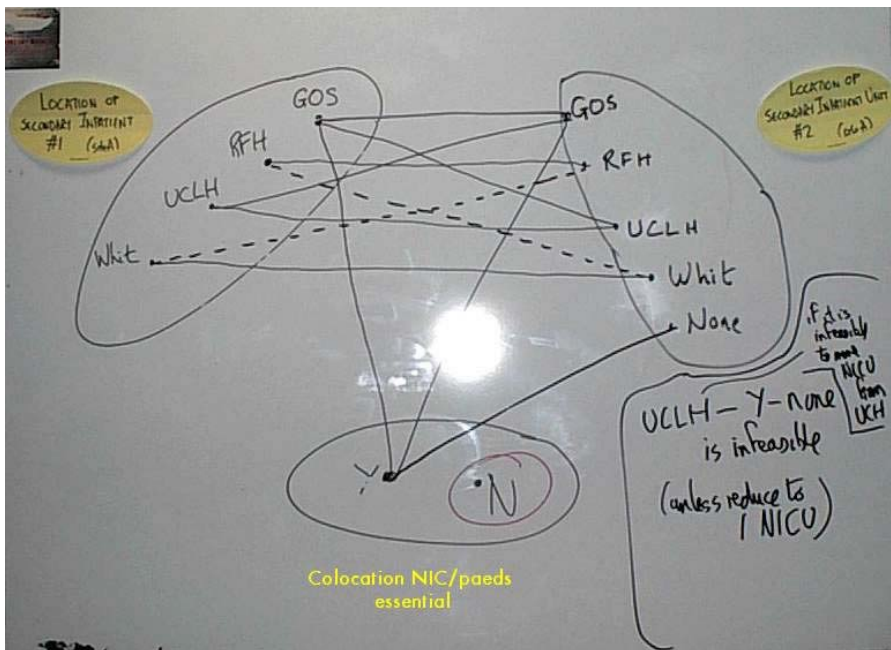
The process by which this advance was made was typical of the Strategic Choice approach. At any time one of the facilitators was actively engaged with the group, sometimes asking for clarification to avoid miscommunication, sometimes steering the discussion in what seemed likely to be productive directions, and sometimes operating the technical aspects of SCA with ovals and marker pens. The second facilitator would at times be capturing the evolving structure on the STRAD software [8] but more often observing the discussion from a slightly less engaged perspective. (Full details of the STRAD software can be found at the website

http://www.btinternet.com/~stradspan/.) This is a valuable backup, as the lead facilitator, in the thick of things, can easily fail to notice aspects of group dynamics or problem content. And of course the roles of the two facilitators were exchanged periodically. (See [9] on the role of the facilitator.)

During any stage of the discussion, aspects of the problem situation surfaced that were clearly relevant but not to the topic immediately under discussion. These were captured (on ovals) for possible later reference. Of particular interest were *uncertainties*, areas of missing information or disagreement whose resolution might remove obstacles to progress. Other aspects were collected together under the heading of *comparison areas*, in effect criteria which could prove relevant to the choice between alternatives.

In this first workshop, attempts were made to achieve further reduction of the disabling complexity of the problem. For example, it became clear that members of the group were using the phrase 'Ambulatory Care Center' without a shared understanding of what it would consist of. Would it conduct minor surgery and use anaesthetics? Allow self-referral? Deal with minor injuries? Admit children to general Accident and Emergency? Operate 24 hours per day? These design issues were resolved.

Two initial attempts were made to employ the *comparing* mode of Strategic Choice. In the first, on the assumption that there would only be a single inpatient unit, the relative advantages and disadvantages of two possible locations for it were explored. In the second, the relative merits of having one versus two inpatient units (locations undefined) were examined in a similar way. No clear conclusion was reached; and indeed the exercises pointed up the difficulty of agreeing on just one element of the eventual package while leaving others un-specified. What these exercises did do was to flush out ideas on relevant criteria for future use, and to serve as a rehearsal for later uses of the comparing mode.

At the end of this first workshop the accumulated uncertainties were reviewed, and for each of those thought to be of significance a group member agreed to come back with some additional information. Their initials were written on the corresponding ovals, as evidence of their commitment. It was agreed that the second workshop would focus on the relationship between the number (not locations) of inpatient units and Ambulatory Care Centers and the level of community provision; and on how these link to tertiary, adolescent and maternity services.

22.3.2 Workshop 2, February

Before proceeding to new work, the members of the group were asked to review the conclusions reached at the previous workshop and whether they were happy to proceed on the basis of the progress made there. It was important that the group did not feel 'railroaded' but accepted the logic of where the argument had got to. (A similar procedure was followed at the start of Workshop 3 also.)

Two issues that had slowed down progress at the workshop were the relationship of decisions that might be made about the location of secondary inpatient pediatric units to the care arrangements for tertiary pediatric inpatients, and for inpatient secondary and tertiary inpatient adolescents. Some graphical representations of alternative allocations of the resulting four patient categories between Great Ormond Street (the existing tertiary center) and an unspecified secondary pediatric inpatient unit had been pre-prepared by the consultants (see Figure 22.4). These appeared to generate a more focussed discussion, and the group rather swiftly agreed to a modification of one of the schemes illustrated, in which a significant role for adolescent tertiary services would go wherever the adult expertise was located. (Members of the group amended the drawings themselves, always an indication that a representation has proved useful.) The result was that these

Figure 22.4 Options for adolescent and tertiary care patterns of provision if pediatric and adolescent services or secondary and tertiary care were to be co-located
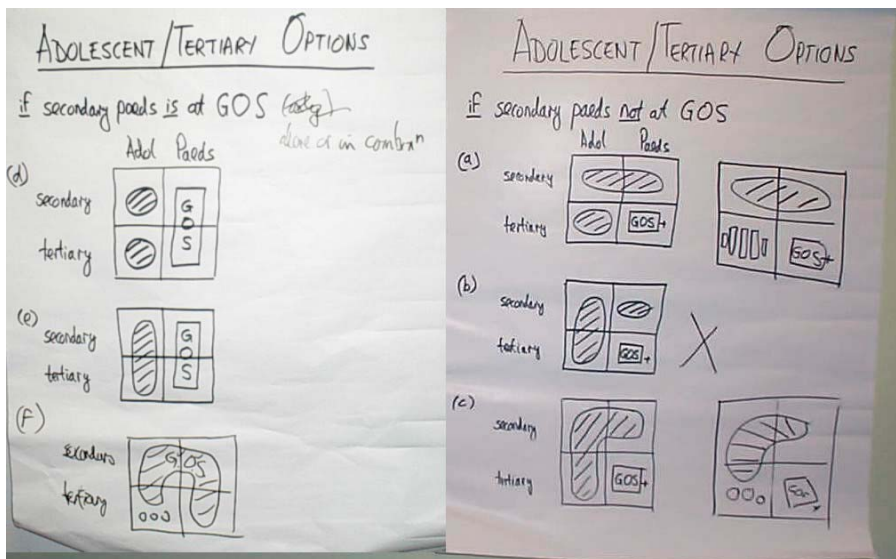
issues lost their ability to entangle the subsequent discussion in unresolved questions.

Other inter-related work that had been commissioned by Workshop 1 was to investigate the 'critical mass' of annual inpatient admissions needed for an inpatient unit, in particular to provide an adequate range of cases for the training of junior doctors; and to clarify existing and predicted activity levels. Discussion of the reported results was not conclusive, but tended to support a single inpatient unit solution.

As agreed previously, the group took as their initial problem focus

• the number of inpatient units

• the number of Ambulatory Care Centers

• the level of increase in community services.

Ovals were used to locate other inter-linked decisions around the boundary of this problem focus, as a guarantor that the impact of any decisions within the focus on these other issues would subsequently be subject to scrutiny (see Figure 22.5). A tabled paper, commissioned by the previous workshop, had specified the days and hours of opening, and consequently the types of patient which could be handled, corresponding to each level of community service investment.

An *option graph* showing the options in each of these three decision areas, and the relationships between them was developed through group discussion, and is shown in Figure 22.6**.**

Either one or two inpatient units were considered, as well as up to three ambulatory centers, and an increase in community and primary care services that might range from zero to large. The lines drawn in Figure 22.6 are *option bars*, indicating incompatible options. Each of these bars resulted from discussion in the group – e.g., about the level of particular scarce resources needed to maintain that combination of options. This discussion also led to the exclusion of particular options on policy or practicality grounds. Then, by the process called the Analysis of Inter-connected Decision Areas (AIDA), the feasible combinations of options, one from each decision area, were worked out (see Figure 22.7).

There were rather few feasible combinations of options remaining. Discussion of these led the group to a further 'policy' conclusion, that no scheme with only a single 24-hour access point could be contemplated. This meant that any combination involving only a single inpatient unit required a

Figure 22.5 Decision focus for Workshop 2*
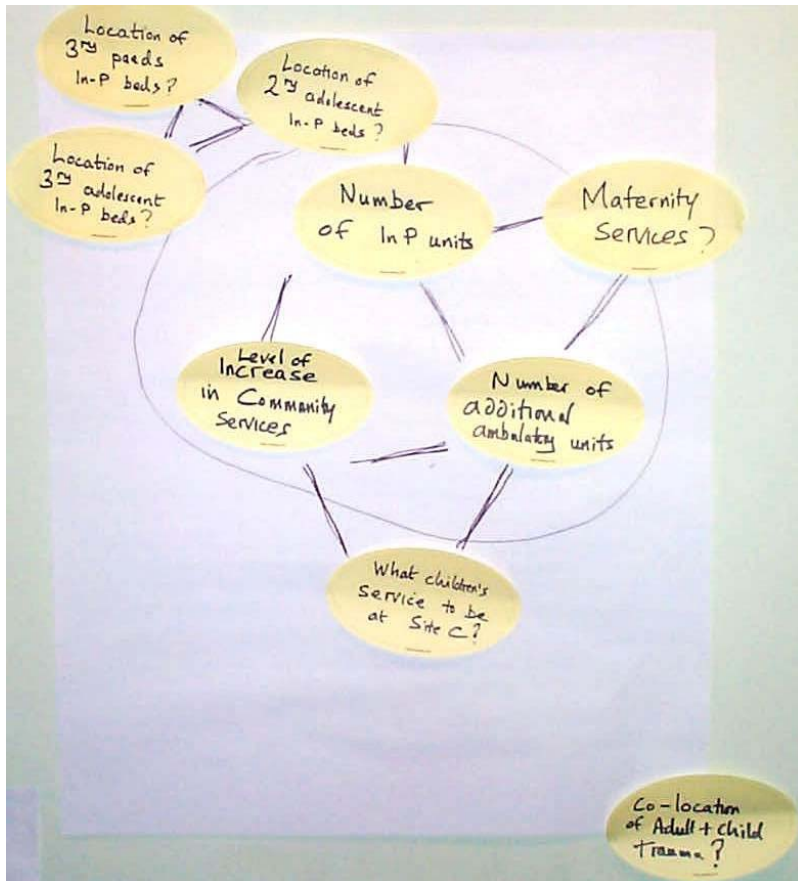
* Text of "Post-Its": Location of 3^{ry} pediatric in-patient beds; Location of 3^{ry} adolescent in-patient beds; Location of 2^{ry} adolescent in-patient beds; Number of in-patient units; Maternity services?; Level of increase in community services; Number of additional ambulatory units; What children's services to be at Site C; Co-location of adult and child trauma

'large' increase in community and primary care services (since a 'medium' investment corresponded to seven-day, 8 a.m. to 8 p.m. working, and ambulatory centers had been defined as having approximately 12 hour daily opening times). The remaining schemes, marked B, D, E and F in Figure 22.7, had either one inpatient unit and a large increase in community provision, or two inpatient units and a medium increase in community provision. In the former case there could be either one ambulatory care center or two, while in the latter there could be at most one ambulatory care center.

Figure 22.6 Workshop 2 option graph showing options for number of inpatient units, ambulatory units and increase in provision of community and primary care, and their infeasibilities.
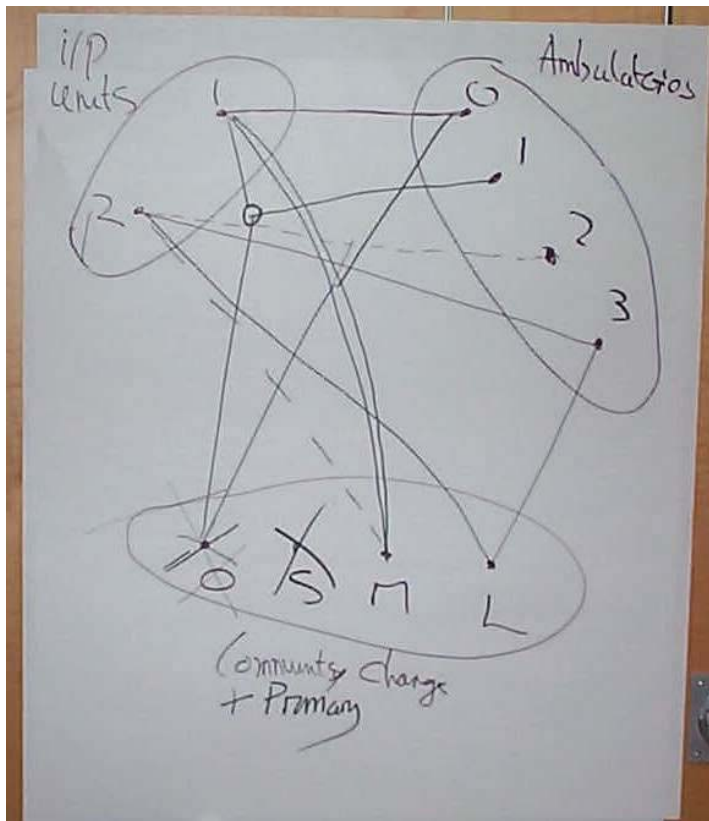
The group was now ready to compare two distinctively different schemes:

- 1 inpatient unit, 2 ambulatory care centers, large community increase. vs.

versus

- 2 inpatient units, 1 ambulatory care center, medium community increase.

These were placed on a standard *comparative advantage* chart, on which the criteria identified at the last workshop were added in agreed order of priority. This chart is shown in Figure 22.8**.** After discussion of each criterion, group members each marked their estimates of the balance of advantage between the schemes with adhesive stickers. This array was then, in further discussion, consolidated into a range of possibilities and a central point. This assembled information was assessed in a final group discussion, in which the

Figure 22.7 Workshop 2 option tree showing feasible decision schemes defined by numbers of inpatient units and ambulatory units and increase in provision of community and primary care
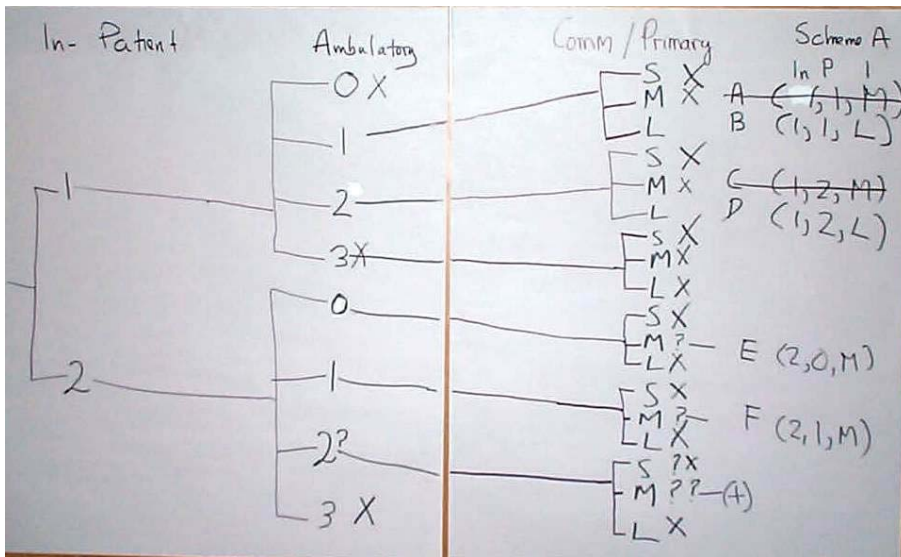

prevailing view was that there was a clear comparative advantage in favour of the single inpatient unit scheme and a large increase in community services.

22.3.3 Workshop 3, March

Once again research carried out by the Health Authority in response to uncertainties surfaced at the last workshop was presented. But first the group was asked to confirm whether the decision at the last workshop was for the (1, 2, L) scheme. This generated a lengthy discussion, not all of it directly germane to the decision at hand. Matters debated included the possible sequencing of changes, the needs of different types of patient, connections to other parts of the health service, and the likely public reaction. During this discussion it was agreed to rename Ambulatory Care Centers as 'Specialist Children's Centers' (SpeCCs) to provide a more appropriate and acceptable image. Halfway through the morning, the group was ready to confirm a decision in favour of a single inpatient unit.

After the break, discussion was joined on the question of how many SpeCCs should accompany the unit – i.e., should it be scheme B or scheme D in Figure 22.7? A simplified version of the comparative advantage chart was used (Figure 22.9) in which the criteria that favoured scheme B, those that favoured scheme D, and those that were neutral between them were

Figure 22.8 Comparative advantage chart*
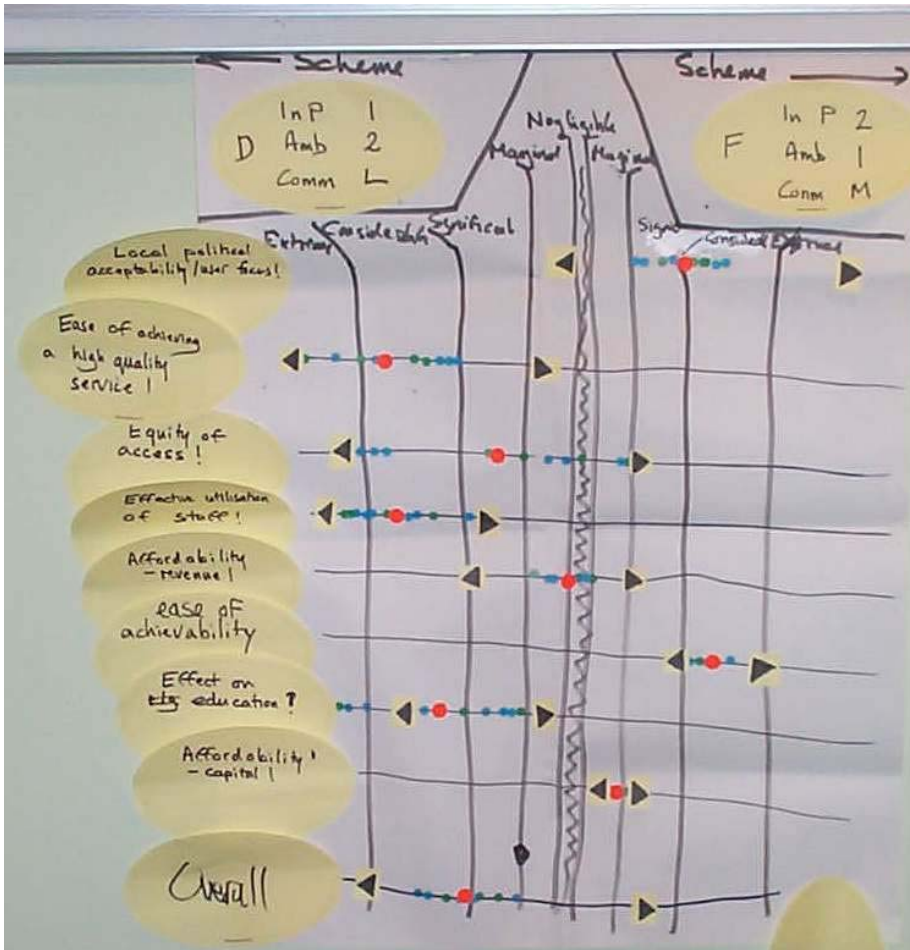
* Comparison of scheme D (1 inpatient unit, 2 ambulatory units, and large increase in community provision) and scheme F (2 inpatient units, 2 ambulatory unit, and moderate increase in community provision). Is advantage negligible, marginal, significant, considerable or extreme? Text of "Post-Its" for comparison areas: Local political acceptability/user focus; Ease of achieving a high quality service; Equity of access; Effective utilization of staff; Affordability – revenue; Ease of achievability; Effect on education; Affordability – capital; Overall [advantage]

identified. The criteria used for this comparison were generated by the group, and were not those used in the previous workshop, as the issue under consideration was different. The weight of factors in favour of a single SpeCC was fairly rapidly persuasive for the whole group.

Figure 22.9 Comparing number of SpeCCs*

* Text of Text of "Post-Its": [Scheme considered] 1 inpatient unit; 1 SpeCC (Specialist Children's Center); 24/7 community provision.
For: Public understanding; Enables 12 hour opening; Viability; Effective use of staff; Administrative ease; Quality of service; Effective use of resources; Comprehensive provision; Radically different ∴ change culture; Staff training p/g [post-graduate].
Neutral: Staff training u/g [under-graduate]; Professions allied [to medicine] diluting experience.
**Against:** Access; Political acceptability; Staff conservatism; Effect on tertiary at other site

Having come down in favour of one inpatient unit and one SpeCC, the remaining question, and the most politically charged, was their location.

Once again an option graph was used to identify the option bars and hence the locational schemes that remained feasible (Figure 22.10). The option bars broadly indicated the impossibility or undesirability of co-location of the units, or of geographical concentration within the Health Authority area. Extensive further discussion followed on availability of space on particular sites, public transport accessibility, political acceptability, ease of implementation and effect on existing services. All these issues and others were captured on ovals. In the process, the schemes under consideration were whittled down from eight to four.

Figure 22.10 Location options for scheme composed of 1 inpatient unit, 1 SpeCC (Specialist Children's Center), and 24/7 community provision
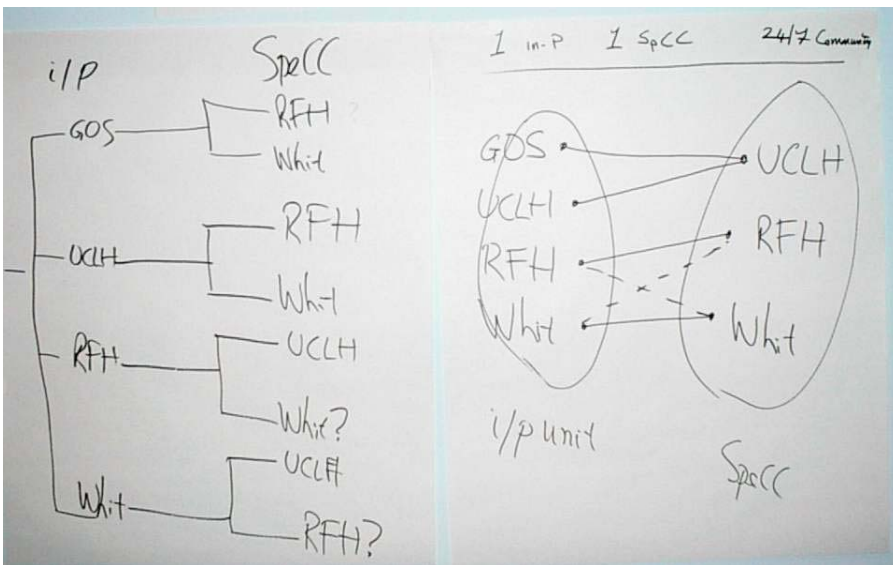
At about this point an unexpected uncertainty surfaced. It became clear in the discussion of some of these criteria that not all group members had secure mental images of the geography of the boroughs and the locations of all of the facilities under discussion. A London street map was hurriedly obtained and roughly transcribed to flip-chart size. It was clear from the reactions that several minds were made up, or at least provisional decisions confirmed, by the provision of this simple graphical aid!

It was agreed that the final assessment should be made by confidential ballot. Each group member was given five adhesive stickers, which they could allocate freely between the alternatives. There was no comparative advantage chart, but the criteria of the previous discussion were displayed

for consultation. The result was clear-cut. The same location for the SpeCC received all but two of the 60 'votes'. One location for the inpatient unit received two and a half times as many choices as its nearest competitor. These two locations in combination received 50% more than all other combinations combined. These results were regarded as decisive by all the participants, who accepted it as legitimate, and as the concrete crystallisation of the logic that they had been elaborating and clarifying over the entire workshop process.

It had been a long journey from the state of disabling complexity and uncertainty which the group had experienced at the first of these workshops. The process and its outputs had the assent of the whole group, including representatives of those institutions that would lose services. The workshop concluded with a discussion of procedures for resolving the various issues 'parked' along the way; and on how to take the recommendations forward through the various stages and decision-making required before they could be implemented.

22.4 IMPACT OF THE STUDY

22.4.1 Reporting the outcomes

For legitimacy and implementation to be achieved, the results of the workshops had to be fed back to the Children's Strategy Working Group and also communicated to key individuals and stakeholders. These two strands were progressed through a mixture of formal and informal processes.

The final workshop had been held on a Friday. It was recognised in the final discussion that group members would be under immense pressure to reveal the workshop outcomes as soon as they returned to work. Attempting to keep the recommendations confidential for the time being was simply not an option. This meant that a careful dissemination strategy was crucial if the workshop gains were not be lost through hostile media coverage and instant political opposition. Already between the second and third workshops, and before the most sensitive decisions on unit locations had been reached, some information had leaked and articles had appeared in the local papers headlined "Royal Free fights to save children's casualty services", "Who will care for our children" and "Hospital plan must not make children suffer".

The Health Authority representatives were instructed to ensure that their Chief Executive and those of the hospital trusts were informed of the workshop outcomes before the end of the weekend. The Health Authority Chief Executive in fact succeeded in briefing all the local Members of

Parliament (MPs), the Minister responsible and the Regional Health Authority by the following Monday.

Presenting the outcomes as a set of recommendations on service organization and not just on the location of inpatient services was identified as important if the proposals were not just to be seen as service closures. Over an extended period there had been a series of hotly contested plans to close hospitals (and accident and emergency units) in London. Some of these could be justified as a re-alignment to take account of population shifts out of Central London; or alternatively to allow concentration into large units that could support increasingly specialised and technologised services. However, popular perception was that such closures were driven by a Government agenda to cut health service costs rather than improve provision. There was thus a raw nerve to be touched.

The way in which the proposals would be seen by the multiple stakeholders not represented in the workshops was therefore a major area of concern. While this would have been true anywhere, the location of Camden and Islington in the center of London and the proximity to the offices of the national media made it even more pressing, as did the presence of the homes of many national journalists in the two boroughs. As one of the local MPs had just ceased being the Secretary of State for Health, another was a current Cabinet Minister and a third was an influential junior minister, the sense of political pressure was even more acute. The workshops were being held in the run-up to the 2001 General Election, expected to be held on May 3. Any publicly aired proposals to close units were likely to become incorporated in election campaigning and would thus potentially receive much publicity but little dispassionate consideration.

The second main strand of the process of feeding the workshop results into the policy process was a report to the Children's Strategy Working Group. This was the group from which the workshop participants were drawn, and whose endorsement of the results of the workshops was required. (Formally the workshops' recommendations were advice to the Strategy Group.) There had already been an interim report back between the second and third workshops. At this meeting, few members of the workshop group, apart from the Health Authority members, were present. Having put time aside for the workshops, most members had not prioritised attending this meeting as well. The consequence was that the feelings of exclusion felt by people who would have liked to be part of the workshops, but were not, expressed themselves as mistrust of the report of the facilitators and of the process they described. This mistrust was difficult to counter in the absence of participants who could describe their experience of that process.

Consequently, the Health Authority staff and the facilitators prepared more carefully for the final report-back meeting, six weeks after the third workshop. In order to convince the Strategy Group of the robustness both of the recommendations and of the process by which they were reached, effort was put into ensuring that several members of the workshop group attended. Special attention was paid to ensuring that members who were not representatives of the principal hospitals were present as it was felt that, as more disinterested parties, their voices would carry more weight. While there were some reservations, particularly from the representatives of the neighbouring health authorities who were concerned that the needs of their residents may not have been considered sufficiently, the workshop outcomes were well received overall and endorsed.

22.4.2 What happened next

At the beginning of April 2001, the government decided to postpone the general election by one month because a major foot-and-mouth disease outbreak made campaigning in many rural areas impractical. One result of this delay was a potential gap in policy announcements by Government ministers; the planned succession of announcements of initiatives, necessary to maintain campaigning momentum was disrupted. The announcement on April 23 by Alan Milburn, the Secretary of State for Health, of a restructuring of the management of the Health Service [10] can in this light be seen as a political initiative to fill a news gap. His proposal to abolish health authorities was totally unexpected and came abruptly in the middle of an already existing process of setting up Primary Care Trusts and transferring budgetary, but not planning responsibilities, from the Health Authorities to the Trusts. The eventuality of such a change had not figured in the uncertainties considered during the workshops, nor could it have done, as even well informed observers had no inkling of this proposal.

The consequences for the reorganization of children's health services were terminal. No Chief Executive would take the risk of becoming embroiled in a potentially controversial service change at this juncture. All the Health Authority officers who would have been responsible for carrying through the changes had to concern themselves with their immediate futures – all of their posts were to be abolished and they had to apply for posts in the new structure or elsewhere. Responsibility for planning health services in Camden and Islington passed to the new North Central London Strategic Health Authority (SHA), one of the 28 new SHAs covering the whole of England to be set up by April 2002.

The North Central London SHA consisted of Camden and Islington together with Enfield and Haringey, and Barnet, the neighbouring health authorities

that had been more sceptical of the workshop proposals. (These authorities had just been merged in April 2001.) The senior management of the new SHA proved to be drawn from these authorities and few Camden and Islington managers were appointed to senior positions in it. It could have been argued that children's services should be considered across the whole SHA area. However, in fact, the new SHAs were under much closer central scrutiny and direction than the former health authorities. Major changes in service provision were thus more politically exposed. The proposals informed a much wider discussion of children's, young people's neonatal and maternity services across the wider area.

However, there has been action as a direct result of the workshops. Community-based care has been radically reformed on the lines recommended in the workshops: opening hours have been extended and seven-day cover provided. Opening hours are likely to be extended further towards 24 hour, seven-day provision. This was achieved as a direct result of the consensus reached at the workshops, and could be implemented without either a consultation process or sanction from the Department of Health. The provision of ambulatory care has also been strengthened. At the workshops, these changes had been developed and proposed as an integral part of a comprehensive service model which included the desirable and necessary alterations in inpatient provision, rather than as stand-alone initiatives. These other changes at present remain in abeyance – though the pressures which provoked the workshops do not.

The experience of the workshops has also underpinned subsequent moves towards a Children's Services Network in Camden and Islington, and the full advice remains as an available resource when the issues of inpatient care are eventually addressed. They have a continuing status because of the process by which they were reached. As one key participant put it [3],

> "I think one of the features of the group and this piece of work was that it was a well embedded, you know, it's been well embedded in the folklore of Camden and Islington. The tradition of Camden and Islington, for many years, and individuals have been around and around this set of problems and been involved in work over a number of years. And so the people who were involved were all well able, for a fairly sort of strategic exercise, were well able to be articulate and to contribute and to think rationally."

22.5 DISCUSSION

Many lessons can potentially be learned from a rich encounter of this kind. Here we will focus on two broad areas which we think worthy of further attention.

22.5.1 Working between workshops

There is now a considerable literature on the pragmatics of engagements using problem structuring methods (PSMs). (See in particular [11].) Broadly, the literature deals with aspects of the client-consultant interaction in the context of model-based group decision support. There are also discussions dealing with method-specific issues.

The main focus of these accounts is on what happens in the workshop itself. There are of course exceptions to this rule. In her survey of the views of clients of the SODA (Strategic Options Development and Analysis) approach on the role of facilitators, Ackermann [12] explicitly includes a 'pre-workshop' phase in which the consultant establishes the framework of the intervention with the principal contact. The structure of the Strategic Choice approach [7] includes future 'explorations' within the concluding 'progress package' of explicit outputs. This automatically incorporates a perspective on future commitments to be made subsequent to the workshop, once those explorations bear fruit in the reduction of key uncertainties. Also, Mingers and Gill [13] include the possibility of the use of different methodologies not only between different phases of an engagement, but also across different engagements. Wong [14] makes a useful categorisation of the modes of work engaged in by PSM practitioners, namely:

- A workshop – in which the consultant(s) engage simultaneously with the complexity of subject matter, and with the complexity of interaction of the stakeholders about the subject matter.

- An interview – in which the consultant(s) engage with a single member of the group, most commonly to elicit information to structure or populate the model

- The backroom – in which information already elicited from participants either individually or collectively is processed by the consultant(s) alone in preparation for a subsequent interaction with stakeholders.

However, the rule nevertheless persists. These counter-examples broadly take the single one-time workshop as the norm. There is little attention paid to aspects of practice especially relevant to multi-workshop interventions, and to what happens in the gaps between those workshops. The particular

opportunities and difficulties of single engagements that incorporate a sequence of workshops are not well addressed.

It may be surprising to those who have not taken part in one, but the amount of analytically-based work that can be achieved in a single one-day workshop is quite limited. Four one and a half hour sessions must find room for mutual introductions and acclimatisation; an introduction to the method to be used; the setting of expectations; a 'scoping' period in which participants are reassured that their particular concerns will be on the table; periodical summarising of the degree of progress made; confirmation from time to time that the progress that appears to have been made does indeed have the positive assent of all participants; and a final period in which the day's events are assessed, and subsequent actions agreed upon or confirmed.

Furthermore, a successful workshop is not 'run' by the facilitator(s). For large periods s/he is silent (though attentive) and the discourse is generated between the participants. The benefit of this in terms of 'ownership' of the process and outcomes is evident. However, there is an equally evident cost in terms of the time-economy of the event – the most effective path between two points will not be a straight line.

The implication of this is that unless there has been a great deal of preparatory work (and quite possibly if there has) it will be rather unusual for a complex set of inter-related issues to have been pursued through to effective closure in a single day's work. It is of course quite possible that sufficient clarity will have been achieved that the subsequent working out of implementation consequences can be left to more conventional, and less labour-intensive, processes. In effect, after the initial stages of problem structuring, what to do will appear 'obvious' (see [15]).

In other cases, however, it may be that the first workshop will, in effect, identify a subset of the issues which the group agrees to prioritise – but without the time to tackle that agreed problem focus adequately. There will be other situations, and the case discussed here is one of them, when the implementation questions are highly political; that is, the interests of stakeholders are likely to be differentially affected by alternative solutions to the identified question. In such cases, the continued involvement of the group of stakeholders in working out the implications of a consensual problem structure is crucial to the legitimacy of any set of proposed commitments.

There are thus a number of situations in which a single engagement will incorporate a number of workshops in sequence. Some of the features that come to the fore when this is the case have to do with the conduct of the

workshops, while others concern the potentialities of the spaces between the workshops.

One feature of the first kind is the importance of achieving continuity of membership of the group. Fluidity of attendance can be consistent with continuity of representation of the stakeholders. But it is not compatible with a methodology in which later stages take as given certain assumptions and conclusions agreed at a previous meeting. The result of rotation of membership, or even of designated alternates, is a dilution of ownership of the developing problem structure. Retracing of the earlier stages with the possibility of coming to different conclusions is scarcely a practicable option, given that the majority of the group have traversed this terrain and established their own workable road-map.

Where a sequence of workshops is anticipated, therefore, the selection of committed participants is crucial. They need to be strongly advised of the expectation that they will not allow other engagements to displace their agreement to attend all the component workshops. It follows that the complete set of workshop dates needs to be established in advance. This was the procedure carried out, successfully, in the Camden and Islington study. Attendance was complete and unvarying, except in the case of one Community Health Council, and of one missed meeting by the representative of a non-central stakeholder.

The other principal requirement at all workshops except the first is to pay particular attention to the re-confirmation of the position reached at the end of the preceding workshop. There is more than one reason for doing this. The first is to re-introduce members to the conceptual world which they had been constructing and inhabiting. It will generally have been quite some time since the last meeting – to allow time for inter-workshop activities to be carried out – and memories will need re-activating. The second is that in the intervening time members of the group will have been subject to a range of influences – views of colleagues, unanticipated events – which might have caused them to revise their opinions. Finally, the strength of the conclusions from such an engagement is that of its weakest (i.e., least convinced) link. It follows that no opportunity should be lost to test out the commitment of members to the evolving problem structure. Indeed the public re-affirmation of support for that structure makes it more difficult psychologically for members later to renege from the action consequences of that structure.

It is the gaps between the workshops, however, that present the major additional opportunity for progressing the business of the engagement. The size of this opportunity will, of course, depend on the size of the gap. In one recent case, force of circumstances limited the period between two

workshops to little more than the intervening weekend [16]. In general, a longer gap provides more opportunities for inter-workshop activities, but against this must be set any urgency associated with the implementation of conclusions, and also the decay of a sense of involvement and of group identity.

One advantage simply lies in the availability of more time for the consultants to reflect on how to make the activities that they are supervising more productive for the participants. Ackermann and Eden [17], in a description of a case study using the Oval Mapping Technique, repeatedly describe activities that needed to be carried out hurriedly in the interstices of the process. Catching up on material missed or not completely captured on the software, tidying up clusters of concepts, carrying out quick analyses, setting up the elicited material in a form appropriate for presentation to the group, and (especially) reviewing progress with the principle client – all these were conducted in 15-minute coffee breaks, over the lunch period, or in time snatched after the workshop before the consultants had to leave for the airport to travel home. Having to think on one's feet under pressure is undoubtedly a very concentrating experience [18]. Having additional time between workshops does not remove this invention spawned by necessity, but adds the potential for more considered views and more extensive analysis.

In the case described in this chapter, this scope was exploited in a number of ways. Certainly interaction with the 'client' (the Director of Public Health and her team) was used extensively. Other members of the group became aware of this, and there was even some sensitivity about how this selective access might be biasing the process. As one of the participants said in a follow up interview,

> "….the process seemed to be reasonably clear and did seem to be based on fair principles. The one worry that occasionally went through me was whether [one of the Health Authority officers] had had pre-meetings with you, and whether in fact we were being led down a pre-laid path. And I don't know. But that was the only worries I ever had in that meeting, was just sometimes she, as an observer seemed to be further down the road than I was. And I wondered whether that was because she'd practised."

On reflection, an explicit advance statement about this aspect might have defused possible anxieties.

Typically there were two meetings with this client group between each workshop. At the first we would discuss the progress at the preceding

workshop, and run through the explicit activities agreed to at the workshop to ensure that they actually happened. For the facilitators, these were tasks largely concerned with workshop process. For the Health Authority, these often related to work agreed to reduce identified uncertainties. The opportunity to reduce uncertainties during the course of the workshop sequence, rather than as part of a commitment package to be pursued as a post-workshop task , strengthened the approach.

At the second meeting we would review the new information generated, and discuss detailed plans proposed by the consultants for the structure of the coming workshop. These meetings also gave the clients an opportunity to ensure that we were adequately aware of tensions beneath the surface whose manifestations might not have been easy for us to interpret. These briefings informed both the structure that we proposed, and our handling of issues and individuals on the day.

The available time also enabled the consultants to think intensively and extensively about the way to sequence the procedures that would constitute the next workshop, and also about particular content questions that were proving intractable. An example of the latter was the development of a graphical representation of possible configurations of adolescent and tertiary provision in relation to secondary facilities for children. This proved successful at the second workshop in disentangling what had proved till then to be a disabling thicket too dense to be sorted out in mid-workshop. An example of the former was the decision to develop a mutation of the comparative advantage chart for use at the third workshop in comparing schemes with different numbers of 'SpeCCs'. It was felt by the consultants that a simplified form might be adequate, and would avoid the over-repetitive use of a single tool.

Although we did make use of the month-long intermissions to develop quite elaborate 'running orders' (including contingency plans) for the impending workshop – as we did in initial preparation before the first workshop – these were of variable utility in practice. It was always necessary to deviate from the programme at various points and to improvise as situations developed in unpredicted ways. Sometimes the workshop's path rejoined the anticipated one, and in other cases we proceeded on a different course. Devising the running order was, however, always a valuable use of inter-workshop time. Its existence re-assured the client that the effort and political commitment that they were putting into the workshops was matched by due consideration on our part. And it also ensured that the consultants had journeyed mentally down into the grain of the problem situation. This meant that we were well prepared to respond rapidly and confidently to the unexpected analytic,

interpersonal, and inter-organizational challenges that the dynamic of the workshop would throw up.

22.5.2 Problematic implementation

As described above in Section 22.4.2, the workshops, although perceived by participants to be effective events in themselves, substantially failed to bring about the desired changes. Failures of OR interventions, either hard or soft, are seldom reported. (An exception is the review of failures and successes by Tilanus [19].) However, all practitioners know that interventions fail for reasons other than methodological incompetence, and successes are frequently achieved through ungeneralisable and undocumented fixes and hacks [20]. So it useful to reflect on what happened in this case, that made the outcomes so much less than the promise.

We can look at three contributory factors:

- Some key stakeholders were not present

- Some participants could not carry their constituencies

- Unforeseen circumstances

Absent stakeholders In Section 22.2.2 we described the process of deciding upon workshop membership. To realise the advantages of open interaction and engagement between members, workshop numbers need to be limited. In this case, not even all health specialties and roles in the Health Authority area could be represented. (This excluded, crucially as it turned out, representatives from a neighbouring health authority.) Non-professional health interests were only represented by the CHCs as permitted intermediaries.

Inevitably, group size limitations meant that key political interests, both local and national, could have no spokespersons in the workshops. However, these interests were not totally unrepresented. Participants brought them into the discourse as comparison areas or uncertainty areas (e.g. local political acceptability and effect on children's and adolescents' mental health services) and at this remove were captured as labels on post-its. Their influence on the workshop processes was through these proxy representations, which were the results of what is described in Actor Network Theory as a series of translations and inscriptions [21, 22]. This theory explores how human and non-human actants are enrolled in a network which may or may not be stable and induce action. In this case the workshops could not stably enrol all the absent key actors in coordinated

action, as instanced in the unwanted critical prominence given to the ongoing process by the local newspaper.

One strategy for avoiding this pitfall is to move towards the actual incorporation of more stakeholders into the discursive process. There is now a range of approaches designed for large group interventions, notably Open Space Technology [23], Future Search [24-26] and Team Syntegrity [27]. The principle has been described as "getting the whole system in the room". What is traded off against this inclusivity (and the legitimacy that it imparts) is the possibility of engaged conversation between all participants. The various approaches use different methods, none of them model-based, to synthesise outputs from multiple small group conversations into a large group consensus. The complementary strengths of large group intervention approaches and PSMs suggest a potential for mutual borrowing.

Failure of delegacy Although it did not affect the eventual outcome, it became evident in the immediate aftermath of the workshops that the consultant from one of the hospitals proposed to lose its inpatient department was in some difficulties in maintaining this agreed position inside the hospital. This is a not unfamiliar situation in inter-organizational uses of PSMs. Indeed the phenomenon is widespread – witness the experience through the years of both ambassadors whose negotiated accommodations are repudiated by their governments, and trade union negotiators who fail to get their wage deals endorsed by their members.

We can use a similar analysis based on Actor Network Theory to understand the process of failed delegacy, the question of "who speaks in the name of whom" (Callon [21], p. 214). Participants are involved in a sense-making process [28] which is contingent upon the composition and discourse of the workshop. That which makes sense within the workshop and appears to be a reasonable resolution of conflicting demands may not be seen as sensible when reported back to constituents outside the workshop. If the links in the chain that connect the organization to the workshop through the representative are not sufficiently strong then, in Callon's phrase, "translation becomes treason".

This problematic potential for workshop-based approaches is intensified for a linked series of workshops such as that employed in this case. Revealing work in progress is disruptive to the internal workings of the workshops (and maybe indeed be destabilising if first one option for service relocation is floated and then another); but not doing so weakens the representivity of the participants. They become less able to speak to and for their constituencies: this is the cost of becoming more embedded in the network and worldview of the workshop.

Unforeseen circumstances We have described how seemingly remote occurrences (here, the foot-and-mouth epidemic) disrupted the anticipated sequence of events. This put so much pressure on the Health Authority management, that even their representatives, who had commissioned the workshop with the full backing of their managers and were the most committed to the proposals, could not in the end carry their constituency. In Actor Network Theory terms, allies had not been locked into place and had become implicated in other networks – in this case ensuring they continued to have jobs. The attempt to make the issue of "how do we ensure a critical mass of pediatric patients" become an *Obligatory Passage Point* for all discussion, and action had failed.

Through this rudimentary analysis (which will be elaborated elsewhere) we can see how success within the workshop did not necessarily result in success outside the workshop. Within the workshop, concepts generated in the discourse became fixed as they were written onto post-its and persisted through the workshops. They became 'boundary objects' [29], which inhabit different social worlds [30] and are capable of being interpreted and applied in the different professional forms of life and understandings of the workshop members. However, they were not effective representations to people outside the workshop. Furthermore, participants were not effective as brokers or boundary spanners [31] to communicate effectively the workshop results to other audiences. (The exceptions to this were the Strategy Group, to which the workshop closely related, and initially the Chief Executives of the hospital trusts.) Successful workshops, especially in an inter-organizational field exposed to the public gaze need to be able to transverse boundaries of perception not only between participants but also between participants and wider communities.

As even this introductory account shows, Actor Network Theory provides a framework which illuminates the strengths and potential weaknesses of workshop-based approaches such as SCA. We have adumbrated both the attempted process of translation of absent actors, such as neighboring health authorities, into members of a network rooted in the workshop; and how the process centered on the workshop failed to make its participants part of a stable network which would effect change. A more detailed analysis of this and other workshops would examine how effective the rhetorical devices of SCA – shaping, designing, comparing and choosing – can be in enrolling participants in networks in which their interests are represented and where these new networks arrangements embody irreversible change. Such further analysis would, in particular by paying attention to the workshop and the wider world simultaneously, provide indications of how best to employ these devices. Such an analysis has the potential, therefore, both to respond to the criticisms that have been made of SCA that it has pragmatic effectiveness

but no theoretical underpinning; and also to improve practice. Practice improvements may be looked to through the direction of facilitators' attention to the steps necessary to ensuring robust relationships between the activities within the workshop, and actors and actions external to it, thus increasing the likelihood of apparently successful workshops leading to substantive desired change [32].

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