# Hybrid professional identities and 'calculative practices:' The case of GPs in the English National Health Service acute care commissioning

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# Abstract

The objective of this research is to contribute to knowledge and understanding by exploring: first, the professional identities of English General Practitioners (GPs) and other clinicians in the newly-formed Clinical Commissioning Groups (CCGs) and second, their level of involvement in CCG 'calculative practices' (Miller, 1990, 2001). The institutional field studied is acute care, i.e. hospital, commissioning in contemporary England. To achieve its objective, this thesis asks four research questions: 1) 'How appropriate is it for clinicians to be involved in CCG acute care commissioning?' 2) What motivates clinicians to assume leadership roles in CCGs?' 3) How involved are clinicians in CCG calculative practices?' and 4) To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' The theoretical framework used is based on the concept of 'calculative practices' and elements of the Institutional Logics Theory (ILT). This research employs three research methods – documents' content analysis, semi-structured, in-person interviews, and non-participant observation of CCG meetings with the public and NHS conferences. The interview subjects are NHS managers and accountants, as well as clinicians. This thesis answers the four research questions and then proposes some additional, incidental to this research findings and contributions to policy/legislation and practice. In conclusion, this study deliberates on the viability of the purchaser-provider split of the early 1990s that established the foundations and *raison d'être* of CCG commissioning and dwells on the possibility that one day the general taxation-funded and free at the point of service National Health Service (NHS) in England may cede its way to a US-inspired model of full blown privatisation.

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# List of Abbreviations

A&E – Accident & Emergency

BMA – British Medical Association

BT – British Telecom

CAQDAS – Computer-Assisted Qualitative Data Analysis

CCG – Clinical Commissioning Group

CEO – Chief Executive Officer

CFO – Chief Financial Officer

CQC – Care Quality Commission

CSS – Commissioning Support Service

CSU – Commissioning Support Unit

DH – Department of Health

DHA – District Health Authority

DHSS – Department of Health and Social Services

ERA 1988 – Education Reform Act 1988

EU – European Union

FT – Foundation Trust

GDP – Gross Domestic Product

GP – General Practitioner

HA – Health Authority

HCHC – House of Commons Health Committee

HM Treasury – Her Majesty Treasury

HSCA 2012 – Health and Social Care Act 2012

HSCB 2011 – Health and Social Care Bill 2011

HSJ – Health Service Journal

ICER – Incremental Cost Effectiveness Ratio

IFRS – International Financial Reporting Standards

ILT – Institutional Logics Theory

IMF – International Monetary Fund

IT – Information Technology

KPI – Key Performance Indicator

LAT – Local Area Team

LES – Locally Enhanced Service

MP – Member of Parliament

NAO – National Audit Office

NHS – National Health Service

NHSCB – NHS Commissioning Board

NPG – New Public Governance

NPM – New Public Management

PBC – Practice-Based Commissioning

PCAOB – Public Company Accounting Oversight Board

PCG – Primary Care Group

PCT – Primary Care Trust

PM – Prime Minister

PPBS – Planning, Programming, Budgeting System

PR – Public Relations

R&D – Research & Development

RQ – Research Question

Rt. Hon. – the Right Honourable

SHA – Strategic Health Authority

SLA – Service Level Agreement

SME – Small and Medium-Sized Enterprise

UK – United Kingdom

US – United States

VFM – Value for Money

WHO – World Health Organisation

WTO – World Trade Organisation

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# CHAPTER 1

# INTRODUCTION

## 1.1. Prologue

> "Accounting affects the type of social reality we inhabit, the way we understand the choices open to individuals and business undertakings, and even how we assess ways of maintaining the nation's health ... It is fundamental to the manner in which we administer the lives of others and ourselves. Yet, the calculative practices of accounting are largely invisible to the public eye…" (Miller, 2001, pp. 392-393).

The English National Health Service (NHS) has been experiencing the effects of a momentous institutional re-organisation in the last two-three years. As one of the largest organisations in the world (Lapsley and Schofield, 2009), the NHS provides healthcare services to millions of people in England and the rest of the UK. Nowadays, this general taxation-funded institution is facing a number of serious challenges, most of which are also typical of other developed Western countries (Erler *et al.*, 2011) – ever increasing demand for healthcare coupled with shrinking resources, high public expectations, and fast developments in medicine and technology. In today's environment of financial austerity, healthcare institutions and the professionals therein need to provide their services much more effectively and efficiently than previously (Blumenthal and Dixon, 2012).

Any large-scale reform of the socially important and cherished by the British people NHS would be worthwhile investigating in scholarly research, especially in the current context of financial constraints. This Ph.D. thesis focuses, therefore, on the most recent, far-reaching restructuring of the NHS in England and more particularly on the effects of changes to the commissioning of acute, i.e. hospital or secondary, healthcare. Commissioning involves

much more than simply buying something (Light and Connor, 2011). Acute commissioning, among other things, deals with the planning and purchasing of acute healthcare services from providers of such services (usually NHS hospitals) by commissioning bodies. The 2010-2015 Coalition government's plan to reform the commissioning of healthcare in England was first announced in July 2010 in the white paper, *Equity and Excellence: Liberating the NHS* (DH, 2010a). After a consultation period with interested parties, the proposed reforms were slightly modified and then took effect on 1 April 2013, a result of the enactment of the *Health and Social Care Act 2012* (from now on, 'HSCA 2012') one year earlier. Clinicians, most of whom family doctors or General Practitioners (GPs), were tasked with the new duty to lead commissioning in England. New commissioning bodies, known as Clinical Commissioning Groups (CCGs) were legislated all over the country. The reforms to commissioning are just one, but financially, politically, and socially significant, reform introduced by the HSCA 2012.

Despite the fact that healthcare commissioning plays a key role in how the NHS in England spends its money, most English people do not know what commissioning is and who handles it (HCHC, 2010a). As the opening quote of this thesis states, the "calculative practices of accounting are largely invisible to the public eye…" (Miller, 2001, pp. 392-393).

### 1.2. Objective of this thesis

The objective of this doctoral thesis is to contribute to knowledge and understanding by exploring the professional identities of GPs and other clinicians in the newly-formed CCGs and their level of involvement in CCG calculative practices. Both healthcare and CCGs are situated in the interplay of numerous institutional forces, be they political, economic or

social. A plethora of competing priorities exists in large public sector institutions, such as the NHS (Lapsley and Skærbæk, 2012), a fact which makes them intriguing to study.

### 1.3. Why does this research matter?

First, financial constraints in the public sector, such as the ones triggered by the 2008 credit crunch, are particularly apparent in healthcare. This sector has traditionally consumed a very large portion of Western countries' tax resources.[1] The agents studied in this research are clinicians (mostly GPs) in the newly established by the HSCA 2012 commissioning bodies, CCGs. There are 211 CCGs in England. Clinicians in CCGs are important to study from a financial constraints point of view since they allocate billions of pounds worth of healthcare budgets each year to various healthcare providers, i.e. they are purchasers of healthcare. By the end of 2013 for instance, CCGs handled £65 billion, or 68%, of the £95 billion NHS annual budget.[2] The remaining 32% were spent by non-CCG bodies – for example by NHS England for primary care (general practice) and specialised commissioning (the commissioning of rare or expensive to treat diseases). The significance of these monetary amounts is tremendous. Various previous types of commissioning bodies have consumed a traditionally large portion of the NHS budget, as well.[3]

[1] To highlight the social and financial importance of the NHS in general, it is important to note for example that the NHS in the UK, including England, was allocated the biggest percentage of the overall UK public budget in 2011-2012 (HM Treasury, 2012): of the total £322.5 billion for all public services, the NHS was allocated an estimated £101.1 billion, followed by the Department of Education (£51.2 billion) and the Department of Defence (£28.6 billion).

[2] Available at: <http://www.england.nhs.uk/2013/03/27/gp-commissioning/> [Accessed 17 June 2013].

[3] In 2011-2012 for example, the predecessor commissioners of the current CCGs, the Primary Care Trusts (PCTs), were allocated close to £93.9 billion, or about 90%, of the total £104 billion that the Department of Health (DH) spent on the NHS in that year (NAO, 2013a). In 2010-2011, this amount was £89.9 billion, or 89.5%, of the total NHS budget of £100.4 billion (NAO, 2011, p. 10).

Second, non-financial constraints are also apparent in the healthcare field. One of the non-financial constraints brought to the fore in this research is cross-occupational boundaries. Nowadays, in many international health systems, there has been a pronounced need for "getting doctors to be more engaged in management, leadership and service improvement," that is, there is a need for clinical experts to also become good managers and leaders (Clark, 2012, p. 437). The HSCA 2012 set in law the involvement of family doctors, i.e. GPs, in CCG commissioning. "As the custodians of the processes and micro-systems of health care, doctors are ideally placed to lead improvements," (*Ibid.*) reasoned the government. Thus, GPs in England were given the new, legislated duty to engage in, among other things, 'participative budgeting' (Bryer, 2014) and allocate millions of pounds each year to the CCG whose members they were. Multi-million pound budget allocations were also done by previous NHS commissioning bodies (Daniels *et al.*, 2013).

Given that financial management and accounting information play an ever more significant role in the management of healthcare, do the new commissioning roles of GPs conflict with their identities as healthcare professionals (Pettersen and Solstad, 2014)? Is it the case that medical doctors are people who possess a strong social identification with their occupational group or are they individuals who are easily malleable into new occupational identities? This research focuses on similar concerns with cross-occupational challenges and constraints in the context of CCGs.

### 1.4. Definition of key terms

First, what is a 'clinician'? Laurant *et al.* (2010) distinguish between two types of clinicians: 'physicians' (people with a degree in medicine who are fully licensed to practice medicine,

such as GPs and specialist consultants) and ‘non-physician clinicians’ (advanced Practice Nurses, such as Nurse Practitioners, specialist nurses, and clinical nurses; physician assistants; pharmacists; and allied health professionals, such as physical therapists, speech and language therapists, dieticians, and paramedics). Each country has its own specifications as to what a ‘physician’ and a ‘non-physician’ clinician means. In this research, the term ‘clinician’ has a more narrow definition than just someone belonging to the medical profession. Here, the term designates these medical practitioners who can be involved, statutorily, according to the HSCA 2012, in CCG commissioning. These are “member[s] of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002” (HSCA 2012, §28(1E)). These medical professionals are mostly GPs, but also specialist medical consultants, and nurses.

Second, Professor Peter Miller from the London School of Economics defines ‘accounting’ as ‘an ensemble of devices and ideas formed at particular times and in particular locales, rather than an immutable and universal starting point” (Miller, 1998, p. 608). CCG commissioning may be seen as such an example of accounting; it is an ensemble of ‘devices and ideas’ formed in a particular ‘time’ (2010-2013) at a particular ‘locale’ (England). This Ph.D. thesis is in accounting and adopts this broad definition of the word ‘accounting.’ It does not assume that accounting is limited to just bookkeeping, financial reporting, managerial accounting, auditing, and taxation. Besides, Miller states that accounting is “an assemblage of calculative practices and rationales…” (p. 605). By extension, CCG commissioning is also a set of calculative practices. In another work, Miller writes that accounting is “a process of attributing financial values and rationales to a wide range of social practices, thereby according them a specific visibility…” (Miller, 1990, pp. 316-317). Thus, CCG commissioning gives ‘visibility’ to certain ‘financial values and rationales,’ too.

Third, what are ‘calculative practices’ (Miller, 1990, 2001)? These are “technologies of government (Rose and Miller, 1992: 183) … the mechanisms through which programs of government are articulated and made operable” (Miller, 2001, p. 379). CCG commissioning may be seen as such a ‘technology’ of the Coalition government that instituted it; it is a mechanism through which the ‘programme’ of government was ‘articulated’ and put into operation.

Fourth, let us define another key term, besides ‘calculative practices,’ which appears in the title of this thesis, ‘Hybrid professional identities and ‘calculative practices:’ The case of GPs in the English National Health Service acute care commissioning.’ This term is ‘professional identity.’ Practices and identities are two inter-related concepts: the ‘What do we do?’ question refers to practices, while ‘Who are we?’ refers to identities (Glynn and Raffaelli, 2013). In this research, ‘professional identity’ has social identity elements since medical professionals have traditionally been members of exclusive social and professional groups.

Tajfel, cited in Ashforth, Harrison and Corley (2008, p. 327), defines ‘social identity’ as, “that part of an individual’s self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership.” Clinicians in CCGs do possess a professional medical identity by virtue of their social membership in medical associations and circles. Perhaps, there is a certain level of ‘value and emotional significance’ that they attach to this membership. Unlike personal identity, social identity focuses not so much on individual attributes (demographic and personal characteristics, such as gender and race), but on ‘levels of self’ that distinguish among groups of individuals (Ashforth, Harrison and Corley, 2008).

Fifth, 'hybrids' have been defined as "composite phenomena produced by elements usually found separately. In biology, for example, hybrids are produced by crossing different species. In organisational terms, hybrids similarly represent a composite of two distinct modes of organising that achieve a degree of stability and longevity" (Fischer and Ferlie, 2013, p. 33). GP-commissioners may be seen as such hybrids – part medical professionals and part commissioners (administrators, businessmen and businesswomen, leaders, strategists, as it will be shown in another chapter). Their professional identity may also be seen as hybrid – a commissioning identity and a medical identity.

### 1.5. Expected contributions, i.e. gaps to fill, and research questions

This research seeks to contribute to current knowledge and understanding in accounting, management, and identity studies by identifying and filling a number of research gaps in the extant literature. Next, these research gaps will be presented one by one, together with the four research questions whose answers are expected to help fill these gaps.

#### Gap 1

Since the HSCA 2012 is a recent piece of legislation (it became effective on 1 April 2013), there have been relatively few academic studies that simply mention or examine in detail the CCG commissioning reforms (Asthana, 2011; Conrad and Guven-Uslu, 2012; Gray and Higgins, 2012; Hodgetts, 2012; Petsoulas *et al.*, 2011; Robinson *et al.*, 2012). These reforms have mostly been addressed by the practitioner literature (the *British Medical Journal*, the *Health Service Journal*, and the *Lancet*, to list just a few). This research tries to respond to

Guven-Uslu and Conrad's (2011) call for further academic research on NHS clinicians and managers, many of whom are now CCG commissioners.

**Gap 2**

Some academics are skeptical about the commissioning leadership of the new clinician-commissioners (Gridley *et al.*, 2012; Richardson, 2013). While the changes to commissioning certainly mean that clinicians now have a leading role in, for example, population-based budgeting, Robinson *et al.* (2011) doubt that GPs will be able to meet their commissioning challenges on their own. They will have to engage with other stakeholders, such as the government, interest groups, and civic society in general. Petsoulas *et al.* (2011, p. 185) express the concern that GPs "generally lack experience and expertise in large-scale, secondary care contracting." Devlin (2010, p. 1076) asks the vital question:

> "[A]re we sure that GP commissioners will be better agents for patients (individually and collectively) than PCTs [Primary Care Trusts, the old commissioners]? While GPs may be 'closer' to what individual patients want, it is not obvious why this would make them more expert at weighing up the relative benefits to patients, and the opportunity costs of budget allocation decisions. Indeed, it seems unlikely that many GPs will currently have either the expertise or interest in making these decisions."

To the author's knowledge, no other study has asked directly of NHS managers and clinicians about whether this 'lack of experience and expertise' is just a perceived problem or whether it is actually causing problems in CCG commissioning. Besides, no other research has so far asked of NHS clinicians and managers about how they personally feel about clinicians' involvement in commissioning, often a set of calculative practices. After all, commissioning involves a very different knowledge and skill set from medicine (what clinicians have been actually trained in). The knowledge and skill base most needed in commissioning is business,

management accounting, strategic, and calculative in nature – planning, budget preparation and allocations, contracting with providers, paying for services, de-commissioning of services, etc. (see section 4.5).

Unlike the former practice-based commissioning (PBC) that placed the ultimate accountability for acute care commissioning on Primary Care Trusts (PCTs), the most recent commissioning reforms placed the ultimate accountability for it on GP-led CCGs. Cox (2011) sees some ethical dilemmas behind this shift since the new statutory duties of GP-commissioners would place them in the impossible position where caring for patients might no longer be their primary concern. This research will try to find out whether the above concern with the fitness of clinicians to be involved in CCGs (calculative entities) is justified.

**Gap 3**

This research will incorporate Miller's (1990, 2001) concept of 'calculative practices' in the context of CCGs, something that no other study has done, so far. Miller presents management accounting as a 'technology of government' that "link[s] together responsibility and calculation … to create the responsible and calculating individual" (*Ibid.*). A similar take on the CCG commissioning function (as a 'technology of government') has not been done before, although it seems to be highly appropriate. Regarding accounting practices, Miller states:

> "Rather than confront individuals daily over the allocation of resources, why not provide funds to an individual who will have both the responsibility and the freedom to spend the money as they see fit? Why not, in other words, seek to produce an individual who comes to act as a self-regulating calculating person, albeit one located within asymmetrical networks of influence and control?" (Miller, 2001, p. 381).

The NHS clinicians involved in CCGs may also be seen as such 'responsible,' yet 'free' persons who are being 'produced' by the system as 'responsible and calculating individuals.' As it was already noted in section 1.4, CCG commissioning may be viewed as a 'technology of government.' Thus, the first research question is:

**RQ 1:** 'How appropriate is it for clinicians to be involved in CCG acute care commissioning?'

This research focuses only on acute care commissioning for capacity reasons. By all means, GPs are involved in several other sorts of commissioning, as well – prescribing, mental health, and others. Answering this first research question would help fill the first three gaps delineated above.

**Gap 4**

Empirically, this research extends the stream of accounting scholarly research by addressing the issue of commissioning within the English healthcare field. While some accounting research has concentrated on the commissioning for education, introduced in the UK by the *Education Reform Act (ERA) 1988* (Edwards *et al.*, 2000; Ezzamel, Robson and Stapleton, 2012; Laughlin *et al.*, 1994), healthcare commissioning in the new CCGs, entities collectively responsible for billions of pounds of healthcare budgets, has surprisingly not yet attracted the attention of the accounting community. Thus, this research contributes to the burgeoning academic literature in accounting on the recent NHS commissioning reforms.

**Gap 5**

This thesis reviews the literature on relevant NHS structures (past and present NHS systems and institutions, various commissioning reforms that stem from the 'purchaser-provider split,' etc.) but, most importantly, it also looks at the agency (individual actors) side of CCG commissioning. This is done via the concept of professional identities. Kilfoyle and Richardson (2011) from the accounting literature have looked at both structure- and agency-centred approaches to better understand the budgeting process in management accounting. Armstrong (2011), again from the accounting literature, has also explored the behavioural (agential) side of budgeting. Studies of the agency element behind budgeting and other calculative practices from a CCG perspective lack in the accounting literature.

**Gap 6**

To the author's knowledge, no other study has so far examined why exactly some clinicians in England agree to undertake what seems to be difficult leadership roles in the new CCGs. To be a CCG leader – Accountable Officer, Chair of the board of governors, etc. – is a highly responsible undertaking. Membership in a CCG is mandatory for all English GPs, as mandated by the HSCA 2012, but undertaking a CCG leadership role is not. The following, second research question will help fill the fourth, fifth, and sixth, literate gaps:

**RQ 2:** 'What motivates clinicians to assume leadership roles in CCGs?'

Knowing the personal motivations of the clinicians involved in CCG leadership roles is an important issue to explore, given the enormity of the monetary responsibility bestowed onto

them. Motivation is important to study since it affects the way one does his or her job. It also casts some light on personal values and beliefs.

**Gap 7**

Calculative practices have penetrated the realm of medicine via CCG commissioning. Peter Miller writes:

> "Terms such as budgets, costs, return on investment, and so forth are no longer the preserve of the specialist. The calculative practices and language of accountancy have seeped into everyday life to an extent that would have seemed improbable to an observer of economic and social life half a century ago" (Miller, 2001, p. 391).

This 'seeping' of calculative practices and the language of business and accountancy into clinicians' everyday lives may or may not change their daily activities or practices – taking care of the sick, frail, and vulnerable. It would be interesting to see whether clinicians are very much or little involved in CCG calculative practices – another important gap in the literature. From here, the third research question is:

> **RQ 3:** 'How involved are clinicians in CCG calculative practices?'

**Gap 8**

This research also contributes to the literature on hybrid medical-managerial professional identities. A similar hybridity or 'financialisation' within knowledge-intensive organisations has been studied in Cushen (2013). So far, most of the research on medical hybrids has focused on the hybrid doctor-manager professional identity primarily from the provider's perspective (i.e. in hospitals) (Ferlie and McGivern, 2014; Ferlie *et al.*, 2011; Fitzgerald and

Ferlie, 2000; Fulop, 2012; Goodall, 2011; Hallier and Forbes, 2004; Kelly, Doyle and O'Donohoe, 2015; Llewelyn, 2001; Macinati, 2010; Noordegraaf, 2007; Waring and Currie, 2009), not so much from the commissioner's perspective (Pettersen and Solstad, 2014).

Extant research has focused on professional restratification into medical surveillance roles in general practice (McDonald *et al.*, 2009; O'Riordan and McDermott, 2012). For instance, McDermott *et al.* (2013, p. 4) find that, "GP managers have a high level of certainty of their identity as a GP rather than as a manager; and both GP managers and non-GP managers oscillate between multiple identities depending on the different situations they are in." Moreover, research on the identity of NHS medical commissioning mangers has been done in previous types of commissioning organisations (McDermott *et al.*, 2013), but not in CCGs, partly because CCGs are relatively new organisations. Looking at the hybrid professional identities of clinicians within CCGs is a gap that this research will try to fill, empirically.[4] By exploring such new organisations, this thesis aims to be a current and relevant study of present-day socially important policy and practice.

If CCG clinicians are involved in medical-commissioning hybrid roles thanks to their CCG calculative practices, will this affect deeply, just superficially, or not at all their professional identities? Therefore, the following, fourth research question is also asked:

**RQ 4:** 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?'

[4] Professional identities, but among accountants, have recently been studied in the accounting literature, as well: Becker, Jagalla and Skærbæk (2014) explore the identities of accountants in the public sector, while the collective identities of management accountants have been studied by Morales and Lambert (2013). Also, the identities of managers within professional accounting firms have been the focus of Kornberg, Justesen and Mouritsen (2012).

This last research question will address the effect of hybridity and calculative practices on clinicians' professional identities in CCGs. Now, let us turn toward the theoretical underpinning of this research.

### 1.6. Theoretical framework

The main contribution of this research is not theoretical, but empirical in nature. This research may be seen as an elaboration of existing theory or an empirical application of existing theory to increase understanding of the subjects studied – GPs in CCGs. The theoretical take of this research is based on Miller's concept of 'calculative practices' described in section 1.4 and on some concepts from the Institutional Logics Theory (ILT) (Friedland and Alford, 1991; Scott *et al.*, 2000; Thornton, 2004; Thornton, Jones and Kury, 2005; Thornton and Ocasio, 2008; Thornton, Ocasio and Lounsbury, 2012). The ILT concepts used here are: the business logic, the professional logic, the governance logic, the political logic, and the dynamic interplays among them. ). Institutional logics are defined as, "the socially constructed, historical pattern of *material practices, assumptions, values, beliefs, and rules* [my emphasis] by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton and Ocasio, 1999, p. 804). More on these institutional logics concepts will follow in Chapter 5. The ILT is a relatively new theory and is a development of the neo-institutional theory (DiMaggio and Powell, 1983; Meyer and Rowan, 1977). To the researcher's knowledge, no other study on the CCG reform in England has so far used elements of the ILT. Reay and Hinings (2005, 2009) have discussed similar healthcare reforms from the ILT perspective but in the Canadian context.

As it will be shown in Chapter 4, CCG commissioners act as: philosophers, accountants, economists, strategists, and managers, to name just a few, i.e. they are involved in calculative and non-calculative practices. CCG commissioning is itself a calculative practice, as we saw earlier. Miller writes that governments have first, a "programmatic aspect" that can be called "political rationalities" of government (Miller, 1990, p. 317). These rationalities are "statements, claims and prescriptions" that set out "the objects and objectives of government" (*Ibid.*). The second aspect of governments, according to Miller, is 'technologies of government, "The term *technologies* can be used to refer to this wide range of calculations, procedures and mechanisms of government. Technologies … complement the programmatic aspects, enabling them to be represented as operable in principle" (*Ibid.*).

### 1.7. Research methodology and methods

This research assumes the interpretivist ontology. It employs a qualitative research methodology and uses primary and secondary data. The data will be used as a basis for answering the four research questions. The primary data come from twenty-one semi-structured, individual interviews with NHS clinicians (mostly practicing or retired GPs) and senior managers and accountants working for the NHS in England. The interviews were conducted in person between September 2012 and September 2014 at the interviewees' places of work. The secondary data come from two government documents (DH, 2010a and the HSCA 2012) and from non-participant observation of four CCG meetings with the public and three national NHS conferences. More on the methodology and methods used will be discussed in Chapter 6.

## 1.8. Structure of this thesis

This thesis is structured as follows. The next two chapters are contextual in nature – they situate CCG commissioning within its broader context (time and space). Chapter 2 is a review of the literature on reforms in the public sector in general and in the NHS in particular. Chapter 3 is a review of the literature on CCG acute care commissioning. Chapter 4 reviews the literature on the work identities of clinicians and commissioners and their practices, i.e. work-related activities. Chapter 5 presents the theoretical vantage point of this study – concepts from the ILT and Miller's (1990, 2001) 'calculative practices.' Chapter 6 is concerned with the research philosophy of this research, i.e. its methodology and methods. Chapter 7 presents and analyses selected excerpts from the research data. Chapter 8 is the discussion chapter. It seeks to answer the four research questions from Chapter 1. It also presents some additional, incidental to this research, contributions that came to the researcher's attention after data collection. Chapter 9 provides a short conclusion, research limitations, and directions for future research.

# CHAPTER 2
# REVIEW OF PUBLIC SECTOR REFORMS AND IDEOLOGIES AND THE NHS

## 2.1. Introduction

The purpose of this chapter is to provide a background overview of various public sector reforms and ideologies and the NHS. Public sector reforms and ideologies have impacted significantly on healthcare and other fields in the UK and abroad. More specifically, this chapter presents the historical and ideological concepts of public administration (PA), New Public Management (NPM), and New Public Governance (NPG); then, it introduces the ideology of the Coalition government (May 2010 – May 2015), the government that initiated and implemented the most recent NHS commissioning and other reforms; lastly, it provides an overview of the NHS as a large and cherished public sector institution. This contextual chapter is important for the understanding of CCG commissioning since it familiarises the reader with broader social, economic, and political forces that stand behind the creation of clinician-led CCG commissioning.

## 2.2. Public sector reforms and ideologies

The issue of ideology has attracted substantial attention in the public sector literature (Higgs, 1993; Williams, 2005). According to Williams, ideology affects not just one's objectives and aspirations, but also the ways in which one judges reality. While the former influence is obvious, the latter is not so clear, posits the author. Ideology, according to Williams, transpires through the questions one asks, through the way one formulates problems and issues, through the analytical methods one adopts and through the evidence one seeks. In

Williams' view, even those who believe themselves to be ideologically neutral may in fact adhere to an implicit ideological stance by tackling an issue in a particular manner. Thus, any social science analysis is bound to a certain type of ideological conviction. Ideology may inspire reforms or the upholding of administrative systems.

Administrative systems, such as the NHS, are certainly not a new phenomenon. They existed for example in ancient Egypt to help fortify irrigation channels from the annual flood of the Nile and build the Egyptian pyramids. The Chinese Han dynasty (206 BC-AD 220) and the Greek, Roman, and Spanish empires were also administrative empires (Hughes, 2003). Drawing upon the UK's experience, Osborne and McLaughlin (2002) distinguish four stages of development in the public management of administrative systems.

The first stage started from the late nineteenth century and may be called the period of the 'minimal state.' The authors note that the former UK Prime Minister (PM) Margaret Thatcher used to refer frequently to this period of public management. Government provision in this period was seen as a "necessary evil" (p. 7). The second stage of public management started in the early twentieth century and was characterised by an "*unequal partnership* between government and the charitable and private sectors" (*Ibid.*). This period was influenced, the authors continue, by an ideological shift toward social reformism and Fabianism: the state provided a minimum of essential public services and the charitable and private sectors provided the rest.

Institutional change is a characteristic of administrative systems and has been an issue within the public sector for a long time (Dopson, 1997; Ferlie, Hartley and Martin, 2003). The metaphysics of processional change and continual becoming take centre stage in Chia (1999)

and McMurray (2010) and may be applied to the NHS, as well. From a more recent perspective, ‘publicness’ (Anderson, 2012) is defined as the characteristic of an organisation that reflects the extent to which the organisation is affected by political authority. The NHS seems to have a lot of ‘publicness.’ The third and fourth stages of public management, which are discussed next, are particularly telling examples of the influence of political ideology on public institutions.

### 2.2.1. Public administration (PA)

The third stage of public management, the ‘welfare state,’ characterised the period from 1945 to the 1980s (Osborne and McLaughlin, 2002). The term that is most often used to describe this third period is ‘public administration’ (PA). Osborne and McLaughlin refer to William Beveridge, the renowned welfare state reformer from the post-World War II period, to explain that underpinning the PA model was the belief that charitable and private organisations had failed in the provision of public services because of a fragmentation and duplication of services and because of these services’ inefficiency and ineffectiveness. Therefore, governments at the time were to meet all the needs of their citizens “from the cradle to the grave” (p. 8).

PA was characterised by a hierarchical model of bureaucracy. The officials staffing pubic services in this period were permanent, presumably neutral, and motivated only by “the public interest” (Hughes, 2003, p. 17). Public services were supposed to be managed in an objective and professional way, note Osborne and McLaughlin (2002). Many scholars agree that the theoretical foundations of PA were derived from Woodrow Wilson and Frederick Taylor in the US and from the founder of sociology, Max Weber, in Germany.

### 2.2.2. New Public Management (NPM)

The fourth stage in the development of public management is that of the 'plural state' (*Ibid.*). This is the stage of the so-called 'New Public Management' (NPM), also known as 'neo-liberalism' or 'managerialism.' The NPM period started in the late 1970s and elements of it certainly continue to influence public services today. Neo-liberalism in the UK is usually ascribed as an ideology of the Conservative government (1979-1997). The New Labour (2010 – May 2010) and the Coalition (May 2010 – May 2015) governments have continued using elements of the neo-liberalist ideology although these governments have shared different philosophical stances.

The NPM movement that started in the 1980s is an international trend. Mulgan (2003, p. 151) observes that in the 1980s, the public service bureaucracies in many countries, not just in the UK, underwent substantial re-structuring. This was part of an international movement towards a public sector reform. In Mulgan's view, each country's reformers followed different paths, according to their country's particular constitutional traditions and ideological leanings. Nonetheless, the reforms shared sufficient common elements "to be counted as a single movement and not just a haphazard collection of isolated changes" (*Ibid.*). In short, there was a worldwide ideological shift from a bigger role of the state in the economy and society toward a greater role of markets and private sector organisations, remarks the author. NPM spread all over the world (for example, see Doolin (2002) for NPM in the New Zealand context). "Many have started speculating whether NPM is actually rooted in our everyday lives, if it has ever existed or if we are in a post-NPM world" (Liguori and Steccolini, 2014, p. 320). Despite these existentialist doubts, examples of NPM reforms may be found in:

financial de-regulation, the privatisation of publicly owned entities, reductions in welfare entitlements, and greater reliance on the private sector in many industries, including healthcare.

The Conservative government of Margaret Thatcher used to criticise the welfare state which aimed to provide a minimum standard of public services to everyone, an example of the rationing mentality typical of the period following World War II (Osborne and McLaughlin, 2002). This universal state provision was perceived by many as inefficient and ineffective compared to the market provision of social goods (Mulgan, 2003). Hughes (2003) provides a detailed account of the facets of public administration that NPM critiqued. Yet, the main reason for the change from bureaucracy to managerialism, according to him, was that the old model did not work: PA was perceived as tied up in poor service and in process and was out of touch with reality.

Rose and Miller (1992) in their widely influential article observe that neo-liberalism suggests that big government is not just inefficient. It is also malign – political parties are forced to make unrealistic promises, while competing for votes. This fuels rising public expectations and an over-reliance on the government that can only be met by public borrowing on a large scale:

> "Because 'the welfare state' depends on bureaucracy, it is subject to constant pressure from bureaucrats to expand their own empires, again fuelling an expensive and inefficient extension of the governmental machine. Because it cultivates the view that it is the role of the state to provide for the individual, the welfare state has a morally damaging effect upon citizens, producing 'a culture of dependency' based on expectations that government will do what in reality only individuals can" (p. 198).

There was a clear trend at the time away from collectivism and towards individualism: "By the late twentieth century, however, the perceived needs of citizens had moved on, away from

a concern with a basic level of service for all and towards services designed to meet individual needs" (Osborne and McLaughlin, 2002, p. 8). This period saw the Reagan revolution in the US and the Thatcher revolution in the UK and was accompanied by deep changes in public management, changes which Peters (1993) refers to as 'the hollow state,' or 'governing from a distance,' away from central government. Rubin and Kelly (2005) note that if legislators have little or no role in setting performance goals, prioritising these goals or evaluating them, then they gain little or no power or influence. Central government may also shift some day-to-day decision making and performance evaluation power away from itself and closer to local governments. All this leads to 'hollowing out' of the central government's power, i.e. to a disempowerment via devolution of power to local level.

'Governing from a distance' is usually linked to the concept of decentralisation of central government's power. Decentralisation has been a very popular concept in the last quarter of a century in the sense that almost everyone has supported it (Pollitt, 2005). Decentralisation, this cornerstone of NPM, involves the notion of authority being spread out from a small to a large number of actors and decision makers – usually, from a central authority to more numerous local authorities; thus, decentralisation puts authority closer to citizens (*Ibid.*).

Besides decentralisation, NPM is characterised by other traits – a focus on outcomes and results, rather than processes, meeting specified objectives, public budgeting reforms, and so on. Mulgan (2003) writes that managing for results has led to results-oriented budgeting in which funds are allocated for specific programmes or purposes. Results-oriented budgeting is not an invention of neo-liberalism but is widely used by it: Mulgan observes that the earliest instance of results-based budgeting preceded the NPM reform movement by several decades.

'Program budgeting' for example was introduced in the US during World War II and became known in the 1960s as the planning, programming, budgeting system (PPBS).

One challenge for NPM has been the difficulty of specifying objectives and measuring achievement in many aspects of governmental activity; for example, often objectives are unprecise because policy goals are complex and made up of shifting and conflicting values (*Ibid.*). Policy goals, notes the author, may be contested by various groups with competing interests. "Attempts to capture public policy goals in a simple formulation typically lead to vague and porous objectives sufficiently broad to cover all likely developments but without the rigour needed to provide clear direction or generate unambiguous measures of success or failure," writes Mulgan (2003, p. 185). Besides, public budgeting reform has ranged from minor to dramatic (Rubin and Kelly, 2005). The more dramatic changes, in these authors' view, have included a shift from simple line-item budgeting to programme and performance budgeting, performance contracts, contracting or leasing with the private sector, output and outcome measurement, and fiscal decentralisation.

One of the main goals of NPM is to increase transparency and accountability. Programme administrators, for instance, are usually held accountable for delivering their contracted results (*Ibid.*). The incorporation of output and outcome performance information into the budgeting process is meant to help weed out ineffective programmes. Such programmes waste resources by not achieving their goals at all, or by not achieving them optimally (*Ibid.*). Mulgan (2003) observes that the NPM accountability reform agenda has tried to reorient public sector accountability away from inputs, processes, and political accountability for detailed decisions towards an accountability for results that is given directly to customers and through regulation. These accountability reforms have been met with mixed results. In fact,

an enhanced accountability has been difficult to achieve in the complex network of decentralised public bodies.

Managerialism has been the object of criticism, just as PA has. It has been criticised for its economic basis, neo-Taylorism, politicisation, reduced accountability in practice, difficulties to achieve contracting out, ethical issues, implementation and morale problems, etc. (Hughes, 2003). Needless to say, the NPM reforms discussed above apply also to the healthcare sector in the UK. Talbot-Smith and Pollock (2006) note that in the 1990s, the NPM measures aimed to increase efficiency and choice; however, the NHS hospitals and community services, already short of resources at the time, faced the additional cost of competing for funding, dealing with risk, and administering and monitoring hundreds of complex contracts. In the 1990s, within a short period of time, more than a third of the newly-formed hospital trusts faced serious financial difficulties. Some were forced into mergers and service closures. NPM-based ideas contributed to the development of performance measurement and management systems that exposed in publicly available tables' format the 'poor' healthcare providers (Ferlie *et al.*, 2013). The early quasi-market experiment in health (1990-1997), a focus of discussion in Chapter 3, led to the disintegration of the old vertically-integrated NHS into purchasers and providers. These two were linked by contracts, rather than by administrative hierarchy, observes the same source.

It is worth noting that NHS trusts (groups of hospitals) in the 1990s were no longer given free support from the Department of Health (DH)'s regional offices for their capital planning, estates' management, and Information Technology (IT) (Talbot-Smith and Pollock, 2006). For the sake of efficiency, they now had to buy these services out of the revenue they earned from the health services they 'sold.' The authors observe that all NHS service providers now

had to pay an annual charge (originally 6%) on the value of their land and equipment. This money came out of the revenue trusts 'earned.' This is known as the capital charging system and is paid to HM Treasury, similarly to property tax. The NPM idea behind capital charging was that trusts needed to become more economical with the use of their capital assets. They were encouraged to sell off any assets they did not need or assets that were too valuable (for example, land in cities) by having to pay for their use, note the authors.

Some commentators see severe consequences of the NPM philosophy on healthcare (Light and Connor, 2011; Pollock, 2004). For example, Light and Connor (2011) share the view that if healthcare is commercialised by being exposed to market pressures, hospitals will learn as sellers how to exploit buyers and customers in whatever ways this makes them money. Thus, depending on how incentives are structured, hospitals might overtreat or undertreat. The NPM reforms have attracted further criticism in the literature (Ferlie *et al.*, 2013). The following externalities have been noted: an exaggerated focus on productivity and operational management (Dunleavy, 1995), a disengagement (or 'democratic deficit') between public services agencies, public services workforce, including clinicians, and society in general (Weir and Beetham, 1999), and excessively vertical and fragmenting effects (Sullivan and Skelcher, 2002).

The NPM concept of privatisation has been seen as the reason behind the "dismantling" of the NHS by various governments over the past quarter century (Pollock, 2004, p. vii). This, in her opinion, is not unique to Britain since universal healthcare systems are being dismantled and privatised all over the world. Healthcare has become a commodity to be bought, rather than a right, she claims, and this has been the guiding philosophy of the Word Bank, the International Monetary Fund (IMF), the World Trade Organisation (WTO), the World Health

Organisation (WHO), and many more. NPM, according to some scholars, has transitioned to a particular type of governance.

### 2.2.3. New Public Governance (NPG)

A potential successor of NPM is New Public Governance (NPG) (Osborne, 2006). Ferlie *et al.* (2013) see the idea of this chronological succession from NPM to NPG as too simplistic. Often however, NPG is considered to be the successor of NPM. NPG originated in the late 1990s after NPM had already emerged. Both trends, NPM and NPG, are still clearly visible in the social and business worlds and practitioners shop freely between them (*Ibid.*).

Before discussing NPG in greater detail, it is worthwhile to first discuss the concept of 'governance.' There are various definitions of the word 'governance,' including such that include NPM (Klijn, 2012). In some of the literature, governance is equated to NPG. The term 'governance' has its roots in the Greek word *kubernan*, which means 'to steer.' It later developed through the Latin terms *gubernare* and *guvernator* and mostly meant 'to steer' or 'to pilot a ship' (Storey and Grint, 2012). The French philosopher Michel Foucault (Foucault, 1991) has used the word 'governance' in the same sense. To govern a ship, Foucault writes, one needs to take charge of the crew, the boat and its cargo, to deal with weather conditions and rocks, and to establish good working relations among the sailors. One governs a household in a way similar to governing a ship. Governing a family is not only about safeguarding the family's property. It is about the wellbeing of the family members themselves, as well, continues Foucault. The same principle applies to the governance of the NHS. There are various eventualities that need to be considered if this large and complex institution is to be governed effectively.

Foucault's work on the art of governing has been enlightening to the study of reforms within the NHS. Veitch (2010) for example builds on Foucault's work on the art of governing to study New Labour's proposed reforms to the NHS at the time. Veitch sees a similarity between these proposed reforms and the politics of 18th century France: the French government wanted to distance itself from patients by transferring the task of patient care to patients' families, the Church, and charities. This way, the government turned from "curer" to "advisor" and "supporter" (p. 323). In today's context, a similar shift of responsibility is illustrated by the debate on the shift from the provision of care to the promotion of care by the Secretary of State for Health.

As was already noted, the term 'governance' is sometimes used synonymously with NPG. While NPM is mostly based on organisational economics and principle-agent theory, NPG is primarily based on network theory (Ferlie *et al.*, 2013). While NPM is linked to individual organisations, NPG has a multi-organisational focus (a network focus) and an interest in network concepts, such as 'whole-of-government accounting' and consolidation accounting issues (Almquist *et al.*, 2013). These authors observe that while NPM is based on a vertical and hierarchical view, NPG has a horizontal focus: NPM is concerned with the outcomes of individual organisations, while NPG – with these of collaborative efforts among several organisations. Besides, NPM uses performance information in a 'command and control' way, while the function of performance information within NPG's networks "is mainly to support processes of debate and dialogue among the partners with different competencies, who are dependent on each other but not in a hierarchical sense" (p. 4). NPG also helps enhance the quality and innovative capacity of information dispersed by various actors and enhances

democratic legitimacy by making possible the early involvement of stakeholders in policy dialogues (Klijn, 2012).

According to Klijn, one may regard both NPM and NPG as reactions to the growing complexity of contemporary society and the difficulties of the traditional welfare state to cope with this complexity. The increased specialisation in today's world, including the increased specialisation in healthcare (Scott *et al*., 2000), has led to enhanced interdependencies (Klijn, 2012). Klijn also notes that the growing individualisation has formed citizens who are more critical of their governments than in previous years; besides, traditional societal ties, such as family, religion, and neighbourhood, seem to have lost some of their strength in Western societies. "These arrangements must, on the one hand, satisfy demands for more integrated service delivery, with citizens participating ... Both NPM and governance recognize this growing complexity but have different attitudes toward coping with it" (p. 202).

Rhodes (2012) sees three waves in the governance literature – network governance, meta-governance, and interpretive governance – and points out that interpretive governance is the new way forward. The first wave, network governance, "evokes a world in which state power is dispersed among a vast array of spatially and functionally distinct networks composed of all kinds of public, voluntary, and private organizations with which the center now interacts" (p. 34). According to the author, the proponents of the first wave kind of governance are "self-confessed modernist-empiricists with a reified notion of structure rooted in an explicit social science theory of functional differentiation" (p. 39).

The second wave of governance, meta-governance, is a critique of the first wave. The proponents of meta-governance claim that the state is a material object, a structure, and a social form. They draw on the critical realist ontology by using such notions as "emergence" and "mechanism" (*Ibid.*). The second wave critiques argue that the state has been "hollowed out" of its centralised powers (p. 36). Another view is that the state has not been hollowed out, but that it governs indirectly: governance is more like indirect policy steering within complex multi-level systems than like direct policy imposition (Ferlie *et al.*, 2013; Newman, 2001). The state "has reasserted its capacity to govern by regulating the mix of governing structures such as markets and networks and deploying indirect instruments of control" (Rhodes, 2012, p. 39). Examples of indirect instruments of control are the use of negotiation, diplomacy, and other less direct modes of steering, writes Rhodes.

Further on, Rhodes notes that there are three ways in which the state may steer the other actors involved in governance (Rhodes, 2012). The first way is that the state may set the rules for the other actors involved in governance to abide by and leave them to act within these rules. The second way is that the state may steer these actors by 'storytelling.' For the purposes, it may organise dialogues, create meanings, shape the beliefs and identities of the actors, as well as influence what they think and do. The third way is that the state may steer the actors by the way in which it distributes resources, such as money. Perhaps, the HSCA 2012 is an example of the first way of steering – rule setting. An example of the second way of steering may be the House of Commons Health Committee reports (HCHC 2010a, b; HCHC 2011a, b, and c) on PCT commissioning where expert evidence was sought from a wide range of experts – storytelling. An example of the third way of steering may be the creation of clinician-led CCGs – distribution of financial resources.

Coming back to the three waves of governance, according to Rhodes, the third wave consists of 'interpreting the changing state:'

> "An interpretive account of governance represents a shift of topos from institutions to *meanings* in action. It explains shifting patterns of governance by focusing on the actors' own interpretations of their *beliefs and practices*. The everyday practices arise from agents whose beliefs and actions are informed by *traditions* and expressed in stories. It explores the diverse ways in which situated agents are changing the boundaries of state and civil society by constantly remaking practices as their beliefs change in response to *dilemmas*. It reveals the *contingency* and contestability of narratives" (Rhodes, 2012, p. 39).

Further, Rhodes (2012, p. 40) notes that this third wave of governance has an "actor-centred or bottom-up approach" to explaining patterns of rules since, in the case of failings in existing patterns of rules for instance, a system's failings are not just given by one's actual experience, but are also constructed from one's interpretation of experiences infused with traditions. Thus, Rhodes brings up an interpretivist ontological element to the concept of governance. The concept of ontology, or worldview, will be introduced in more detail in Chapter 6.

### 2.2.4. The Coalition government's ideology: May 2010 – May 2015

The former Coalition government (Hickson, 2009; Painter, 2013) is the one that initiated and carried out the latest NHS reforms. This government consisted of the Conservative Party (right wing) and the Liberal Democratic Party (centre-right wing). As already noted in Chapter 2, prior to the Coalition government, the UK was ruled by the Conservative Party for 18 years (1979-1997) and by the New Labour Party for 13 years (1997 – May 2010). The Coalition government needed to prove itself quickly, so it acted quickly, suggests Timmins (2013).

Over the five days in May 2010 when the Coalition was formed, something important happened – it was not just the case that the Coalition government agreed to eliminate the deficit over a Parliament (twice as fast as New Labour had planned it), but it also agreed to fixed-term parliaments (*Ibid.*). This plan gave the Coalition only five years in which to govern, but possibly only five years in case the economy did not pick up, posits Timmins. Besides, the Conservatives had perhaps over-absorbed Tony Blair's statements in his autobiography that he had made the mistake of wasting his first term in office by not acting boldly enough on public service reform, observes the author. Thus, the Coalition became immensely bold in terms of public service reform and quickly,

> "launched the most ambitious programme for government since the Attlee administration of 1945. In three short years, the Attlee administration had introduced a national health service and a new social security system; nationalised the Bank of England and a clutch of utilities including coal and electricity … and built half a million new homes despite material shortages. The Coalition programme came close to matching that ambition. There was to be not just the NHS reform but a radical restructuring of tuition fees; the introduction of "free" schools … a major restructuring of the Financial Services Authority and the Bank of England; a merger of the Competition Commission and the Office of Fair Trading; elected police commissioners; more elected mayors; a big reform of public sector pensions; a new "localism" offering individuals new rights … and much else – all while eliminating the deficit, imposing by far the biggest cuts to government spending in living memory" (p. 46).

Again, as noted in the above quote, the most recent NHS reforms were not the only reforms quickly introduced by the Coalition government. These reforms are just one example of the many reforms adopted by the Coalition in its hopes to act fast, achieve results, and gain the public's trust. It seems like the 2008 world economic crisis, while creating 'windows of opportunity for significant policy change to take place' (Doetter and Götze, 2011), were not the only driving force behind the recent NHS reforms. Political drives and aspirations also lie at the heart of this important institutional change.

Before the NHS reforms, the Coalition Agreement of 2010 (HM Government, 2010) paid particular attention to the reduction of the deficit, European Union (EU) issues, civil liberties, pensions and welfare, and the environment. With regards to the environment, for instance, Timmins (2013) observes that the Coalition Agreement specified at least seventeen specific commitments, among which were the rollout of smart electricity meters and the creation of wildlife corridors that were meant to preserve the UK's biodiversity. Yet, the NHS, the biggest public service in the UK that consumes about £100 billion a year, or about a third of all departmental spending, received little, if any, attention in this agreement. The NHS got a little more than half a sentence in this agreement, "The parties agree that funding for the NHS should increase in real terms in each year of the parliament, while recognising the impact this decision would have on other departments" (p. 45).

The silence vis-à-vis any future reforms of the NHS during the pre-2010 elections campaign (Timmins, 2013), including the silence in the Conservative and Liberal Democratic parties' manifestos, was surprising considering the fundamental reforms proposed in the July 2010 white paper, *Equity and excellence: Liberating the NHS* (DH, 2010a). The Conservative party (the Tories) had even promised that if it were to win the elections, there would be no more disruptive and costly top-down reorganisations of the NHS (Timmins, 2013). Prior to the 2010 elections, the Tories had promised not to cut the NHS budget and to keep the NHS away from continuous 're-disorganisations' (Tallis, 2013). Within a few months of this promise, "the Coalition was boasting of the most radical shake-up of the service since 1948, the mother of all top-down reorganisations" (Tallis, 2013, Kindle p. 133).

The NHS reforms of 2010-2013 are mainly the workings of one man in particular – Andrew Lansley, a Conservative and the Coalition government's first Secretary of State for Health.[5] He had previously held the post of Shadow Secretary of State for Health under the New Labour government for an unprecedented six and a half years (Timmins, 2013). Lansley, the son of a pathologist, comes from a family of public servants: his first wife was a GP, while his brothers were a teacher and a policeman, the source notes. The young Lansley was the principal private secretary of Norman Tebbit, the man who had privatised British Telecom (BT) at the time. Tebbit, Timmins notes, was one of Lansley's personal heroes. Due to his experience with BT's privatisation, which was based on the ideas of free competition and markets, Lansley developed a preference for market forces, such as the privatisation of the energy sector (Jupe, 2012), as a solution to the issues facing the NHS. Before entering politics in 1990 as head of the Conservatives' research department, Lansley was a director of the British Chambers of Commerce (Timmins, 2013). At the Chambers of Commerce, he worked with the young David Cameron (the current UK Prime Minister (PM)) and George Osborne (the current Chancellor of the Exchequer and Second Lord of the Treasury), both of whom are also Conservatives. In the summer of 1992, Andrew Lansley suffered a minor stroke. His experience in the NHS at the time reinforced his genuine attachment to the NHS (*Ibid.*).

### 2.3. Overview of the NHS

The National Health Service (NHS) is the general taxation-funded, public healthcare service in the UK.[6] It is the biggest integrated (Crisp, 2011) and the largest publicly-financed healthcare system in the world (Asthana, 2011). The NHS in England alone serves 52.23

[5] Andrew Lansley's post was assumed by Jeremy Hunt in September 2012.
[6] In 2001 for example, 86% of the NHS revenue came from general taxation, 12% from national insurance contributions, and 2% from user charges (Maynard, 2005).

million of the total of 62.24 million (or 83.8%) UK population (Davies, 2012). The Scottish, Welsh, and Northern Irish NHS systems are managed separately[7] from the English NHS (Crisp, 2011). The annual budget of the English NHS exceeds £100 billion (*Ibid.*). All individuals living in England are entitled to NHS healthcare which is usually free at the point of access.

The NHS services in England alone are provided by a 1.35 million staff and an additional 159,000 staff work in local authority adult social services departments (NAO, 2013a). Just under a half of these 1.35 million staff is clinically qualified (Davies, 2012). According to the same source, the NHS deals with about one million patients every 36 hours and, in a typical year, the people in England visit GP practices 300 million times, make 19 million visits to Accident & Emergency (A&E), and make about five million calls to the NHS Direct telephone line (now called NHS 111). Besides, annually, there are about four million ordinary and day-case admissions to English hospitals and about 45 million outpatient appointments. Out of the total contacts per day, 51% (or 836,000) are GP or Practice Nurse consultations, 24% (or 389,000) are community, non-hospital contacts, 94,000 (or 6%) are in-bed, emergency admissions to hospital stays, 7% (or 124,000) are outpatient attendances, and 49,000 (or 3%) are A&E contacts (*Ibid.*). The UK spends less than the European average on healthcare as a percentage of its GDP, perhaps an indication of its efficiency. The 8.7% of GDP spent on healthcare in the UK in 2008 was less than what the French spent in that year (11.2%), what the Germans spent (10.5%) or what the Americans spent (16%). Nevertheless, this 8.7% of GDP was a significant part of national expenditure at the time (Crisp, 2011).

[7] The structure of the NHS is distinctive in the four constituent parts of the UK – England, Scotland, Wales, and Northern Ireland; yet, the NHS is based on common principles in all four nations (Davies, 2012).

Founded on 5 July 1948,[8] the NHS is a treasured symbol of pride and national unity (Llewelyn and Northcott, 2005) that is revered around the world. It is a national icon in the sense that it is by far the most popular of Britain's public services, "a jewel in the crown of welfarism … and very much the envy of billions of people around the world whose health services are less developed, less accessible, more expensive and more exclusive" (Lister, 2008, p. 1). Thus, the NHS was proudly featured during the opening ceremony of the 2012 London Olympics. Besides the NHS, there is a small private healthcare sector in England that provides services for which there are usually long waiting lists in the NHS (Gaynor, Laudicella and Propper, 2012). The private sector does not cover all the healthcare services that the NHS does; the private healthcare sector is highly specialised, mostly dealing with elective surgery. For example, about 20% of all varicose vein repairs, hernia surgeries, and hip-joint replacements and about two-fifths of cosmetic operations are privately financed. The private sector, according to the same source, does not deal with medical emergencies, the kind of cases which fill NHS A&E departments (Klein, 2005).

The NHS has its own constitution which establishes its principles and values and sets out patients,' the public's and staff's rights. According to this constitution, the NHS belongs to the people and has lofty aspirations:

> *[The NHS] is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most* (DH, 2013b, p. 2).

[8] More on the history of the NHS may be found in Doetter and Götze (2011), in Dr. Charles Webster's *The National Health Service: A political history* (Webster, 2002) or in Timmins (1995).

The *NHS Constitution* also lays out the pledges that the NHS commits itself to achieve and the responsibilities of the public, patients, and staff. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers, and local authorities are required by law to take into consideration the *NHS Constitution* while making decisions and taking actions (*Ibid.*). The *NHS Constitution* is renewed every ten years, while its accompanying handbook is renewed every three years. The *NHS Constitution* was last updated on 26 March 2013 (*Ibid.*).

The seven principles that guide the NHS in all that it does are: 1) that it provides a "comprehensive service, available to all," 2) that "[a]ccess to NHS services is based on clinical need, not an individual's ability to pay," 3) that the "NHS aspires to the highest standards of excellence and professionalism," 4) that it "aspires to put patients at the heart of everything it does," 5) that it "works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population," 6) that it is "committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources," and 7) that the "NHS is accountable to the public, communities and patients that it serves" (pp. 3-4). *The Handbook to the NHS Constitution* (DH, 2013a) clarifies each of these seven principles.

The NHS is not a stand-alone organisation. It is closely linked to the DH and to Her Majesty (HM) Treasury. The DH is responsible for the overall performance of the NHS and has broad responsibilities: it "sets the direction on promoting and protecting the public's health, taking the lead on issues such as environmental hazards to health, infectious diseases, health promotion and education, and the safety of medicines" (p. 5). The DH is also responsible for adult personal social services which are not part of the NHS. HM Treasury, on the other

hand, is the government's economic and finance ministry. It controls public spending and sets the direction of the country's economic policy, so that sustainable economic growth may be achieved.[9] Among other things, HM Treasury is responsible for public spending, including capital investment, the delivery of infrastructure projects in the public sector (for example, the building of new hospitals), and facilitating private sector investment in UK infrastructure projects.

### 2.4. Conclusion

From the above literature review, it becomes clear that the CCG reforms are not an isolated event. Ever since its creation, the NHS has been in the midst of various forms of governance, ideologies, party and individual aspirations. It would be hard to gain a better understanding of the subjects studied (GPs in CCGs) without this contextual information. Now that some important features of public sector reforms and ideologies – PA, NPM, NPG, and the ideology of the former Coalition government – and the NHS have been addressed, this research will turn towards another contextual chapter, Chapter 3, which will elaborate on some important aspects of the literature on acute healthcare commissioning, past and present.

[9] Available at: <https://www.gov.uk/government/organisations/hm-treasury/about> [Accessed 24 November 2013].

# CHAPTER 3
# REVIEW OF ACUTE HEALTHCARE COMMISSIONING IN THE ENGLISH NHS

## 3.1. Introduction

The aim of this chapter is to familiarise the reader with the specific institutional field studied in this research – acute healthcare commissioning in the contemporary NHS in England. This familiarity is important because in its absence, it would be difficult to understand the contributions to knowledge and understanding that this thesis proposes. The chapter starts with a definition of the terms 'acute' care and 'commissioning.' It then presents the 'old' (2005 – 1 April 2013) and 'new' (since 1 April 2013) commissioning systems in the English NHS. Afterwards, Clinical Commissioning Groups (CCGs), the particular healthcare commissioning organisations which this thesis focuses on, are presented in terms of governance, accountability, and support. Then, some key literature on the 'new' commissioning is reviewed, followed by a review of other key literature on prior forms of commissioning in the English NHS – GP fundholding and Practice-Based Commissioning (PBC).

## 3.2. Commissioning of acute healthcare in the English NHS

### 3.2.1. Definitions of 'acute' healthcare and 'commissioning'

This research examines the recent changes to the agency ultimately responsible for the allocation of significant financial resources from the DH, i.e. central government, to a local level within the 'acute' healthcare sector. This allocation is done, as it will be shown later,

through the process of ‘commissioning.’ ‘Acute’ healthcare, or simply acute care, according to the Health Foundation, is specialised medical care received in either an A&E hospital department or in a less urgent hospital setting following a GP referral to a specialist consultant (hospital physician or specialist). The referral may be for surgery, complex tests or other procedures that cannot be done in the community, i.e. outside of hospital. [10] The Health Foundation notes that the term ‘acute care’ is reminiscent of the acute or emergency phase of a patient’s condition in hospital before he or she moves on to community settings. Besides, the terms ‘acute,’ ‘secondary,’ and ‘hospital’ care are sometimes used synonymously for medical services carried out in a hospital by specialised staff (usually doctors and nurses) using specialised medical equipment.

It is important to distinguish acute care from mental health, primary (GP care or family practice), social (for the elderly, frail or disabled), ambulance or end-of-life (hospice) care. Acute care, the Health Foundation clarifies, usually provides treatment for a short period of time, until the patient is well enough to be supported in the community. The source also notes that about half of all patients treated in acute hospitals are emergency cases (unplanned care), while the remaining half are planned admissions (admitted either as day cases or with overnight stays), an option that usually requires a letter of referral from a GP. It is important to mention here that GPs in England do not work in hospitals; they work in GP practices, sometimes called ‘GP surgeries,’ as independent contractors of the NHS.

Acute care affects virtually everyone’s life – most of us are born in hospital, some of us are treated in hospital, many of us die in hospital. Storey, Bullivant and Corbett-Nolan (2011) rightly observe that healthcare’s governance is concerned with some of the most crucial

[10] Available at: <http://www.health.org.uk/areas-of-work/topics/acute-care/> [Accessed 10 July 2013].

questions in today's societies: who exactly should make decisions about the allocation of scarce resources across the whole healthcare system, should more money be allocated for taking care of the terminally ill than for those in A&E, should more money be spent on mental health and less money on cancer treatments, should local A&Es be closed down because a superior service is provided further down the road? These are the kinds of questions that 'commissioning' is meant to give answers to.

Before studying the recent changes to acute care commissioning, it would be necessary to first define the term 'commissioning.' The commissioning of healthcare services has been defined by the DH in the following way:

> "*understanding the health needs* [my emphasis] of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved *to decide what services* [my emphasis] will best meet those needs and *to design these services* [my emphasis]; *creating a clinical service specification* [my emphasis] that forms the basis for contracts with providers; establishing and *holding a range of contracts* [my emphasis] that offer choice for patients wherever practicable; and *monitoring* [my emphasis] to ensure that services are delivered to the right standards of quality" (DH, 2010a, p. 2).

Thus, the main elements of commissioning are the following. The first one is to assess the needs and develop a strategy for each health condition, group of conditions or client group within a local population of patients (HCHC, 2010a). This strategy, continues the above source, tries to determine what services are needed by the local population and the minimum standards these services should abide by. The strategy also tries to provide a framework for purchasing these services. The second element is to purchase the services via formal contracts between purchasers and providers. Public sector contracting and its challenges have been widely researched in the 1990s (Allen, 2002; Bartlett, 1991; Bennett and Ferlie, 1996; Rose

and Miller, 1992; Stewart, 1993) and also more recently (Petsoulas *et al.*, 2011). The third element is to monitor and evaluate these services.

Given the above definition, it is clear that commissioning is not simple. The commissioning process has been described as "complex and multi-stranded" (Jones and Lee, 2011, p. 92) and as involving strategic planning, procuring, monitoring, and evaluation (Quayle, Ashworth and Gillies, 2013), among others. According to HCHC (2010a), commissioners are to be advocates for their respective patients and communities by securing appropriate high-quality healthcare services; they should also be custodians of taxpayers' money by securing best value in the use of resources.

Healthcare commissioning requires extensive work with a variety of financial and non-financial reports, including budgets, a central concept in management accounting. Budgets, as noted by Wildavsky (1979), are financial constructs concerned with the translation of resources into a variety of human purposes: a budget may be described as a series of goals with price tags attached to them. Commissioning authorities work with devolved from central government budgets (Hughes, 2003), i.e. their budgets are allocated for various purposes at commissioning, i.e. local, level, rather than at central, DH, level. One of commissioners' main duties is to make sure that their expenditures do not exceed these in their allocated budgets (DH, 2010c).

The issue of who should handle commissioning has been a topic of debate in public management for a long time. Should commissioning be done by civil servants, by clinicians, or by both? Harradine, Prowle and Lowth (2011) observe that the place of clinicians in the

management of hospitals[11] has been an issue of concern since the birth of the NHS. According to these authors, different approaches have been tried to attract clinicians into management and budgetary processes in the past (for example, into specialty costing and clinical and management budgeting), but due to their role conflicts and the inadequacy of information systems, these attempts have often failed to progress or gain universal adoption until CCGs came to light.

### 3.2.2. Overview of the 'old' commissioning of acute healthcare: PCTs and SHAs (2005 – 1 April 2013)

The 'old' NHS system, i.e. the one preceding the recent NHS reforms, spanned from 2005 to 1 April, 2013. It is depicted in Figure 1. In the old system, the DH devolved resources and responsibility for the delivery of NHS services to Primary Care Trusts (PCTs). PCTs were created in 2002 and were overseen by Strategic Health Authorities (SHAs) (NAO, 2013a). In turn, PCTs devolved resources to providers, including NHS trusts and NHS foundation trusts (FTs), many of which operated acute hospitals.[12] PCTs and SHAs were the healthcare commissioners of acute and other care under the 'old' NHS system.

The DH allocated resources to PCTs based on the PCT local populations' estimated needs, while aiming to ensure equal access to healthcare and help reduce health inequalities (*Ibid.*). PCTs were "afforded a great deal of discretion" in the use of the funds allocated to them by the DH (Palmer, 2011, p. 69). Most of the entities in Figure 1 – the arms' length bodies, also

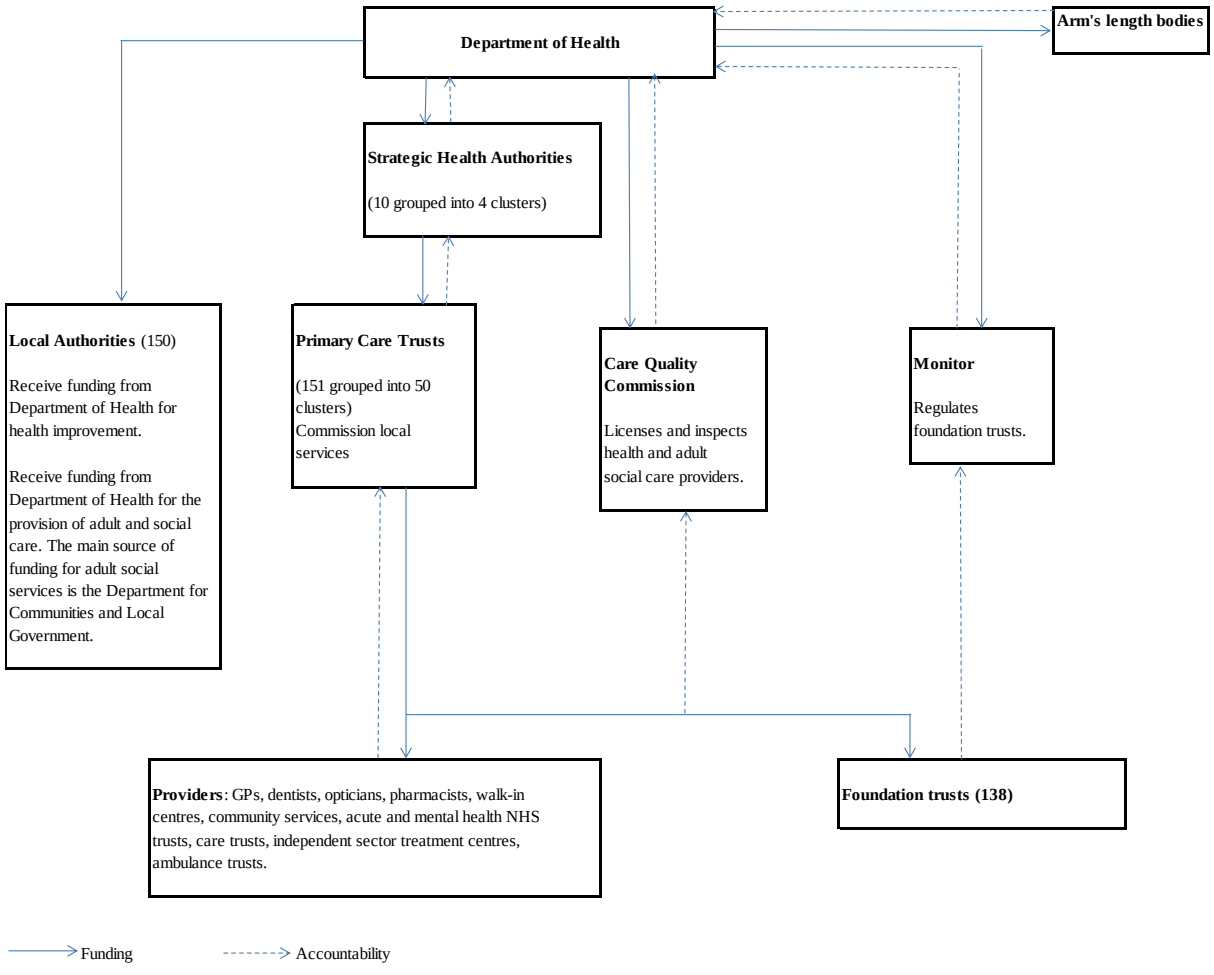
[11] It is difficult to say exactly how many acute hospitals are included in the English NHS because since 1992 hospitals have been administered by NHS trusts (and later also by NHS foundation trusts (FTs)). Each trust can encompass several acute hospitals (Pollock, 2004).

[12] NHS FTs, which are self-governing institutions, do not have a statutory duty to make a surplus in any given year (NAO, 2012b). NHS trusts, however, should show a three consecutive years' overall surplus. If not, under the 'old' NHS system, they used to receive financial support from their commissioners or directly from the DH.

called quangos, Monitor, the Care Quality Commission (CQC), and local authorities – are beyond the scope of this research and are included in Figure 1 for informational purposes only.

**Figure 1**

**The Department of Health's pre-1 April 2013 delivery network**




Adapted from: National Audit Office (2013a, p. 6)

The ‘old’ commissioners – PCTs and SHAs – were considered by many people, including the Coalition government, to be expensive and bureaucratic organisations. The manifestos of all three major political parties (Conservative, Liberal Democrats, and Labour) before the 2010 general elections focused heavily on cutting back on management costs and achieving efficiency gains (Timmins, 2013). This commentator sees in these cut backs an expression of one of most politicians’ ‘favourite pastimes’ – ‘bureaucrat bashing.’ The Conservatives, Timmins specifies, promised a 30% cut back in NHS administration costs, or a £4.5 billion cut. Labour, on the other hand, promised to cut the NHS red tape and make the £20 billion of efficiency savings required by the so-called ‘Nicholson challenge.’ Explaining how exactly administration costs would be cut was missing from the three manifestos, writes Timmins. The Liberal Democrats’ manifesto intended to cut by half the size of the DH, to scrap SHAs, and to replace PCTs with elected local health boards.

The idea of cutting down on NHS administration costs is not new. The policy document, *Creating a patient-led NHS: Delivering the NHS improvement plan* (DH, 2005) intended to move funds away from management and towards ‘front line’ services by reducing the number of PCTs, SHAs, and other NHS bodies (HCHC, 2010a). It was decided in May 2006 to reduce the number of PCTs from 303 to 152, specifies the same source. In October 2006, new chairmen and chairwomen were appointed to these new, less numerous PCTs.

Commissioners and providers (usually hospital trusts and their hospitals) in the ‘old’ NHS showed a variety of financial performance. In its report, *Securing the future financial sustainability of the NHS* (NAO, 2012b), the NAO points to the fact that in 2011-12 most commissioners (SHAs and PCTs) declared a surplus: all 10 SHAs declared a surplus, while

only three of the 151 PCTs declared a deficit. The combined deficit of these three PCTs was £49 million, while the combined surplus of the remaining 148 PCTs was £571 million.

Another important point to note regarding the 'old' commissioners is that some of them would give financial support to their provider trusts and FTs in case these trusts experienced financial difficulties, such as deficits: "Any assessment of the underlying financial sustainability of the NHS, however, must also recognise that SHAs and PCTs agreed non-recurrent funding to some trusts: direct financial support to increase income; and other non-recurrent funding, including support for transitional costs or business changes" (p. 8).

This NAO report (NAO, 2012b) concludes that without direct financial support from the DH or from commissioners, some NHS trusts, FTs, and even some PCTs would not have broken even, would have reported a larger deficit or would have had a smaller surplus in 2011-12. The report estimates that SHAs and PCTs provided £151 million in additional revenue to NHS trusts and £10 million to FTs in 2011-12. It shows that without a 'one-off' direct support, fifteen more NHS trusts might have posted a deficit in 2011-12. The report also identifies seven PCTs that might have reported a deficit for 2011-12 if they had not received additional resources from their SHAs or if they had not benefited from reallocations between PCTs within the same PCT cluster, reallocations totaling £89 million.

One criticism that the 'old' commissioners used to receive was the ease with which they helped financially their troubled providers. Some PCTs had agreed to make advance payments of amounts due to trusts under contracts in 2011-12 (*Ibid.*). Some of these trusts had needed the advance payments to manage cash flows and to pay creditors, notes the NAO report. Besides, according to the report, some PCTs waived fines for providers who failed to

achieve infection targets: rather than levying penalties, these PCTs expected trusts to use the saved money to improve their performance in these areas. Commissioners also agreed payments to trusts to reflect increased work, i.e. activity, in cases where measures to reduce referrals from primary care or emergency admissions had not been in place.

It is not just commissioners, but also the DH itself, that helped some provider trusts:

> "[T]he Department provided injections of cash to some trusts, in the form of public dividend capital, to strengthen the balance sheet, provide working capital or cover cash shortages resulting from deficits. All financial support is intended to help maintain services for patients, and is conditional on plans for recovery to a more sustainable position" (NAO, 2012b, p. 8).

Some commentators note that commissioning had become "an end in itself, rather than a means to better patient care" (Light and Connor, 2011, p. 821). This perceived ineffectiveness of the 'old' commissioning system was probably caused by the numerous top-down reorganisations of the NHS. Partly because of their central role in the NHS, PCTs were constantly subject to criticism; scarcely a week passed by without the uncovering of new PCT failings (HCHC, 2010a). For example, data inadequacies and disagreements about measuring quality (Bennett and Ferlie, 1996; Ranade, 1995) were among the factors that hindered effective contracting in the public sector in general and in PCTs in particular (Devlin, 2010). Besides poor data, skills deficit was another perceived reason for the failings of PCTs. According to Light and Connor (2011), policy leaders from Parliament, the King's Fund, and the Nuffield Trust issued detailed reports on the ineffectiveness of what is now the 'old' commissioning. Most of these reports, observe the authors, note how PCTs lacked the skills and resources, purchasing power, and appropriate data to commission effectively. Devlin (2010, p. 1075) observes:

> "Primary Care Trusts … the main budget holders in the NHS, are viewed by some as having been unable to use their commissioning role to drive improvements in technical and allocative efficiency … A recent House of

> Commons Health Committee report … concluded that many PCTs were passive; attributing weaknesses to a lack of skills and clinical knowledge ... Others … suggest that PCTs simply were not given a fighting chance, and could not match the power of hospitals and other NHS providers."

The idea that commissioners were not given a fair 'fighting chance' compared to hospitals, as mentioned above, is supported by Light and Connor (2011, p. 821): "[T]he government gave more power, higher salaries, and greater freedoms to the hospitals" than to commissioners in the early days of commissioning. In the later days of PCT commissioning, write Light and Connor, ministers still did not understand that "commissioning bodies need[ed] to attract top talent, have excellent data on how well providers perform, and have significant purchasing power in order to reward providers" (*Ibid.*).

### 3.2.3. Overview of the 'new' acute healthcare commissioning: CCGs (since 1 April 2013)

Figure 2 summarises the structural changes introduced by the HSCA 2012,[13] i.e. the 'new' NHS. It is important to note here that the recent changes to acute commissioning, as well as other changes introduced by this Act of Parliament, are not a matter of simple policy, but of legislation. Legislation is a law passed by Parliament which, according to Rose and Miller (1992, pp. 189-190), "translates aspects of a governmental programme into mechanisms that establish, constrain, or empower certain agents or entities and set some of the key terms of their deliberations." Thus, the HSCA 2012 is both an obstacle ('constraint') and a vehicle of 'empowerment' to the actors and entities involved in commissioning.

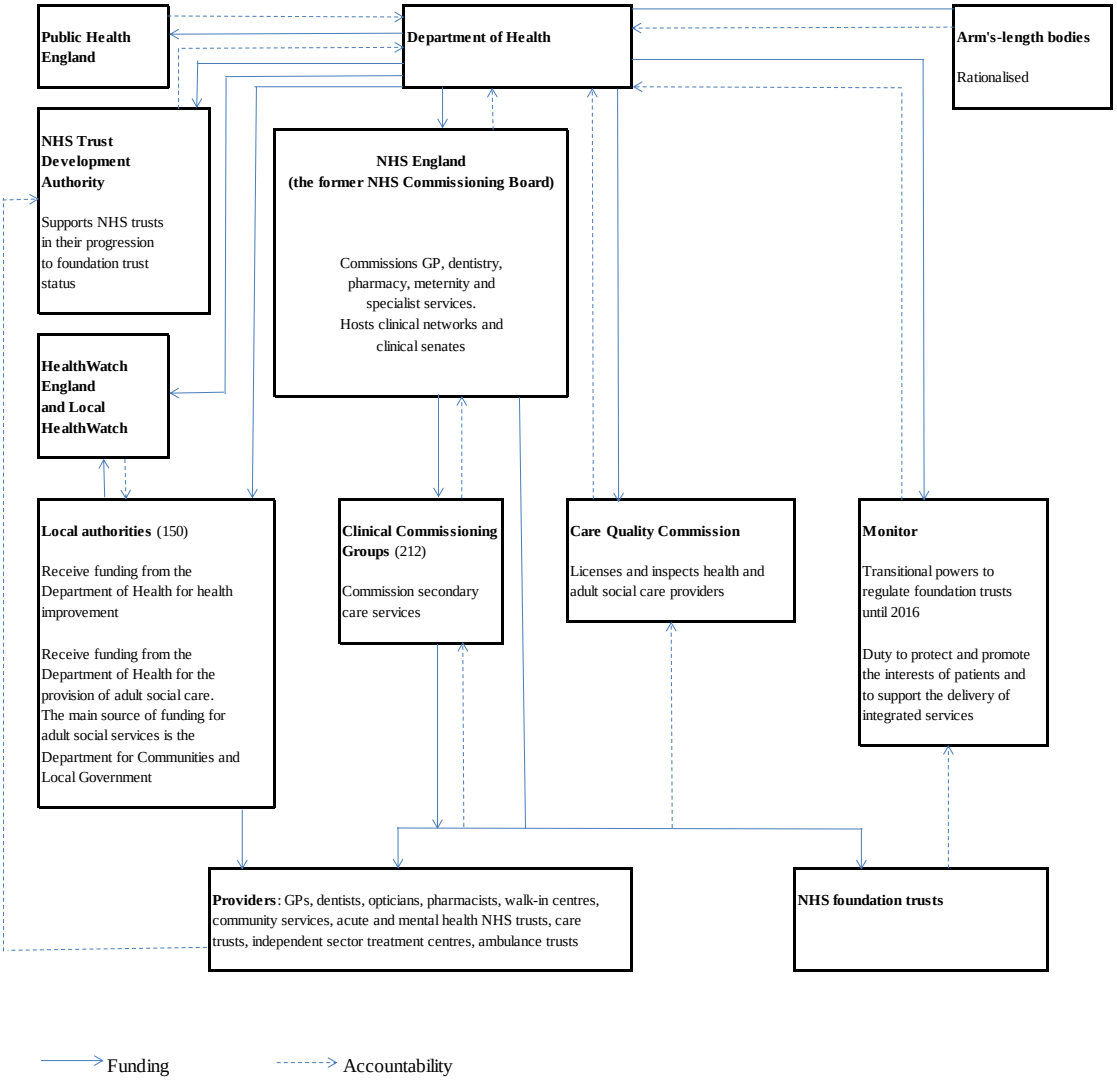
[13] For more on the HSCA 2012, please consult: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> [Accessed 2 September 2013].

On 1 April 2013, the ‘old’ system of commissioning healthcare, including acute care, changed fundamentally: the PCTs and SHAs ceased to exist, so that “layers of excessive bureaucracy” could be slashed and so that it might be “down to front-line medical professionals to structure services around what works best for patients” (Asthana, 2011, p. 816). The abolition of SHAs and PCTs was meant to reduce NHS management costs by about 45% (Asthana, 2011; DH, 2010a, b). The responsibility and resources for commissioning acute care, as well as most other types of care,[14] except specialised and primary care which are commissioned at a national level by NHS England, passed from the 10 SHAs and 152 PCTs to the 211 new CCGs, the ‘new’ acute care commissioners.

[14] CCGs currently commission: community health services, maternity services, elective hospital care, urgent and emergency care, including ambulance and out-of-hours services, older people’s healthcare, children’s healthcare, rehabilitation, mental healthcare, healthcare services for people with learning disabilities, continuing healthcare, and infertility services (Davies, 2013). Acute care is just one, but very costly, service that CCGs commission (see also Naylor and Goodwin, 2011).

**Figure 2**

**The Department of Health's post-1 April 2013 delivery framework**




Adapted from: National Audit Office (2013a, p. 8)

The 211 CCGs comprise of GPs, nurses, allied health professionals, pharmacists, and other health professionals, but mostly of GPs.[15] For 2013-14 alone, the DH had granted the NHS in

[15] When the recent reforms were first proposed, CCGs used to be called GP-led consortia (Holbeche, 2011). This name was later changed to CCGs, following advice from the NHS Future Forum 2011, to reflect the fact that professionals other than just GPs, such as nurses, are also part of these consortia (Storey and Grint, 2012). See also Davies (2013).

England £95.6 billion, 68% of which had been passed to CCGs (Davies, 2012; NAO, 2013b). The resulting £65 billion handed down to CCGs is a sum that is close to the Gross Domestic Product (GDP) of Morocco (Belfiend, 2012). Therefore, CCG commissioning is worth studying from an accounting point of view – these statutory entities are authorised to handle a very significant amount of money every year (billions, not just millions). Over 40% of the NHS expenditure (NAO, 2011), i.e. about £38 billion, is accounted for by acute care trusts. Thus, acute care commissioning is important to study in view of the material proportion of the NHS expenditure that it consumes, as already noted in Chapter 1.

One of the other important changes to the 'old' NHS is that the NHS Commissioning Board (NHSCB) was established in October 2012. On 1 April 2013 however, this board was renamed to NHS England. NHS England provides leadership to the whole new NHS commissioning system, including the new CCGs (NAO, 2013a). It has four regional offices and 27 Local Area Teams (LATs). The CCGs are currently supported and held to account by NHS England and placed under the regional offices and the LATs (NAO, 2013b). Davies (2012) observes that NHS England, an independent arm's length NHS body, is directly accountable to Parliament for the outcomes of the NHS. The HSCA 2012 designates the Chief Executive of NHS England as its Accounting Officer, a designation which contrasts with the practices of other arm's length bodies' – their Accounting Officers are appointed by the DH's Accounting Officer (NAO, 2013b).

According to the same source, the most recent NHS reorganisation has cost the NHS £1.1 billion up to 31 March 2013, while 10,094 full-time equivalent members of staff have been made redundant due to the reforms. One hundred and seventy NHS organisations have closed down, while 240 new NHS organisations have opened up. The average redundancy payment

has been £43,095, while £95.6 billion have been granted to NHS England for 2013-14 alone. Moreover, £2.4 billion has been the DH's estimate of savings in administration costs as a result of the reforms up to 31 March 2013. Sky News (2013) remarks that over the past three years, more than 32,000 NHS managers have received exit packages. Of these, 330 have received payoffs of more than £200,000 each and just under 2,000 have received payoffs between £100,000 and £200,000 each. These figures, notes the source, came in the same week that the NHS workforce statistics showed that the number of nursing jobs lost since the election in 2010 had been over 5,000.

#### 3.2.3.1. Governance of CCGs, including clinicians' involvement

When should we stop funding cancer care for those who are terminally ill but might treasure a few extra months with their families? Dilemmas like this are within the scope of healthcare governance (Storey, Bullivant and Corbett-Nolan, 2011) and commissioning in particular. Each option will attract advocates and opponents. So, 'Who should decide and how?' ask the authors. Should the timing of funding cancer care, for example, be decided by: the DH, civil servants, clinicians, patients, and/or the local community?

More than 90% of patient contacts in the NHS are said to occur in primary care via GP consultations.[16] Except in emergencies or with specialist referrals, patients in England usually see their GP first (Hausman and Le Grand, 1999). "Modern political rationalities and governmental technologies" are linked to "the powers of expertise," remind Rose and Miller (1992, p. 173). Besides, GPs are seen as "general health experts with strong links to their local populations and a good degree of trust within their local communities" (Geyer, 2013, p.

[16] Available at: <http://www.bmj.com/content/348/bmj.g2408/rr/692631> [Accessed on 23 March 2015].

49). All these are reasons why GPs are considered by many to be ideally placed to understand the healthcare needs of their catchment areas. Clinicians are the conventional health experts, although patients also have undergone a certain 'proto-professionalisation' or 'medicalisation' (De Swaan, 1988; Dent and Haslam, 2006), i.e. in today's information age, patients have learned how to communicate to their doctors what problems they experience using medical vocabulary and knowledge found online.

In the 'new' NHS, the governance arrangements within CCGs may be described in the following terms:

> *"All CCGs will be required by law to have a governing body, the main function of which will be to ensure that the CCG has in place appropriate arrangements to exercise its functions effectively, efficiently and economically, and that it complies with such generally accepted principles of good governance as are relevant to it. The governing body will include at least one registered nurse, a specialist doctor and two lay members – one of whom will have a lead role in overseeing key elements of governance, such as audit, remuneration and managing conflicts of interest"* (DH, 2012, p. 9).

Geyer (2013, p. 49) purports that GPs have usually acted as patients' advocates and that GP-led commissioning would respond to "increasing demands for greater localism and autonomy within the English NHS." Clinical commissioning would also "shift decision-making as close as possible to individual patients" (Asthana, 2011, p. 815). Harradine, Prowle and Lowth (2011, p. 55) find out in an empirical study that a clinical manager is able to "make savings within his clinical specialty of approximately £200,000 per annum. These savings were from adjustments to workload planning and additional payment rates." While making savings may often seem to be a promising side of clinical involvement in management (and commissioning), based on the above study, Gridley *et al.* (2012) question the assumption that GPs are best placed to commission in ways that meet quality standards and lead to equitable outcomes. These commentators note that "[t]here is little evidence to suggest that GPs will

succeed where others have failed and a risk that, without top-down performance management, service improvement will be patchy, leading to greater, not reduced, inequity" (p. 87).

Geyer (2013) is aware of the fact that there are both pros and cons to GP commissioning: it could align clinicians' financial and clinical responsibilities, encourage decentralisation, promote local accountability, and enable GPs to shape the healthcare system to better serve patients. At the same time, Geyer writes that among the cons of GP commissioning could be: an increase in local variability of health outcomes (post code lottery), the growth of inappropriate relationships between commissioning GPs and large providers, such as pharmaceutical companies, who have a clear financial interest in influencing commissioners' decisions, threats of lawsuits around complex commissioning contracts, a loss of the traditional GP culture, etc. Richardson (2013), among others, is also skeptical of GPs' dual commissioner-provider role, i.e. of their conflict of interests in the new system. In other words, GPs have to provide primary care and at the same time commission (buy) secondary (hospital) care for their patients. Wouldn't this dual role of purchaser and provider incline GPs toward adjusting their referral practices to secondary, including acute, care in such ways that would seem the most financially convenient to them?

#### 3.2.3.2. Accountability of the new acute healthcare commissioners

The topic of accountability has received a lot of attention in the accounting, management, and sociology literatures (Almquist *et al.*, 2013; Armstrong and Tomes, 1996; Butler, 2005; Cochrane, 1993; Dubnick, 2005; Goddard, 2005; Hodges, 2012; Hoskin, 1996; Jönsson, 1996; Laughlin, 1996; McKernan and McPhail, 2012; Messner, 2009; Mulgan, 2003;

Sinclair, 1995; Smyth, 2013). Yet, this thesis does not address the topic of accountability in detail due to having a different focus. The new upward and downward accountability relationships within the English NHS, legislated by the HSCA 2012, are innovative and complex (Baker, 2013). In *Department of Health: Accountable Officer system statement* (DH, 2012) for instance, the former Accounting Officer of the NHS, Sir David Nicholson, first describes his own accountability to Parliament, as Permanent Secretary and Principal Accounting Officer, and shares that he is accountable to Parliament for the appropriate stewardship of the resources allocated to the NHS. Under the 'new' NHS, the post of NHS Chief Executive no longer exists: Sir David Nicholson became the Chief Executive of NHS England instead. His current successor is Simon Stevens. The Chief Executive has sole Accounting Officer responsibility in the DH for the proper and effective use of resources voted by Parliament for the NHS. This top level accountability is described in the above DH document (p. 6):

> *"Under the new system … most day-to-day operational management in the NHS will take place at arm's length from the Department. [This distancing of the DH from the various NHS bodies] … is intended to empower front-line professionals … [and] will reduce the Department's direct involvement in operational decision-making."*

Both NHS England and CCGs are held to account under the 'new' system in the following manner:

> *"The NHSCB will in turn appoint and hold to account the Accountable Officer of each CCG. Accountable Officers will be responsible for the stewardship of resources within each CCG, ensuring that the organisation complies with its duty to exercise its functions effectively, efficiently and economically … As the NHSCB Accounting Officer will be accountable for the entire NHS commissioning budget, he will prepare a set of annual accounts which consolidates the accounts of the NHSCB itself with the individual accounts of all CCGs … Both the accounts and the governance statement will be consolidated into the Department's annual report and accounts … [T]he NHSCB will be audited by the National Audit Office, like the Department and other ALBs [arm's length bodies]"* (pp. 8-9).

There are strict accountability relationships between CCGs and NHS England. NHS England has a number of ways to satisfy itself (and the DH) on how CCGs discharge their responsibilities and ensure that they act with regularity and propriety, while providing value for money in the services they commission from providers (DH, 2012). Some of NHS England's levers of accountability assurance include: 1) a Commissioning Outcomes Framework developed to provide transparency and accountability about the quality of services that CCGs commission; 2) the on-going assurance of CCGs which is done via an annual performance assessment that looks at how well CCGs have met their financial and other statutory duties; 3) a requirement for CCGs to publish an annual report with information about how they have discharged their functions; and 4) powers of intervention in case a CCG is unable to effectively fulfill its duties (*Ibid.*; Davies, 2013). While organisations are being held accountable for the actions taken in their name in all sectors, in the public sector collective accountability usually attaches itself to the executive government and sometimes to specific governmental agencies, especially if these agencies are independent statutory bodies (Mulgan, 2003), such as CCGs.

#### 3.2.3.3. Commissioning Support Units (CSUs)

Commissioners, under the 'new' NHS are given the option to work with commissioning consultants. NHS England started by hosting 19 Commissioning Support Units (CSUs)[17] whose role was, and still is, to help CCGs by carrying out various functions, grouped into service lines,[18] such as: service redesign, contract negotiations, management and monitoring,

[17] CSUs were previously called Commissioning Support Services (CSSs) (Davies, 2013).

[18] CSUs could exercise functions that were categorised into seven service lines during the early stages of the CSU assurance process. These service lines are now thirty (Williams, 2012a): business intelligence (such as data

information analysis, and risk stratification (Davies, 2013). CSUs' involvement in service redesign[19] may be limited to an advisory or communications capacity, but it may also be extended to engagements in the redesign of healthcare services (Thiel, 2013). The redesign of healthcare services and care pathways is hoped to lead to significant cost savings in the long run since providers can make efficiency savings (achieve the same or better outcomes with the use of fewer resources) by reducing their costs or by redesigning care services (NAO, 2012a).

The idea of using commissioning consultancy is not new: the former commissioners, PCTs and SHAs, also had the option to hire the services of consultants. If a CCG hires the services of a CSU, the ultimate accountability for the quality of services received still rests with the CCG, not with the CSU. CCGs are under no obligation to use the services of CSUs: commissioning work may be retained in-house (within a CCG), shared with another CCG or delegated to a CSU (Williams, D., 2013). These three different options and the risks associated with each are explored in Williams, J. (2013). According to this author, the NHSCB's 'model constitution' framework for CCGs, first published in April 2012 and superseded by the so-called 'model constitution' for CCGs in October 2012, explains further these three options.

CCGs and CSUs are currently linked contractually by Service Level Agreements (SLAs). The *Health Service Journal (HSJ)* found that some CCGs opposed disclosing their SLAs for reasons of commercial confidentiality. Some commentators are of the opinion that while

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management and integration), business support (such as legal services, HR, and finance), clinical procurement, and communications services, among others (Williams, 2012b). These services follow the NHSCB's assurance process guidelines.

[19] An example of a service redesign would be a change in the way health conditions (for example, diabetes) are treated.

confidentiality issues in the NHS are not new, resorting to closed doors appears to go against greater accountability and transparency in the commissioning function (Thiel, 2013). Besides, one should not forget that national and EU laws apply to commercial confidentiality. Another critique towards CSUs, besides the one on the danger of reduced accountability and transparency, is the high cost of commissioning consultancy. Light and Connor (2011, p. 822) write,

> "With exceptions, expert commissioners and contractors will have to be hired from external consulting organisations that charge £400 an hour and shift control of the NHS into for-profit hands. Thus "commissioning" will be defined by corporate agents in diverse ways with much less accountability than national targets, tariffs, and guidelines imply."

It is still too early to tell what the future of CSUs will look like – whether they will continue to be hosted by NHS England or whether they will be opened up to privatisation, a process called 'externalisation,' which was recently pushed further in the future for practicality reasons. There have already been several cases of CSU mergers (Welikawa, 2014).

### 3.3. The 'new' commissioning in the literature

Over the past 20 years, the NHS has experienced many major reorganisations. Depending on one's definition of the word 'major,' there has been at least one such reorganisation per year (Geyer, 2013). Every new Minister of Health, continues Geyer, announces how he will solve the NHS's problems with a brand new reorganisation of some type. This tendency toward centralised reorganisation is amplified, according to the author, by critical and sensationalist UK mass media that revel "in exposing NHS incompetence, waste and mistakes (and the accompanying human tragedy) and … [demand] instant answers, responsibility, change and, if possible, retribution" (p. 50). Thus, the newest changes to commissioning are not a stand-

alone reorganisation. Their roots go back more than 20 years, not just in the history of the New Labour government, but also in this of the Conservative government (Timmins, 2013).

The commissioning function, including the commissioning of acute care, has attracted the attention of academics both during the old, and the new NHS. A short review of the literature on previous commissioning reforms will follow later. Commissioning in the new NHS has been examined in: Asthana (2011), Currie *et al.* (2012), Devlin (2010), Geyer (2013), Guven-Uslu (2012), Petsoulas *et al.* (2011), Quayle, Ashworth and Gillies (2013), Robinson *et al.* (2011), and Whitehead, Hanratty and Popay (2010), among others. It was the American Alain Enthoven's original idea to have all doctors share the responsibility for shared budgeting and for organising integrated care (combining acute and social services, for example), following the lead of the US healthcare company, Kaiser Permanente (Light and Connor, 2011). GPs and other clinicians, as the commissioning leaders of the reformed NHS, are the focus of several recent academic studies (Asthana, 2011; Devlin, 2010; Martin and Learmonth, 2012; Storey and Grint, 2012). Most of these studies do not belong to the accounting literature *per se*; therefore, a discussion of GP-led commissioning would fill a significant gap in this literature.

It has been claimed that in today's complex world, leadership is increasingly conferred not just to those who hold positions of formal power, but also to clinicians, patients, and even the public (Martin and Learmonth, 2012). The topics of leadership in GP-led commissioning are further elaborated in Storey and Grint (2012). Drawing on the distinctions they establish between leadership and governance, Storey and Grint conclude that in the reformed system, GPs will be expected to undertake certain elements of 'leadership' and certain elements of 'governance.' Three functions of leadership are presented by the authors – vision/direction

setting, mobilisation, and scapegoating. With respect to the first function, vision and direction setting, GP leadership will doubtlessly be sought to help endorse the efficiency savings of £15-20 billion that were recently announced by central government (the 'Nicholson challenge'), note the authors. In exercising this first function of leadership, GP-led CCGs will be aided by NHS England. GPs will exercise the second function of leadership by mobilising their peers. This way, the traditional, prevailing role of GPs as independent contractors of the NHS who exercise autonomous clinical judgement on a patient-by-patient basis will give way to a collective judgement about effective administrative/clinical practice and priorities within CCGs, write the authors. Vis-à-vis the third function of leadership, scapegoating, the authors predict that GPs will turn into scapegoats when things go wrong, given that patients and the public tend to complain intensely about dismantled or reduced services. Yet, GPs will exercise an enhanced leadership role by virtue of being responsible for spending the bulk of the NHS budget – more than £80 billion per annum – on acute and other services.

> "Holding the purse strings in this manner means there will be a strong expectation that they [GPs] must spend far more time than currently in helping to envision new and more effective care pathways ... They can no longer be mere service deliverers" (p. 270).

Three functions of governance – 1) legitimation, 2) conformance and performance monitoring, and 3) regulation/accountability – are also presented by Storey and Grint (2012). Regarding the first function of governance (legitimation), GPs are expected to justify the new healthcare services redesign and priorities from a legitimation point of view. As to the second function of governance (monitoring), this function will be needed as GPs monitor new developments in commissioning, write the authors. The third function of governance (regulation/accountability) will continue to be present within GP-led CCGs due to the newly-legislated regulation and accountability relationships presented earlier in Figure 2.

Besides through leadership and governance theories, CCG commissioning has been analysed in the literature through complexity theory. Geyer (2013) uses a modified Stacey diagram to compare the situation of GPs before and after CCG commissioning. He finds out that the position of GPs before the introduction of CCG commissioning was relatively stable and orderly, in the sense that much of GPs' daily activity was well structured, stable, and repetitive: patient flows were relatively stable, salary rates were established through a structured bargaining process, and so on. Yet, due to CCG commissioning, GPs would move closer to the complexity zone of the modified Stacey diagram, finds Geyer. The reasons behind this shift are the increasingly political and judgemental role that CCG commissioning implies and the increased uncertainty of CCG-commissioned outcomes, posits the author.

From a collaborative business relationships perspective, Quayle, Ashworth and Gillies (2013) use case studies from the criminal justice and IT outsourcing sectors to study the nature of commissioning relationships in the English NHS post-1 April 2013. The case studies look at how BS11000 (a collaborative business relationships framework) is meant to support business relationships. The research shows that business relationships are often too reductionist in nature and based on simple contractual relationships. The authors suggest that "a richer more collaborative business relationship is required for effective provision of services" (p. 18). Even if CCG business relationships are characterised by a spirit of collaboration, the switch to CCG commissioning may "undermine … one of the key mechanisms by which the NHS strives to ensure access to a full range of services wherever people live" (Whitehead, Hanratty and Popay, 2010, p. 1373). This is sometimes referred to as 'the post-code lottery.[20]' While PCTs were responsible for whole populations living in

[20] This 'post-code lottery' clashes with the promise for a greater flexibility in what kinds of health services are available locally and with the national consistency in the access to the same quality taxpayer-funded services for all. The recent NHS reforms are not the first NHS reforms that "confront the trade-off between localism and centralism" (Devlin, 2010, p. 1076).

defined geographical areas, the authors note, CCGs are only responsible for patients registered with specific health services:

> "The White Paper abandons this population based principle – the basis for commissioning by the GP Consortia is for registered patients only, within amorphous and ill-defined boundaries. The ability to plan for the proper geographical distribution of services for communities and local populations will be lost. The incentive to invite practices with easier-to-serve catchment areas to be members (the so-called perverse incentive of "cream-skimming"), and avoid practices in unprofitable catchment areas and in areas with patients who are more sick, will increase with the introduction of commercial organisations to support commissioning, because their priority will be profit" (Whitehead, Hanratty and Popay, 2010, p. 1373).

A commissioning expertise deficit and a lack of interest in commissioning among GPs are not the only risks confronting the new NHS. In line with Devlin (2010), Asthana (2011) sees a lack of appetite among the British public and GPs for such a radical market reform. She identifies a number of unintended risks (large transitional costs and organisational turbulence) resulting from a further NHS reorganisation and sees a potential financial risk in the proposed at the time NHS reforms. She shares the view that in order to reduce the potential for financial risk, CCGs would have to merge to the size of the former PCTs (an outcome which would raise the question about the whole purpose behind this reorganisation) or enter into complex and perhaps costly risk-sharing arrangements with other CCGs. This "reinventing the wheel" (Asthana, 2011, p. 818) would mean that democratic accountability would be compromised given the large resources spent on the reforms.

Similarly to Asthana (2011) who questions the democratic accountability of the NHS reforms, Tallis (2013, Kindle p. 144) calls these reforms a "blatant deception … [and a] contempt for the electorate." Tallis writes about the passage of the *Health and Social Care Bill 2011* (HSCB, 2011) to the statute book in April 2012 and observes that it became law

because good men did nothing or, with a few exceptions, very little to oppose it. This delivery of the,

> "planned destruction of the NHS says something shocking – about the condition of the nation … the debased state of the national conversation about matters of supreme importance, and the marginalisation of professionals who, when faced with the greatest threat for generations to the institution and the values for which they claimed to stand, in most cases preferred appeasement to confrontation" (Tallis, 2013, Kindle pp. 149-150).

The same source, on Kindle p. 125, calls the HSCB (2011) "a toxic bill that few had foreseen and no one other than its proponents saw as desirable … had got on to the statute book." Now that the reforms have been legislated, they need to be abided by, like any other law. There are indeed some attendant risks in giving more decision-making power to frontline clinicians and patients (Devlin, 2010). Devlin states that,

> "encouraging patients to think of the NHS as having a duty to offer unlimited choices of where and how to be treated will, in a budget-constrained NHS, result in disappointment" because "[n]ot all effective treatments can be afforded: GPs have been passed the poisoned chalice of reconciling demand and supply, and the way they engage patients and the public in prioritising spending" (p. 1076).

Healthcare reforms are hard to enact because the influence of institutionalised working practices often makes the envisaged changes elusive (Lockett *et al.*, 2012). The creation of new roles as a result of healthcare reforms, for instance, tends to threaten the power and status of élite professionals, such as clinicians (Currie *et al.*, 2012). This threat may be exercised, in the authors' opinion, through a substitution of élite professionals' labour. Currie and colleagues draw on eleven case sites from the English NHS where newly introduced nursing or medical roles have been found to threaten the power and status of specialist doctors. One of the key observations of their article is that élite professionals respond to

changes to their roles in such a way as to supplant threats of substitution with the opportunity to delegate routine job tasks to other actors. Besides, these professionals strive to maintain any existing resource and control arrangements in ways that enhance their status. It would be interesting to see whether clinicians feel that the recent commissioning reforms threaten their professional status or not.

Devlin (2010) doubts whether, overall, the new commissioning system would be conducted in a more cost-effective way by the more numerous CCGs (211) than by the 152 former PCTs. He acknowledges that some GPs may welcome their new role in commissioning, but also thinks that it may be more likely that CCGs would delegate their commissioning tasks to CSUs, to discharge these tasks on their behalf. Devlin observes that shifting from NHS-employed to CCG-employed commissioners does reduce NHS administration staff and costs but only by shifting these costs to CCGs.

### 3.4. Prior forms of commissioning in the literature

As noted earlier, the NHS in England has been experiencing quick and multiple structural changes (McMurray, 2007). On the average, there has been about one such change every two years, to the point that "organisation, re-organisation and re-disorganisation" could have become emblematic of the NHS (Timmins, 2013, p. 16). The commissioning function has mirrored this trend. There have been several attempts to devolve commissioning to the clinical level, prior to the CCG reforms (Naylor and Goodwin, 2011). Detailed accounts of the history of commissioning may be found in HCHC (2010a) and Timmins (2013).[21]

[21] Timmins' study is a study in government, the Coalition government's politics in particular. Although the reforms are widely known as 'Lansley's reforms,' the actions of both governing parties, the Conservatives and the Liberal Democrats, have had a deep impact on the unfolding of events and the shape of the changes (Timmins, 2013).

### 3.4.1. The period 1948-1991

In the early years of the NHS, an entirely nationalised healthcare system was established in which secondary care was provided by NHS-owned hospitals, while primary care was provided by independent GPs, independent contractors of the NHS (HCHC, 2010a). The period between 1948 and 1974 was a period of stability that experienced no material changes (Timmins, 2013). From the mid-1970s onwards, one could observe a pronounced need to limit the public expenditure growth within the NHS: how to make the NHS more efficient became a priority (HCHC, 2010a). Due to the absence of market mechanisms in the UK healthcare system, a system provided and financed mostly by the government, there was no natural pricing mechanism in the NHS through which the supply of healthcare could be efficiently matched to the demand thereof (Donaldson, Gerard and Mitton, 2005).

In 1989, the absence of such pricing mechanisms led to the most important cultural shift since the birth of the NHS – the so-called 'internal market' established by the Conservative government (HCHC, 2010a). How the internal market would work was outlined in Kenneth Clarke's[22] January 1989 white paper, *Working for patients* (DH, 1989). One year later, in 1990, this white paper was passed into law as the *NHS and Community Care Act 1990*. The changes took effect in 1991. In theory, claim Donaldson, Gerard and Mitton (2005), the lack of market mechanisms in healthcare may be overcome by 'quasi-markets'[23] or 'internal

[22] Kenneth Clarke was the Secretary of State for Health at the time.

[23] The word 'quasi' is used because it is hard to subjugate the healthcare field entirely to market logics, at least in a democratic society like the UK which takes care of its vulnerable groups. Hart (2010, p. 6) for instance notes that healthcare is a field "in which Adam Smith's invisible hand cannot operate without introducing a potentially lethal infection, the profit motive. We may learn to cope with this from car salesmen, but from doctors and nurses it is surely intolerable, both for them and their patients." At the same time, a hospital that does not take account of keeping its costs within reasonable limits would be considered unsustainable and might be forced to close down or become an undue drain on the rest of the healthcare system.

markets,' created via rules and regulations. In this way, continue the authors, incentives may be set up to reward providers and consumers for being efficient. Williams, A. (2005) argues that the perception of an internal market as a value-neutral way of purchasing is an illusion because the ways in which 'efficiency' is measured is not value free.

The internal market is seen by some academics as a type of 'managed competition' within the new 'managerialist' philosophy (Light, 2001) or NPM that is primarily based on ideas suggested by Prof. Alain Enthoven from the Stanford University Business School and Alan Maynard, Professor of Health Economics at the University of York (Kay, 2001). In the mid-1980s, Prof. Enthoven visited the UK and argued that the NHS hospitals lacked incentives for improving the quality and efficiency of the services provided (*Ibid.*). Prof. Maynard argued, the source notes, that the NHS general practice did not provide incentives to GPs to control their costs and to use public resources efficiently; besides, he suggested that a budgetary system and associated incentives be introduced into the UK's general practice for certain secondary care and pharmaceutical services. Prof. Maynard's ideas were what influenced Kenneth Clarke's decision to embrace quasi-markets in 1989.

In the internal market legislation, hospitals were made to compete with one another for resources, just like in a competitive market environment, and to involve medical doctors in management decisions more effectively (HCHC, 2010a). According to Kay (2001), during the early 1990s, the publicly-funded healthcare systems in many Western countries, not just in the UK, experienced similar reforms:

> "Such reforms were designed to exert greater control over state spending on health care and to improve the efficiency with which these systems operated. To help meet these aims, attempts were often made to stimulate competition between hospitals that provided publicly funded services and to encourage doctors and other professionals to control public expenditure on health" (p. 561).

This new system created a new set of key players and a new incentives structure for hospital policy making – now the most sought after employment position was not to be in charge of a Regional or District Health Authority (DHA), but to be the Chief Executive Officer (CEO) or Director of Finance of a NHS hospital (Pollock, 2004). This, writes Pollock, could later be a stepping stone to even more powerful job positions in or outside the NHS. Derek Smith, for example, a former CEO of the King's College Hospital in London, later became the CEO of the London Underground. The internal market is such a fundamental idea that Timmins (2013, p. 17) sees it as "the first building block" of Andrew Lansley's reforms.

### 3.4.2. Genesis of the purchaser-provider split: The 1991 reforms and GP fundholding

Elkind (1998) applies several metaphors, in line with Morgan (1986), to her study of the NHS: the images of 'machine,' 'organism,' 'religion,' and 'marketplace' are found to be particularly relevant to the NHS as an organisation. The religious connotation focuses on the mission of the NHS as a universal and comprehensive service; likewise, the mission of many religions is to provide salvation to humanity. Besides, the NHS is machine like since it is based on technocratic rationality, just like a machine. Being like a living organism reminds of the NHS' likeness to an open system – a living organism is participative and responsive to its environment, not closed to itself. Last but not least, the health service resembles a marketplace, according to Elkind, because of the presence of competition and the 'internal market' in the post-1991 period. The idea of internal market is closely linked to another innovative idea of the early 1990s – the 'purchaser-provider split.' The purchaser-provider

split, with its separation of commissioning from the provision function, was the cornerstone of the 1991 NHS reforms (Klein, 2005).

This split characterises the period 1991 to the present and consists of changing the role of healthcare providers: whereas previously, providers (hospitals) had determined themselves what services to provide to their patients, under the reformed system of 1991, it became the newly-established commissioning bodies, not hospital doctors, who had to purchase the needed healthcare services from providers on behalf of patients (HCHC, 2010a). Thus, commissioning was born in 1991. In order to become providers in this internal market, the source continues, hospitals need to first become NHS 'trusts,' i.e. "separate organisations with their own management" (*Ibid.*).

These changes within the NHS were in part inspired by political and ideological views. Timmins writes:

> "With Margaret Thatcher still at the height of her powers, the creation of "self-governing" hospitals was seen by critics to be merely the first step towards their complete privatisation. GPs fell out bitterly over whether it was morally right to take budgets. There were widespread worries about what would happen if they ran out of money. Others feared an irretrievable breakdown in trust between doctors and patients once GPs were responsible for allocating resources between patients and staying on budget" (Timmins, 2013, p. 17).

Ferlie *et al.* (2013) draw on the concept of 'managerialism' in healthcare when talking about the Thatcher years. The 'professional dominance' era of the pre-1979 period had now given way to the era of 'neo-liberalism,' a concept discussed in Chapter 2.

Under the very first commissioning model, there were two types of commissioners – 192 District Health Authorities (DHA) and GP fundholders.[24] According to Wilkinson (2011), GP fundholding was a voluntary commissioning model in which participating family practitioners were allocated a portion of the secondary care budget. With these funds, fundholders could buy healthcare services from NHS trusts and from the private and voluntary sectors on behalf of their patients (HCHC, 2010a). Initially, GP fundholders could buy just a limited range of care – the budgets covered, for instance, elective (waiting list) surgeries, physiotherapy, and the GPs' own prescribing (Timmins, 2013). Although GPs could buy care from whoever they wanted, they were free to establish new services themselves, writes Timmins.

> "The idea was that at least for some treatments "money would follow the patient" so that hospitals that did more work would earn more. Hospitals that failed to attract patients would earn less – the hope being that they would up their performance in response to competitive pressure" (p.17).

It was often the case that the patients of GP fundholders were able to obtain healthcare treatments more quickly than patients of non-fundholders (HCHC, 2010a). Because of this, there were some accusations that fundholding was violating the fair and equal access of all people to healthcare (Laudicella *et al.*, 2009). By 1997, observe Donaldson, Gerard and Mitton (2005), half of the population was covered by fundholding practices that controlled over 10% of hospital and community health service spending. Besides, GP fundholders tended to enjoy better resources and were located in more affluent areas than non-fundholders, remarks the same source. Despite fundholding's shortcomings, its proponents, such as Croxson, Propper and Perkins (2001), argued that separating the roles of purchasers and providers helped improve the efficiency of the NHS in productive and allocative terms.

[24] Please consult HCHC (2010a) for a detailed table of the different commissioning models since 1991.

Some research has examined the issues of GP fundholding and incentives (Croxson, Propper and Perkins, 2001; Hausman and Le Grand, 1999; Propper, Croxson and Shearer, 2002). Other research has focused on the contracting side of commissioning (Petsoulas *et al.*, 2011; Williams, Flynn and Pickard, 1997). It has been observed that the introduction of the internal market necessitated the use of contracts between purchasers and providers; yet, policy makers appeared to ignore the nature of these contracts by assuming the contracts conformed to the classical contracting model (Allen, 2002). Allen uses socio-legal and economic theories of contracting and examines the contracting between Health Authorities (former types of commissioners) and GP fundholders in a case study of district nursing services in Greater London. She concludes that classical contracting is an inappropriate model for the NHS. Relational contracting is not a very appropriate model, either, she claims. Laing and Cotton (1995) focus on the organisational purchasing behaviour of fundholding. To these commentators, GP fundholders emerged as new and inexperienced purchasers who had to begin developing a new body of expertise. The paper finds that the concerns about the high transaction costs of GP fundholding were justified, given the requirement for contracts to be renegotiated annually (*Ibid.*).

According to Croxson, Propper and Perkins (2001), the 1991 reforms created incentives for GPs to increase their use of hospital services before entering the GP fundholding scheme. Non-financial motives, the authors argue, could curb this behaviour. The paper shows that fundholders-to-be did respond to the financial incentives offered by this early commissioning scheme. Hausman and Le Grand (1999), on the other hand, find that although GPs at the time were concerned with their incomes and responded to financial incentives, they were also influenced by other norms and concerns about their patients. In line with these findings, Spoor and Munro (2003) observe that for fundholding GPs, price was of secondary

consideration as to referral behaviour and conclude that healthcare markets are far more complex than regular markets. In sum, GP fundholding is the earliest predecessor of modern day CCG commissioning.

### 3.4.3. Primary Care Groups (PCGs): 1997-2001

In May 1997, the newly-elected New Labour government decided to put an end to the internal market (HCHC, 2010a). GP fundholding was abolished in the same year. In December 1997, the white paper, *The new NHS – modern, dependable* (DH, 1997) was published. It retained the purchaser-provider split but DHAs were renamed to Health Authorities (HAs) and became the new commissioners (HCHC, 2010a). The purchaser-provider split, initiated by what tended to be a business-minded Conservative government, became increasingly important also under what tended to be a socially-minded New Labour government.[25] Klein (2005, p. 55) notes a dramatic reversal in the usual anti-market inclinations of New Labour:

> "After initially cold-shouldering the private sector on coming into office in 1997 (in line with traditional party ideology), the Government three years later enfolded it in a warm embrace. Having decided that extra billions of public funds would need to be poured into the NHS, the Government came up against the realisation that capacity, as much as money, was the main constraint on improving services in the short term (i.e. before the next General Election)."

Thanks to short-term considerations like the ones evoked in the quote above, the New Labour government embraced the private sector's cooperation in a much neo-liberal manner, just like the Conservatives had done up to 1997. Besides, growth in spending on healthcare increased significantly during the New Labour administration (Ham, 2004). Four hundred eighty-one

[25] A good summary of the post-1991 developments in the NHS is found in Petsoulas *et al.* (2011).

Primary Care Groups (PCGs) were established in 1999 in conjunction with the HAs (HCHC, 2010a).

### 3.4.4. The recently overthrown system: PCTs and SHAs (2002 - 1 April 2013)

Ferlie *et al.* (2013) divide the New Labour government's era into three parts: the early phase of networks and lateral working (1997-2002), the middle period of choice and diversity (2002-2006), and the later period of 'targets and terror' (2006-2010) when some providers' boards and senior management were dismissed for poor performance. During the early period, *The NHS Plan: A plan for investment, a plan for reform* (DH, 2000) announced that by April 2004, all PCGs were to become Primary Care Trusts (PCTs) but this date was later brought sooner – to April 2002 (HCHC, 2010a). The 100 HAs were abolished and turned into 28 Strategic Health Authorities (SHAs) that oversaw PCTs. In 2006, the SHAs were reduced to ten. The 2002 budget announced an increase in funding for the NHS and Alan Milburn, the then Secretary of State for Health, published *Delivering the NHS Plan: Next steps for investment, next steps for reform* (DH, 2002; HCHC, 2010a).

*Delivering the NHS Plan* introduced yet another series of momentous reforms to the NHS – NHS foundation trusts (FTs) were established. FTs are hospitals or groups of hospitals established as public interest companies, outside of central government's control (HCHC, 2010a). These trusts enjoyed (and are still enjoying) more autonomy from central government (Anand *et al.*, 2012) than simple NHS trusts. PCTs were free, according to the same source, to purchase care from the most appropriate provider, be it from the public (NHS entities), private (independent) or voluntary (also known as 'third') sector. This freedom of choice of

provider still exists and is called the ‘any qualified provider’ provision. The provision meant to increase competition and, arguably, improve performance, in the NHS.

What had become of clinical engagement in commissioning in the mid-2000s? Timmins (2013, p. 23) provides the answer: it continued to exist, although it had never proved to be effective enough in the 1990s. By the mid-2000s, Timmins states, the New Labour ministers had come to the realisation that something had been lost with GP fundholding’s disappearance. In 2004, a new type of GP commissioning was announced as ‘practice-based commissioning’ (PBC) in the policy document, *The NHS improvement plan – putting people at the heart of public services* (DH, 2004). PBC was launched in 2005 and was meant to “reignite clinical enthusiasm and engagement” (HCHC, 2010a, p. 13). Adopting PBC was voluntary, just like GP fundholding had been. “Unlike with GP fundholding, which gave GPs the money, PBC … [gave] GPs only “indicative” budgets to commission services on behalf of their patients, while the PCT still … [did] the contracting” (*Ibid.*).

In practice, few PCTs were keen on fostering PBC but there were some exceptions: in Cumbria, Cambridgeshire (the area of Andrew Lansley’s constituency) and Tower Hamlets in London, among other places, PCTs had taken steps towards a total devolution of the budget to family doctors (Timmins, 2013). In other places, PBC operated on a very limited scale. PBC is further elaborated in DH (2009). Its intention was that GPs and Practice Nurses would “reflect their patients’ preferences, leading to greater variety of services from a greater number of providers and for more conveniences for their patients, as well as a more efficient use of resources” (HCHC, 2010a, p. 17).

A highly critical of PCTs two-volume report (HCHC, 2010a, b) was published by the House of Commons Health Committee. Timmins observes:

> "The purchaser/provider split had increased transaction costs, the [House of Commons Select] [C]ommittee said, but PCTs were mainly passive buyers of care, not active shapers of services… If PCTs were to be retained, the committee said, they needed to be strengthened. But if PCT commissioning "does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished"" (Timmins, 2013, p. 24).

Academic studies have been carried out on PBC. Checkland *et al.* (2009) for example conducted detailed case studies of five PBC consortia in three PCTs and found that their respondents articulated a number of 'barriers' preventing change within PCTs: lack of time, resources and personnel, and difficult relationships with the respective PCTs. The researchers' observations suggest that these issues arose out of various kinds of organisational 'sensemaking' (Weick, 1995) and that the apparent 'barriers' had different meanings in different organisational contexts.

CCG commissioning goes further than GP fundholding and PBC by giving GPs a "complete financial responsibility for commissioning a comprehensive range of services. Whereas fundholders and practice-based commissioners were supported by health authorities and PCTs respectively, under the new proposals commissioning will be fully devolved to consortia" (Naylor and Goodwin, 2011, p. 154). Besides, another important difference is that CCG membership is obligatory for all GPs, not voluntary like GP-fundholding used to be: "One of the many shocks contained in *Liberating the NHS* was that all GPs were going to have to be involved in commissioning from a set date – whether ready, willing or able; whether they liked it or not" (Timmins, 2013, p. 31). A recent report by the King's Fund (Ham *et al.*, 2015, p. 4) argues that even though the "squeeze on public finances may not have affected the NHS as much as most other public services" and even though "international

surveys showed the NHS to be performing well" (p. 11), the reforms were legislated and their "effects were both damaging and distracting." These are just "tentative" (p. 7) conclusions that may need to be revised as more evidence is gathered in the future, the source admits.

### 3.5. Conclusion

Chapter 3 introduced the reader to acute care commissioning in the context of the CCG reforms. It also summarised some prior NHS reforms of commissioning (GP fundholding and PBC), the first one of which became effective in 1991. It is important to keep in mind that the 'new' acute commissioning system (the one since 1 April 2013) gave enhanced commissioning responsibilities and accountabilities *statutorily* to local family doctors, but also to some other clinicians, such as some nurses and other health professionals. The 211 CCGs replaced the 'old' commissioners – PCTs and SHAs – and inherited the responsibility to handle multi-million pound budgets passed down to them by the DH. CCG commissioning has its deepest roots in the 'internal market' and purchaser-provider split of the early 1990s and was inspired by US competition and efficiency models.

# CHAPTER 4

# PROFESSIONAL IDENTITIES OF CLINICIANS AND COMMISSIONERS AND THEIR DAILY PRACTICES

## 4.1. Introduction

Chapter 4 provides a review of the literature on the professional identities of clinicians and commissioners and their daily practices in the English NHS. This chapter is important because in the absence thereof, it would be hard to know what exactly CCG commissioners do on a day-to-day basis. First, a closer look at the concept of 'identity' is provided. Next, the topic of what makes a 'profession' and its identity is reviewed, followed by a discussion on 'hybrid' clinical managers' identities and practices from the provider's and the commissioner's side. Later, NHS commissioners' work identities and day-to-day practices are examined in more detail.

## 4.2. A closer look at identity

### 4.2.1. What is 'identity'?

The literature on identities is rich and diverse (see for example, Pullen, Beech and Sims, 2007; Lieblich and Josselson, 1994). A multitude of studies has been published on cultural, ethnic, racial, gender, and work identities, just to name a few. The word 'identity,' on an individual level, has the following definition in the *Collins Concise English Dictionary*, "the state of having unique identifying characteristics held by no other person or thing [and] the

individual characteristics by which a person or thing is recognized.[26]" Identity, on a group level, may characterise several individuals or groups of individuals unified by a "we-feeling" (Rao, Monin and Durand, 2003, p. 796). This social identification is seen by Ashforth and Mael (1989, p. 20) as "a perception of oneness with a group of persons" Identities are certainly not static; they are widely believed to be in a state of flux over time. Bauman (1996) implies for example that over the lifespan of an individual, he or she identifies with multiple identities. These identities are not necessarily cumulative, but are changeable and fluid over time – time "is no longer a river, but a collection of pools and ponds" (p. 25). To Halford and Leonard (1999, p. 117), this imagery suggests that there are "temporary stagnations over a lifetime, a spreading out into relatively stable identities for periods of time but inevitable movement on to new and only tenuously connected identities."

Identities are spatially mobile, in addition to being temporal (Nippert-Eng, 1996). The spatial contextuality of human identity, and therefore of human behaviour and practices, is illustrated by the 'self' one adopts while being at home with one's family, as opposed to his or her 'self' while being at work with colleagues or elsewhere. In addition, Nippert-Eng finds out that some people are comfortable with integrating their home and work identities, while others try to keep these two identities separate. Keeping separate identities, a phenomenon labelled as a 'socially scripted personhood' by Cohen (1994), is perhaps a misconception since this 'personhood' "is not necessarily to say that … [people's] sense of self undergoes an identical transformation [as their social roles]" (Halford and Leonard, 1999, p. 119). Thus, for some scholars, people's behaviour and practices may change depending on the context they are in, but their true self and inner essence (the soul and spirit) remain the same, no matter the context.

[26] Available at: <http://www.wordreference.com/definition/identity> [Accessed on 9 January 2014].

### 4.2.2. History of identity studies

Reviewing the history of identity research is useful to do in order to better understand the professional identities of clinical commissioners in CCGs. Identity is often thought as a meso- or micro-level issue. Group identities are typically linked to the organisational (meso) level of analysis and individual identities are typically linked to the micro level of analysis. However, work identities may be either a meso- or micro-level issue – how an individual understand himself or herself as a member of an occupational or professional group or how he or she understands himself or herself as an individual worker.

Swann and Bosson (2010, p. 589) remind their readers of the origins of identity studies – the time when one of the founding fathers of psychology, James (1950), saw the self as a "source of continuity" that gave a sense of "connectedness" and "unbrokenness." As for work identity, symbolic interactionism (a theory from the early 20th century, made popular by Charles Horton Cooley and George Herbert Mead (Cooley, 1983; Mead, 1934)) would have seen it as a superficial change (just a role identity), deprived of permanency and endurance. The so-called 'dramaturgical movement,' Swann and Bosson (2010) write, was '[s]pearheaded' by Goffman (1959). This movement assumed that people were like actors on a stage. 'The world is a stage,' claimed Shakespeare, and all we do is perform in front of various audiences. "As people take on various identities, the self is merely a consequence, rather than a cause, of the performance" (Swann and Bosson, 2010, p. 590). Further on the same page, Swann and Bosson write that if people could assume various identities, according to the demands of the situation, then they were "interchangeable" and ephemeral, something called the "situationalist approach" to identity studies. The theatrical metaphor assumes that

there is no such thing as an "enduring," "underlying," stable or "authentic sense of self" (*Ibid.*); identity is all about acting and meeting the audience's expectations.

In the 1970s, Snyder (1974) developed a personality measure called a "self-monitoring" scale that tried to distinguish people who were mere actors from those whose self-concept had a more "cross-situational consistency" (Swann and Bosson, 2010, p. 590). The idea of enduring identities then emerged. Markus (1977), again from the psychology field, introduced soon after Snyder the idea of enduring "self-schemas" which "systematically guided information processing about the self" (Swann and Bosson, 2010, p. 590). In the 1980s, social psychologists continued abandoning the symbolic interactionist views on identity and started embracing the idea of a more permanent schema, an identity deeply encoded in memory.

### 4.3. What makes a profession and its identity?

According to the *Collins Concise English Dictionary*, a profession is "an occupation requiring special training in the liberal arts or sciences, esp[ecially] one of the three learned professions, law, theology, or medicine.[27]" This is not the only possible definition of the word 'profession,' however. According to its popular usage, the term may have a wider variety of meanings – a highly skilled occupation or any work from which one derives his or her income (Abbott, 1988; Freidson, 1986, 1994; Saks, 1995). Occupations, such as architecture, accounting, engineering, and nursing, have also obtained the status of professions in some countries, i.e. they have endured a process of 'professionalisation' (Millerson, 1964).

[27] Available at: <http://www.wordreference.com/definition/profession> [Accessed on 9 January 2014].

Larson (2013) and Walby *et al.* (1994) observe that professions are occupations that enjoy special powers and prestige and note that society bestows these rewards on the professions because professionals have acquired special bodies of isoteric knowledge and techniques. These knowledge and techniques have a special 'cognitive' dimension (Larson, 2013). They are linked to the central needs and values of society – legal justice, health, and financial accountability, just to name a few. Professions are expected to be altruistic and devoted to servicing the public (a 'normative' dimension). Whether professionals tend to act altruistically is another question: the main issue with professional groups, according to Saks (1995, p. 3), is whether they indeed "subordinate their own interests to the wider public interest in carrying out their work." The claim to altruistic ideals, continues Saks, is typical of most professions, especially those in the Anglo-American context. Besides, most codes of professional associations require the maintenance of high standards of practice and the delivery of impartial service.

The medical profession, as one directly dealing with individuals' health, is an example of a profession with exceptionally high societal expectations of altruism and selflessness on the part of its members. Saks (1995) remarks that the medical profession in the UK has been strongly inspired by the *Geneva Code of Medical Ethics*, a code adopted by the World Medical Association in 1949. This code calls on medical professionals to make a pledge to consecrate their lives to serving humanity.

Another distinctive trait of the professions, as opposed to the rest of the occupations, is professions' autonomy,[28] self-monitoring, and self-regulation (an 'evaluative' dimension).

[28] Flynn (1999, pp. 22-23) notes that professional, "'[a]utonomy' can be conceptualized at different levels of analysis – for example institutional autonomy refers to the jurisdiction claimed by a professional occupation and the extent to which it can secure legitimacy and state approval, whereas technical or work autonomy refers to efforts to determine terms, conditions and working practices, as well as the division of labour vis-à-vis other

Usually, the professions have their own methods of training and assessment. In recent years, financial scandals, such as the accounting scandals in the Western world that have transpired since the early 2000s (Enron, HealthSouth, WorldCom, etc.), have put into doubt the altruistic nature of certain professions, including the accounting profession (Sikka, 2008, 2009; Suddaby, Gendron, and Lam, 2009). The demise of the Big Five accounting firm Arthur Andersen was caused by its involvement in the Enron scandal. Subsequently, the first US accounting profession regulator was established – the Public Company Accounting Oversight Board (PCAOB). These are telling examples of the shaken status of the US accounting profession (Anantharaman, 2012).

Due to such professional and ethical failures, the claims about the professions' altruistic service to the public "have been regarded as a form of self-serving mystification, more rhetoric than reality" (Walby *et al.*, 1994, p. 60). The medical profession, both in the UK and abroad, has also been affected by negative publicity, especially in the case of medical malpractice lawsuits (Schön, 1991). The cognitive, normative, and evaluative dimensions of the professions create cohesion among their members and help shape professional groups' identities.

During their intensive professional training years, future professionals 'internalise' certain professional values and norms (for instance, responsibility, competence, and altruism). Later, when professional training has been completed and professional practice commences, professionals reinforce these same values and norms via their involvement with colleagues in professional associations (Kitchener and Exworthy, 2008). It may be argued that professional

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groups. Professional autonomy is thus contested, variable and contingent on many factors." Besides, according to Kitchener and Exworthy (2008, pp. 210-211), professional autonomy exists to the extent to which the state, "delegates, to an occupational group, responsibility for defining and implementing the goals of work, setting performance standards, and ensuring the maintenance of standards."

identities, i.e. the feeling of belonging to a recognised professional body, are no different from personal or group identities in the sense that they are changeable and malleable across time and space. Some scholars go as far as to argue that since identities change with time and space anyway, professional identities are not attributive to public policy reforms. For instance, Halford and Leonard (1999, p. 118) contend, "The recognition that identity is highly fluid … and changeable across time and space … presents a challenge to the idea that new managerialist discourses have a transformative effect on identity." Some other scholars take a social constructivist stance as far as professional identities are concerned and think of identities as 'relational,' 'conditional,' and continuously being 'constructed' due to various changes in circumstances (Halford and Leonard, 1999).

On a more negative note, it has been argued in the literature that being a member of a professional body does not preclude a member from pursuing personal self-interests – usually income, power, and status (Freidson, 1986; Larson, 1977; Wizz, 1992). Regarding the social position of professionals, the Chicago School of Sociology, represented by Everett Hughes and his followers, tries to evaluate the actual status of professions and asks "what professions *actually* [my emphasis] do in everyday life to negotiate and maintain their social position. The salient characteristics of the professional phenomenon emerge, here, from the observation of actual practices" (Larson, 2013, p. xii).

Professional power and status are seen by others as maintained by a 'closure' to the professions, i.e. by high barriers to entry. These barriers evoke the image of a cartel or an exclusive clique. Parkin (1979) analyses different strategies of closure by an occupational group from a Marxist standpoint. Thus, 'exclusionary' closure by an occupational group may

be an expression of power by the have's over the have not's, while 'usurpatory' strategies may be attempts by the less powerful to attain the status of the more powerful.

The first school of thought that has emerged around the debate on the changing nature of professionalism is the one claiming that a de-professionalisation is taking place, i.e. that "professionals are losing their cultural authority in terms of prestige and trust" (Exworthy and Halford, 1999b, p. 15, summarising Freidson's understanding of professionalism). This loss is due, the authors explain, to the presence of consumerism and increased levels of education, i.e. the gap in knowledge between professionals and lay people is diminishing. De-professionalisation also occurs because of the public's concern with certain excessive privileges accorded to professionals – high pay and status being the most common ones. The second school of thought espouses the 'proletarisation' thesis, that is the claim that professionals are losing their "independence and becoming subject to the rule of mangers like any other occupational group." The third school is that of 'internal combustion.' This internal combustion, according to Freidson, is due to the "increased bureaucratization of professional associations" and to the "greater specialization within individual professions" (*Ibid.*).

Besides 'de-professionalisation,' 'proletarisation,' and 'internal combustion,' agency (Broadbent, Dietrich and Laughlin, 1996; Jensen and Meckling, 1976; Ross, 1973; Sappington, 1991) and marketing theories (Mitra, Reiss and Capella, 1999) have also provided important insights into professional identities. For example, professionals, including these affiliated with CCGs, figure in the literature as one of three basic types of customer agents, the other two being retailers and personal representatives (Stinchcombe, 1984). Professionals usually provide 'credence,' or trust-based, goods and services to their clients

(Mitra, Reiss and Capella, 1999).[29] The demand for medical services is a demand for credence goods (Watt, 2012). Professional identity from an agency theory perspective is seen as agential – the principal being the patient and the agent – the medical practitioner (Broadbent, Dietrich and Laughlin, 1996). These authors theorise an accountability model of the 'caring professions' (Gorz, 1989) based on the potential for value conflict (low or high), as combined with the level of trust (also low or high) in communal and contractual inter-relationships between agents and principals.

CCG commissioners (agents) purchase from providers (NHS trusts) complex healthcare services that local populations (principals) do not completely understand. Commissioning is highly complex; yet, the changes to commissioning "have not always been accompanied by the development of a sufficient infrastructure to give commissioners the confidence, skills and support they need to live up to the very rigorous demands of policy" (Glasby, 2012a, p. 245). Thus, CCG commissioners may lack a proper support structure if this insufficient infrastructure is still present.

### 4.3.1. We are 'what we do' or we do 'what we are'?

Two conceptions of work or occupational identities have dominated the literature on work, including professional work, and self-concept (Halford and Leonard, 1999). With respect to the first conception, the type of work performed is believed to determine the worker's identity, i.e. 'who we are' is contingent upon 'what we do.' For instance, we treat patients; therefore, we are health workers. We commission NHS services; therefore, we are NHS

[29] Marketers categorise goods and services into three categories: search, experience, and credence (Mitra, Reiss and Capella, 1999).

commissioners. This concept of work identity, the authors write, is based on an '*external*' imposition of identities. The authors posit further that employing organisations 'bend' individuals' aspirations, personal values, and identities towards these organisations' own aims and aspirations. "While personal choice may play some initial role in the choice of occupation, from that point onwards individuals develop distinctive identities as a consequence of their *structural* location" (p. 103). Thus, according to the 'we are what we do' school of thought, work identity is a function of '*structural'* location. This first approach has been particularly popular in industrial and economic sociology, note the authors.

With respect to the second conception, the relationship is reverse – 'what we do' is contingent upon 'who we are.' Witman and colleagues find that when medical colleagues consider their clinical leaders to be 'wise' men and women, only then are these leaders able to influence the clinical activities of their work groups. These wise leaders utilise collegial manners and a so-called medical 'habitus,' a term used by Pierre Bourdieu (Witman *et al.*, 2011). In other words, one is a member of an occupation because one already possesses *a priori* certain personal characteristics that are desirable in the respective occupation – good communication skills, genuine care for others, trustworthiness, intelligence, and so on. Based on this school of thought, a certain line of work may be done (or should be done) by people possessing some desirable individual characteristics or, as the authors put it, "individual, innate, preformed identities are seen to determine the way in which work is carried out" (Halford and Leonard, 1999, p. 102). This is an '*internal*' processes or an '*agentic'* approach to work identities, according to the authors, as opposed to the first approach which was '*structural'* in nature.

Following the assumptions of the 'we do what we are' approach, Gergen (1992) and Morgan (1993) for instance view the working man or woman as a unique individual, with a unique personality, soul, and spirit. If a professional or another worker expresses his or her unique self (soul or spirit), the organisation he or she belongs to would ultimately benefit from this expression. The approach of this second school of thought, in Halford and Leonard's (1999) view, has dominated much of the organisational and management literatures. The authors conclude that depending on which one of the two schools of thought is being followed, one might argue that workers' identities "will change dramatically following public sector restructuring, or that they will change very little, as individuals' stable, inner core resists situational change."

### 4.3.2. Professional stratification and power

The concept of 'power' has long been an issue concerning the professions. Halmos (1970) sees the political power of the professions grow with time. From a post-Marxist, post-industrialist perspective, Bell (1974, p. 129) sees "the clash between the professional and the populace … [as] the hallmark of conflict in the post-industrial society." The issue of professional stratification relates to the internal hierarchies and other divisions of labour in the professions (Freidson, 1994). Although all professionals within a given profession belong to the same, or similar, professional bodies, these professionals may exercise different work roles. Causer and Exworthy (1999) elaborate on this issue. First in their typology is the '*practicing (or rank-and-file)*' professional who engages in the profession's core day-to-day activities. This would be for example the professional accountant who files tax returns on behalf of his or her clients or who conducts audits of client financial statements. Practicing professionals may be divided into two sub-groups: those without supervisory/managerial or

resource allocation duties (the '*pure practitioners'*) and those with substantial supervisory/managerial or resource allocation duties who are not formally called 'managers' (the '*quasi-managerial practitioner'*).

The second group that Causer and Exworthy delineate is composed of those practicing professionals whose primary duty is to manage the day-to-day work of other professional peers and the resources utilised. These are the '*managing professionals.*' If the managing professional continues to directly engage in professional practice, while also acting as a manager, he or she is labeled as '*practicing managing professional*' and if not – as '*non-practicing managing professional.'*

The third and final group presented by Causer and Exworthy is the group of those who have managerial responsibilities over the activities of professional employees, but who are not concerned with the direct management of day-to-day professional operations. This group is called '*general managers'* and "may but need not … be drawn from among those with a background in the practice of the profession itself. We can accordingly differentiate within this group between the *professionally grounded general manager* on the one hand … and the *non-professional general manager* on the other" (p. 84).

What becomes clear from Causer and Exworthy's (1999) professional internal stratification exercise is that five of the six sub-groups (all except the '*non-professional general manager'*) are characterised by a past or present involvement in professional practice, a fact that may re-inforce these sub-groups' members' identity with their corresponding profession. Besides, there is a trend toward what one may call a 'managerialisation' of the professions: "[E]ven among practicing professionals there will be those whose roles are not those of the pure

practitioner, but rather entail undertaking activities of at least a quasi-managerial nature (p. 85)."

Who enjoys more power, status, and prestige – the '*professionally grounded general manager*' or the '*pure practitioner"*? Although some authors (Exworthy and Halford, 1999a, b) have affirmed that taking up managerial tasks has been accompanied by career progression for many professionals, the answer to this question is perhaps not so clear cut. Since the topic of managers and professionals is reviewed in more detail later in this research, here it suffices to introduce the topic of positional power in professional hierarchies.

Sheaff (2008), based on Blau (1864), Dahl (1986), Parsons and Shils (1951), Tawney (1952), and Weber (1947), reminds the reader that power is usually thought to be the probability that an actor will be able to carry out his or her own will despite resistance by others. Sheaff (2008, p. 1) writes, "Weberian organizational sociology asserts that a group's power in an organization depends largely on its positional power, i.e. on the topology of the hierarchies which usually comprise an organizational structure and what place the group occupies within it." He further explains that individuals or groups that occupy 'high' positions within an organisation exercise 'positional power' over their subordinates. These Weberian power relationships apply to a variety of organisations, including professional organisations – the UK's Royal College of Nursing, the Royal College of General Practitioners, the British Medical Association (BMA), the Institute of Chartered Accountants of England and Wales, etc. Weberian theory postulates that a superior's power is a function of the control he or she has over people at inferior levels of the organisation and is also a function of the resources and discretion that are delegated to him or her by those at higher levels in the hierarchy (*Ibid.*). Sheaff sees the exercise of power as a,

> "zero-sum game whose prizes are the allocation of activities, technologies, economic rewards, formal position, status and other perquisites, and of the means of exercising power in future. Usually the main source of power given by a high 'vertical' position in an hierarchy arises from capacity to allocate the use of physical resources and budgets owned by the organization, which above all enables the superiors to appoint, promote or dismiss subordinates" (pp. 1-2).

In the early literature on the professions, professional power was discussed by Johnson (1972). To a certain extent, the power of medical professionals comes from the indeterminacy of clinicians' medical expertise. Larson (2013) calls this power the 'monopoly' of expertise. Walby *et al.* (1994) clarify that medical doctors' knowledge can "never be fully written down, because of the nature of the judgement involved ... Each situation to which a doctor applies his or her professional expertise is different and involves judgement as well as rules." For Flynn (1999), based on Freidson, this indeterminacy of expertise is what constrains external inspection and supervision over a profession. However, Flynn also acknowledges that this discretion or indeterminacy is ultimately governed by resource constraints, "Freidson correctly points out that professional technical autonomy can only be exercised if resources are available, so the crucial issue is whether professionals can determine resource allocation and control resource use or whether distinctive managerial groups have encroached and consolidated control in this domain" (p. 23). In the case of CCGs, medical professionals do have discretion over resource allocation to providers.

The balance of organisational power has to be continuously negotiated and renegotiated via a process of 'negotiated order' (Sheaff, 2008; Strauss *et al.*, 1963). The professional is seen in the literature not just as a controlling agent, but also as a 'reflective' agent (Schön, 1991). In Schön's view, the 'reflective' practitioner is not only an expert; he or she also empowers patients through the use of a 'reflective' contract, a contract that is more flexible and

empowering than the traditional patient-medical professional contract. As can be inferred from the above, the concept of 'power' is not foreign to managerial and professional work in the NHS. McNulty and Ferlie (2002) and Harrison (2002) contribute to another debate – the reengineering and modernisation of UK healthcare from a managerial perspective, i.e. the debate on whether the tendency is towards an increase or decrease of non-medical managers' power over medical professionals and their clinical practices.

In a more recent study, Sheaff (2008) explores the ways in which the balance of power between NHS managers and medical doctors has shifted since 1991 and asks to what extent these changes are attributable to changes in organisational structures or other factors. Ultimately, this commentator tries to determine the implications of these changes to theories of managerial and professional power. Although it may well be the case that GPs in England are paid well according to European standards, Sheaff notes a trend towards "a net strengthening of NHS managerial control and a reduction in GPs' professional autonomy, both individual and collective. Gradually power has been draining from medicine to management in NHS primary care" (p. 14). Sheaff refers to an earlier work with colleagues from 2004 to clarify that the above mentioned managerial-professional power tensions are mostly a function of environmental factors (laws, regulations, and labour market forces), structural factors that are typical of all healthcare organisations, and organisation-specific processes factors (medical resistance to management, professional discipline, etc.).

### 4.4. The 'hybrid' clinical manager: Identities and daily practices

The social sciences have played an important role in informing arguments about the relationship between managers and professionals in the public sector (Flynn, 1999).

According to this source, even though there are no clear-cut boundaries between managers and professionals, these two groups are characterised by different objectives, values, and practices, some of which may even escalate to conflicts between the two groups. Many of the differences between these groups are cultural and based on competing agendas (Sorensen *et al.*, 2013, p. 698). While studying these differences, numerous authors have focused on the role of managers and professionals in the English NHS (Macfarlane, Exworthy and Willmott, 2012; Sheaff, 2008; Smith, 2007).

Management is a vital function for the viability of any business, be it private or public. Thus, Charles Webster, the official historian of the NHS, "has been quoted as saying that management is now the most powerful occupation" (Harrison, 1999, p. 56). General management was introduced at all levels of the NHS in 1983 by the so-called Griffiths Inquiry Report (DHSS, 1983; Macfarlane, Exworthy and Willmott, 2012) which was commissioned by the then-Secretary of State for Health and chaired by Sir Roy Griffiths, the Managing Director of the Sainsbury supermarkets at the time. According to Sherman, Black and Halpern (1983), the objectives of the report were to review the incentives facing NHS management and examine the ways in which the NHS resources were being used and managed. A major recommendation of this report was that the operating since 1974 'consensus' management in the NHS had to be replaced by 'general' management, so that the NHS systems of control could improve (Macfarlane, Exworthy and Willmott, 2012; Pollitt *et al.*, 1991). The Griffiths report "provides a baseline against which subsequent public management reforms (especially those in the NHS) can be gauged" (Macfarlane, Exworthy and Willmott, 2012, p. 135), such as a bigger involvement of clinicians in the management of the health service. Similarly to the most recent NHS reforms, the Griffiths Report "advocated that daily decision making should happen at a local level" and called for a strong general

management team "to ensure the devolution of power with clear lines of accountability" (Rivet, 1998, p. 354). Thus, 'professionalism' and 'managerialism' imbued the Griffiths Report as early as in 1983. These two ideologies paved the way for clinicians' involvement in commissioning: first, in GP fundholding, then in PBC, and now in CCGs.

The clinical and managerial governance within the NHS have been studied for a long time, especially after the Griffiths Inquiry Report. Smith (2007, p. 45) posits that clinical governance "became particularly important for the National Health Service in 1997 when the Department of Health said that quality measures had to be introduced [via *The new NHS – modern, dependable* (DH, 1997)]." Further, Smith (p. 46) observes that in the 1990s, the tension between managers and clinicians in the NHS intensified since managers "tried to streamline for efficiency and clinicians perceived that quality of care was being reduced." It is clear, based on these sources, that professional (quality of healthcare) and managerial (streamlining for efficiency and setting quantifiable targets) mindsets in the NHS collided on numerous occasions.

'Janus-faced,' clinicians have been seen as working in two worlds that are guided by two different worldviews or logics (Witman *et al.*, 2011). That is, clinicians' work is becoming 'hybridised' (Kurunmäki, 2004) between management and medicine. Hayne and Free (2014) evoke 'hybradised professional groups,' i.e. hybrids within the professions, such as medicine. Physicians involved in managerial positions in hospitals have also been referred to as 'two-way windows' that occupy 'boundary roles' (Llewelyn, 2001). Kurunmäki (2004) suggests that medical doctors in Finland for example are more willing to adopt accounting practices and technologies than their UK counterparts because of the presence of more powerful professional accounting associations in the UK than in Finland. In another study, Jacobs

(2005) finds out that there is no evidence from the three countries studied – Germany, Italy, and the UK – that accounting education (a manifestation of a management and accounting worldview) has been incorporated into clinicians' formal education. Jacobs' findings show that in the period studied, there were management and accounting modules offered to medical doctors who were considering clinico-managerial posts in these three countries. These findings, according to Jacobs, do not support the position that medicine has become a hybridised profession; it has become instead 'polarised.' Moreover, clinicians may easily become 'managerialised' in their attempt to ward off managerial encroachment on their autonomy (Waring and Currie, 2009). These authors suggest that rather than viewing professionals as attracted to management roles *per se*, one should view managerial techniques and jurisdictions as strategically drawn into professionals' work practices and identities.

Even though most clinicians in the UK have remained practitioners, rather than managers, throughout their careers and have thus secured high social status and material rewards (Causer and Exworthy, 1999, p. 98), the role of many professionals in the public sector, and in the NHS in particular, is shifting towards managerialism. The introduction of NPM (Hood 1991; 1995 a, b) and NPG discussed in Chapter 2 has a lot to do with this shift. The professional-manager schism is not always clear and straightforward but 'blurred,' as already noted. According to some academics, public sector managers and professionals "derive their legitimacy and purpose from legislation and government policy … and are accountable bureaucratically to higher level officials and politicians. However, in the new … system … it is unclear whose goals and interests will shape the behaviour of local managers" (Flynn, 1999, p. 24). This is to say that the professional-manager schism does not always shape practices in the same way.

In a study on medicine, schools, and social work, Causer and Exworthy (1999) delineate the changing roles of the professionals holding management positions in these three public sector fields. The authors note that there is a general tendency for the managerial component of work to become increasingly important for most professional groups. An example of this trend from a NHS provider perspective is that each NHS trust or FTs has been required to have a medical director, who is a medical doctor, on its trust's board (Causer and Exworthy, 1999; Harrison and Pollitt, 1994). It is clear that medical directors' work is both "*professionally defined*" and "*managerially defined*" (Flynn, 1999, p. 33) in the sense that medical directors are considered to be professional authorities sitting on managerially- and strategically-oriented boards. As Hoggett puts it, rather than managers controlling directly professionals, professionals are converted into managers – they are given budgets and become responsible for semi-autonomous business units. These managerial-professional hybrids combine both 'technical expertise' and 'managerial competence' (Hoggett, 1991, cited in Causer and Exworthy, 1999). It is not surprising to the two authors (p. 100) that despite the inter-professional and inter-sectorial variations in the three institutional fields examined – medicine, schools, and social work – the boundaries between professionalism and managerialism in the public sector are becoming more and more 'blurred.'

This 'blurring' of professional and managerial work practices and identities is evident within CCG commissioning, as well. As it was mentioned in the previous chapters, CCG commissioning has to do with the rationing of multi-million pound budgets to purchase healthcare from hospitals. Flynn (1999, p. 18) notes that "the ultimate source of tension in the public sector" is seen by many people to be the control over decisions on resource allocation. Surprisingly though, clinicians did not struggle to obtain control over resource allocation decisions (actually, quite the opposite) while the 2011 bill was being discussed in Parliament.

It was the Coalition government which enforced on them this control, via legislation (Timmins, 2013).

The 'blurring' of professional and managerial elements characterises not only work identities and practices, but also the prospect of career advancement. Causer and Exworthy (1999, p. 101) for example bring up the term 'managerial assets:'

> "[M]anagerial assets are becoming of increasing importance for career advancement within the professions. To some extent, such assets have always been important in most professions, but their significance is intensifying. For many people engaged in professional activity it may become increasingly inappropriate to ask whether they are a professional *or* a manager, for the essential nature of their work will lie in the combination of both elements."

Some academics have moved away from portraying neo-liberalism as the major force behind the professionalism-managerialism identity blending. For them, NPM has been wrongly presented as a 'blanket discourse' that has been "colonizing the public services" (Thomas and Davies, 2005, p. 689). To these scholars, the strength and cohesion of the NPM discourse are context dependent: NPM does not control the public sector professional in 'deterministic' and 'unidirectional' ways towards a business or market thinking. Rather, it exercises partial control over the public sector's professional in a variety of possible ways that may be more diverse and multi-directional than previously thought.

As introduced in Chapter 1 and as further examined in this chapter, NHS 'hybrids' are a 'composite' of different elements (Fischer and Ferlie, 2013), i.e. they are individuals who engage in managerial activities, while also engaging in medical practice. Hybrids have been studied mostly in the context of healthcare providers. For instance, Waring and Currie (2009, p. 774) describe hospital doctors-managers in the following way: "As professionals internalize management techniques in an endeavor to stave off management encroachment,

they become increasingly managerial in terms of their practice and identity." Hybrids and their practices and identities have not been studied much in the context of NHS commissioning, especially in the newly-established CCGs – a gap that was already mentioned in Chapter 1.

## 4.5. The NHS commissioner: Work identities and daily practices

### 4.5.1. Commissioners as purchasers and procurement specialists

One of the many responsibilities of NHS commissioners involves purchasing and procurement. The procurement process involves needs assessment for a local population and the development of specifications for healthcare products and services (Lonsdale 2012; Lonsdale and Watson, 2005). With respect to the purchasing of acute healthcare, buyer-supplier negotiations lead to the development of contracts through formal contractual arrangements (Lonsdale, 2012). Usually, these arrangements are highly complex and legally binding.

Two of the major challenges to purchasing and procurement in general, and CCG commissioning in particular, have been the presence of incomplete or poor quality information and conflicts of interests and priorities: the former PCTs, for example, had often been criticised for making decisions based "on a very poor information base and with very limited analytical skills" (p. 89). Yet another challenge, according to the same source, has been the concept of 'trust' discussed in Nooteboom (2002) – trust not necessarily in the capabilities of the supplier to deliver the agreed-upon goods or services up to standard ('competence trust'), but trust in the motivations of the supplier ('intentional trust'). Agency

theory's concepts of *ex-ante* 'hidden information' (or 'adverse selection') and *ex-post* 'hidden action' (or 'moral hazard') (Jensen and Meckling, 1976; Watts and Zimmerman, 1986) are seen as two varieties of 'information asymmetry' that are meant to protect the interests of the principal, while constraining the actions of the agent (Broadbent, Dietrich and Laughlin, 1996).

Although purchaser-supplier relationships are often free of unethical self-interest, sometimes opportunism may imbue these relationships. Williamson (1996) defines 'opportunism' as behaviour that furthers self-interest and divides it into 'blatant' and 'subtle' (see Lonsdale, 2012). Thus, Lonsdale would argue, in a worst case scenario, a CCG or a NHS trust would display 'blatant' opportunism if it engaged in breaking written or unwritten contracts, by lying to the other party or by cheating or stealing. 'Subtle' opportunism, on the other hand, "is understood as self-interest seeking with guile and refers to acts whereby there is an incomplete or distorted disclosure of information, the aim of which is to mislead, confuse or disguise true intent" (p. 92). Examples of 'subtle' opportunism, the author further observes, may be: "adverse selection, strategic misrepresentation, asymmetrical lock-in, and moral hazard" (*Ibid.*). A perceived moral hazard within NHS commissioning led in part to moving away from block contracts in acute care:

> "It was, and is, hoped that Payment by Results will eradicate the complacency apparently encouraged by block contracts. The practice of 'up-coding', that is, unjustifiably recording the most expensive diagnosis under the Payment by Results tariff system (Mannion and Street, 2009), is a further example of moral hazard … as is provider-induced demand, another problem thought to have been an unintended consequence of Payment by Results" (Lonsdale, 2012, pp. 100-101).

Although instances of the unethical behaviour described above may not occur often, NHS commissioners need to be skilled enough to recognise such behaviour, should it surface:

"[B]uying organisations [need] to carefully select staff members for critical negotiations, ensure that those staff members receive extensive training and, crucially, provide them with the necessary time to both properly prepare and bargain" (p. 99). In addition, buyer-supplier relations may further be exacerbated if buyer-supplier power relations are present (Lonsdale, 2012).

### 4.5.2. Commissioners as economists

Besides purchasers and procurers, NHS commissioners should also behave like economists. As such, they sometimes need to make decisions based on value for money (VFM) considerations. Watt (2012) adapts the following table (Table 1) from Friedman and Friedman.

**Table 1**

**Different types of spending**

| | On whom spent? | |
|---|---|---|
| | You | Someone else |
| Whose money?<br><br>Yours | Shopping - incentive to get VFM | For example, a present. Incentive to economise but not to get VFM - at least as judged by the recipient. |
| Someone else's | Expense account - incentive to get good value for money, but not to keep spending down | Little incentive to economise or to get good VFM for the recipient. |

Adapted from: Friedman and Friedman, cited in Watt (2012, p. 170)

Watt determines that NHS commissioning falls into the lower right-hand side category, 'Little incentive to economise or to get good VFM for the recipient.' That is, NHS commissioners spend someone else's money (taxpayers' money) on someone else (on their local populations). Commissioning uses someone else's money to purchase healthcare; therefore, the commissioner is an intermediary (an agent or representative) between NHS healthcare providers and the local population, i.e. the link between suppliers and patients (Watt, 2012).

The concept of supply and demand is studied by macro-economics, i.e. commissioners have to reconcile supply with demand, just like economists. Local populations, many of whom are also taxpayers, do not engage directly with healthcare purchasing since it is very complex in nature; besides, local populations cannot control the suppliers of acute healthcare (*Ibid.*). While performing their duties, just like economists, commissioners should also take into account allocative and technical efficiency considerations. Allocative efficiency, according to Williams and Robinson (2012, p. 70, based on Drummond) is,

> "concerned with how budgets should be allocated to achieve greatest efficiency within a population … [while] [t]echnical efficiency is concerned with the efficient production of services (Drummond, 1991). Thus, the interest for allocative efficiency is in what services to provide, while for technical efficiency it is in providing services at the least possible cost."

In making efficiency and resource allocation decisions, commissioners may be facilitated by using two economic approaches – economic evaluation and programme budgeting and marginal analysis (Williams and Robinson, 2012). Cost-effectiveness, cost-utility, and cost-benefit analyses, note the authors, are three types of economic evaluation. Another economic evaluation method is the incremental cost effectiveness ratio (ICER) which divides the difference in cost by the difference in outcomes for each type of medical intervention. All

these economic analysis methods are predominantly quantitative in nature (Donaldson *et al*., 2010) and "make little reference to affordability … [while] the additional health gain in the ICER often comes with additional costs" (Williams and Robinson, 2012, p. 73).

### 4.5.3. Commissioners as strategists, managers, and accountants

Another broad function of NHS commissioners is business and management oriented: they act as organisational strategists, manager, and accountants. Commissioners, similarly to management accountants, are expected to be "knowing subjects and organisational truth tellers" (Lambert and Pezet, 2011, p. 10). If 'accounting' is generally understood as 'calculative practices' (Miller, 1990, 2001), then commissioners will be expected to act as accountants, as well. Commissioning involves so many diverse functions, that it has appropriately been compared to the 'brain,' 'conscience,' and 'eyes and ears' of the NHS (Glasby, 2012b; Smith and Mays, 2005; Wade *et al.*, 2006). Given its centrality in the NHS system, it is surprising that so far, there is only one university in the UK, the University of Birmingham, that offers degree and certificate programmes in public sector commissioning (*Ibid.*).

Just like a strategic planner, the NHS manager should be prepared to do healthcare needs assessments. Needs assessment[30] aims to determine which health services should be provided for a catchment population:

> "The starting point for needs assessment is that there is a mismatch between the services provided and the services we believe ought to be provided. Fundamentally, this is because the factors that determine what services are provided are not the same as the factors that determine what services we believe ought to be provided" (Marshall and Hothersall, 2012, p.43).

[30] For more details on needs' assessment, please see Stevens *et al.* (2007).

Needs assessment is of three types – epidemiological, corporate, and comparative.[31] What services 'ought' to be provided may be a matter of one's philosophical inclinations. The next section elaborates on this matter. Since the healthcare services provided are often driven by decisions made in the past (Marshall and Hothersall, 2012), historical data are taken into consideration when preparing the new budget allocations among different disease types, something a healthcare manager or management accountant would do. Just like insightful managers, NHS commissioners ought to be aware of the fact that what the user or patient demands may not necessarily be what he or she *actually* needs:

> "A … problem with matching service provision to need is that demand is not simply the sum of individually expressed demands for health and social care. Individual service users are sometimes poor at distinguishing between effective and ineffective care, particularly in a healthcare setting. Therefore, even if services perfectly reflected what patients demanded, they would not reflect what they need (Newhouse, 1993)" (Marshall and Hothersall, 2012, p. 44).

From the above citation, one can see that healthcare demand is different from healthcare need. Both are constrained by healthcare supply. There may be situations of healthcare "supply but no need, need but no supply or supply and need but no demand" (p. 45). All this adds to the complexity of the commissioning function.

Commissioners should be both consistent and transparent as to their chosen perception of healthcare need (p. 46). Consistency and transparency are two concepts that financial accountants are often concerned with. Moreover, just like management accountants, commissioners should get involved in participatory budgeting and use management accounting systems and information (Bryer, 2014; Pettersen and Solstad, 2014; Seal and Ball,

[31] For more information on these three types of needs' assessment, please see Marshall and Hothersall (2012).

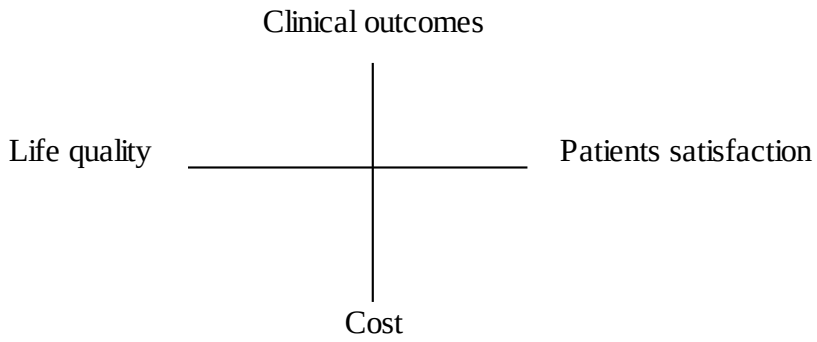
2011). Also, just like managers, they need to think about performance management, a term which Walburg (2006b, p. 23) defines as:

> "the use of interrelated strategies to improve the performance of individuals, teams and organisations. It enables organisational leaders to monitor and respond to how the organisation delivers its goods. The performance management system will involve measuring progress against a series of performance indicators."

Walburg (2006b) sees a difference between illness-specific clinical outcomes and outcomes that are more general in nature, for instance quality of life. Thus, Walburg (2006a, b) develops an 'outcome quadrant' which situates into space four outcomes: clinical outcomes and costs and life quality and patient satisfaction (see Figure 3). The above four outcomes, however, are not the only healthcare outcomes that a commissioner may use in his or her analysis.

**Figure 3**

**Outcome quadrant**




Adapted from: Walburg (2006b, p. 26)

Following the logic of the 'outcome quadrant,' a manager may need to weigh the cost of treatment against the other three indicators – clinical outcomes, life quality, and patients'

satisfaction (Walburg, 2006a). For instance, if the current treatment of a health condition costs more but leads to better outcomes (better life quality, better patient satisfaction, etc.) than alternative treatments, it may be necessary for the commissioner to do a more in-depth cost-effectiveness analysis of the current treatment before ruling out the option of pursuing this treatment.

### 4.5.4. Commissioners as philosophers

Reconciling healthcare demand and need to healthcare supply is often contingent upon one's personal value judgements. This is one reason why commissioners are expected to act similarly to philosophers. Commissioners need to think about health equalities (distributional justice) and procedural justice.[32] Justice and equity are deeply philosophical concepts. Williams and Robinson (2012) opine that given the multiplicity of available ethical principles for priority-setting purposes and the need to put together social values with other drivers for decision making, recent attention has primarily concentrated on procedural justice, i.e. on fair decision processes. The authors note further that one of the most significant sources on procedural justice is Daniels and Sabin (2008), a source that incorporates some elements of '*communitarianism*.' Communitarianism and individualism are two opposed philosophical concepts that differ in the priority they ascribe to communal or personal interests and objectives. Modern Western societies for instance are largely viewed as individualistic in orientation ('to each his own'), while many non-Western societies – as communal ('all for one'). These are two different philosophical stances on community cohesiveness.

[32] A big part of the *NHS Constitution* is based on these two kinds of justice.

The possible definitions of 'healthcare need' are also based on various philosophical stances. For example, Marshall and Hothersall (2012) see need as a 'duty to provide' healthcare services (a deontological philosophical view), a determination set by health professionals (a professional judgment view) or a 'capacity to benefit' (a teleological view). Some people believe for instance that complex and expensive surgeries should be performed on anyone who needs them, regardless of his or her age and physical condition, while others take a different stand – only people with a higher capacity to benefit, i.e. those more likely to survive the surgery and recover well, given their age and condition, should be operated on. All these dilemmas are set in the context of the *NHS Constitution* that stands for health equalities, i.e. absence of discrimination on any kind or basis.

Another philosophical question would be whether the healthcare needs of those partially or entirely responsible for causing their own illness should be attended to in a publicly-funded healthcare system (*Ibid.*). Such would be those who smoke, take illegal drugs, or those who drink excessively. In the presence of tight state budgets, priority setting,[33] or prioritisation, becomes more pronounced than in the ideal but impossible case of unlimited resources.

### 4.5.5. Commissioners as public relations (PR) representatives

NHS commissioners have to engage with the public, just like PR representatives. There are many ways to involve the public in healthcare decision making – through focus groups, surveys, leaflets, and newsletters, just to list a few (Ellins, 2012; Rowe and Frewer, 2005). CCG commissioners are expected to communicate their plans to the public and gather the

[33] Priority setting is defined as "the setting of rules, processes and criteria for restricting access to care on grounds of cost" (Williams and Robinson, 2012, p. 64).

public's opinions and views, something that would help them in future decision making. This is a two-way process. Patients and the public's involvement in the NHS dates from 1974 and has been based on three rationales: the right of the public to be involved ('nothing about me without me'), a 'means for better ends' for patients, and 'active citizenship' that connects people from the same communities thanks to NHS public meetings (Ellins, 2012). Rowe and Frewer (2005), mentioned in Ellins' (2012) work, elaborate on three levels of public involvement in a public agency's decision-making processes: communication, consultation, and participation. The determinant for these three is the direction of information flow: from the public agency to the public, from the public to the public agency, and both ways, respectively.

### 4.5.6. Commissioners as de-commissioners

Another role of CCG commissioners is to de-commission certain healthcare services, if necessary. A service may be de-commissioned for a variety of reasons – because of a change in law, financial considerations, changes in technology, and many more. When "a service that has been used historically may have been superseded or have been found to be ineffective since its inception … disinvestment or decommissioning is necessary" (Marshall and Hothersall, 2012, p. 45). Although de-commissioning is often seen as a loss to some people,[34] and a gain to others, if done properly, it may have positive consequences. Bovaird, Dickinson and Allen (2012, p. 38) see de-commissioning as a generator of "major improvements in the achievement of outcomes that really matter and the junking of processes and outputs that do not matter to citizens."

[34] Puffitt and Prince (2012, p. 111) believe that de-commissioning a health service might demoralise the staff affected since it may be seen by them as a "direct devaluing of their contribution to the organisation, perhaps generating resentment as well as anger and anxiety."

A Maslin multi-dimensional matrix is often used to decide which healthcare services to de-commission and which ones to keep (Prince and Puffitt, 2001; Puffitt and Prince, 2012). This matrix plots on a co-ordinate system the 'needs of the service user' and the 'user-defined' (the person doing the analysis) dimensions for the x- and the y-axes, respectively. The matrix plots the different services which are candidates for de-commissioning as 'high' or 'low' on the x- and y- axes. For instance, 'low need of the service user' and 'high user-defined dimension.' The four possible results are to: 1) lobby, rematch, and de-commission the service (done with difficulty); 2) withdraw or de-commission the service (done with ease); 3) continue the service but monitor and support it; or 4) review and evaluate the service on a regular basis. Some scholars share the view that under the Coalition government, health service de-commissioning in the English NHS is becoming a dominant trend (Bovaird, Dickinson and Allen, 2012). This trend is perhaps exacerbated by the general state of the global economy (Puffitt and Prince, 2012), not just by state politics.

### 4.6. Conclusion

This chapter reviewed the extant literature on the professional identities of clinicians and commissioners and their daily practices. It focused on the multiple hats that NHS commissioners have to wear: these of economists, managers, accountants, philosophers, PR representatives, de-commissioners of services, and many more. It became clear that CCG clinicians are now expected to juggle multiple identities and be exposed to a variety of practices that require the use of numbers, calculations, statistics, and data analysis. Miller (1990, 2001) calls such practices 'calculative,' as we saw in Chapter 1. It was important to familiarise the reader with the various daily activities of healthcare commissioners because

this familiarity would help better understand the research data from Chapter 7. It became clear that GPs in CCGs were influenced by a multitude of rationales – political, economic, and social – when performing their new commissioning duties. These factors are sometimes in harmony, but other times they may clash and conflict with one another. With this in mind, we will now turn to Chapter 5, the theoretical framework chapter.

# CHAPTER 5

# THEORETICAL FRAMEWORK: 'CALCULATIVE PRACTICES' AND CONCEPTS FROM THE INSTITUTIONAL LOGICS THEORY

## 5.1. Introduction

Chapter 5 presents the theoretical framework used in this research – Miller's concept of 'calculative practices' and concepts from the Institutional Logics Theory (ILT), also known as the Institutional Logics Perspective (Friedland and Alford, 1991; Thornton, 2004; Thornton, Ocasio and Lounsbury, 2012, etc.). It is important to think of the objective and research questions from Chapter 1 through the lens of theoretical concepts because often theory gives special insights into business issues. This chapter starts with a presentation of 'calculative practices' and the ILT. It then discusses some existing research on institutional change in healthcare that uses institutional logics. Reasons for the choice of theory are then provided. Afterwards, the theoretical framework of this research is visualised in a figure format.

## 5.2. 'Calculative practices'

'Calculative practices,' as we saw in Chapter 1, are "technologies of government" or "the mechanisms through which programs of government are articulated and made operable" (Miller, 2001, p. 379). As it became clear earlier, CCG commissioners are involved in a wide range of non-calculative and calculative practices as philosophers, economists, strategists, accountants, managers, de-commissioners, and so on as a consequence of a new piece of government legislation. Thus, CCGs, besides centres of philosophical decision making, are

also ‘centres of calculation’ (Latour, cited in (Miller (1990)) or a “functioning calculative network” (Miller, 2001, p. 382). Calculative practices include traditional, textbook-based accounting practices but are not limited to them. For example, complex statistical models are not yet part of the accounting body of knowledge (managerial, financial, audit or tax) but they do involve a large amount of calculations, numbering, modeling, and estimations.

Since this doctoral thesis is in accounting, a short discussion of what ‘accounting’ means is warranted. A definition of the term was already presented briefly in Chapter 1. Miller’s definition of ‘accounting’ is much broader than the traditional, textbook definitions of it – accounting is usually defined in textbooks as the process of identifying, analysing, and recording business transactions, along with preparing financial statements. Miller defines ‘accounting’ (Miller, 1990, pp. 316-317), “not as a narrowly technical mechanism for recording transactions. It is understood as a process of attributing financial values and rationales to a wide range of social practices, thereby according them a specific visibility, calculability, and operational utility …” In a later work, Miller defines ‘accounting’ as “an assemblage of calculative practices and rationales” (Miller, 1998, p. 605). On the same page, the author says that, “[a]ccounting is most interesting at its margins,” i.e. in areas that haven’t entered the mainstream accounting realm yet. Similarly, CCG commissioning is not purely about accounting but about much more. It is in the ‘margins’ of accounting and involves strategy, leadership, organisational behaviour, psychology, philosophy, ethics, medicine, and law, to list just a few. Commissioning is indeed at the margins of accounting as a complex, socially important, and very interdisciplinary process.

‘Problematising’ (Rose and Miller, 1992) is another important concept used by Miller. It is a concept that, “adds [new] practices to accounting at its margins” (Miller, 1998, p. 606). In

this way, accounting constantly grows and expands its boundaries. So, more and more activities or practices may be added to the accounting discipline as time goes on. Governments have a lot to do with this. They, according to Miller, have a 'programmatic aspect' that may be named 'political rationalities:' "This [political rationalities] is the field of statements, claims and prescriptions that sets out the objects and objectives of government" (*Ibid.*). From this perspective, the white paper (DH, 2010a) and the HSCA 2012 may be seen to embody the political rationalities or programmes of government; they helped achieve government objectives.

Another aspect of government, in Miller's view, is "technologies" of government, or a "wide range of calculations, procedures and mechanisms of government" (*Ibid.*). CCG commissioning for example may be understood as such a 'technology' of government. It does involve a lot of calculations, procedures, and mechanisms, as it was shown earlier.

> "Technologies are called upon within political argument to deliver and realize abstract aims such as order, efficiency or whatever. Equally, those who devise and operate these technologies argue for and promote their significance in relation to very general and abstract ends which they promise to bring about. There is thus an essential reciprocity between the programmatic and the technological aspects of government" (*Ibid.*).

One may interpret this quote in the context of CCGs. Such 'abstract aims' or ideals of government may include: improving patient outcomes, achieving NHS cost savings and better patient engagement, and many others. Via these technologies, governments wish to deliver on their programmes or agendas.

## 5.3. What is the Institutional Logics Theory (ILT)?

The ILT is a relatively new sociological theory which has been used in a variety of academic fields – organisation and behavioural studies, management and accounting, and sociology. Institutional logics research has proved very popular among scholars in the last few decades. This kind of research has turned into one of the fastest growing intellectual research areas in organisational theory (Lounsbury and Boxenbaum, 2013). The same source also notes that recently, there has been a growing proliferation of ILT publications in top sociology and management journals, such as: the *American Journal of Sociology*, the *Administrative Science Quarterly*, the *Academy of Management Journal*, and the *Academy of Management Review*. There have been many recent review, as well as theory, papers on the ILT (Greenwood *et al.*, 2011; Pache and Santos, 2010; Smets *et al.*, 2015; Thornton and Ocasio, 2008; Thornton, Ocasio and Lounsbury, 2012). Institutional logics research is still in its relatively early stages, with many opportunities for further theoretical development and refinement (Christiansen and Lounsbury, 2013). However, this research does not intend to make a major contribution to the ILT. Instead, it intends to use elements or concepts of the ILT to enhance understanding of the subjects studied – clinicians in CCGs. This study is an elaboration of the ILT and an empirical application of elements of this theory.

The ILT was pioneered by Friedland and Alford's (1991) paper entitled, 'Bringing society back in: Symbols, practices, and institutional contradictions' and published in the so-called '*Orange book*' edited by Powell and DiMaggio, *The new institutionalism in organizational analysis*. This book is a direct critique of the very popular at the time neo-institutional theory (Lounsbury and Boxenbaum, 2013). The Friedland and Alford (1991) article begins by criticising rational choice and economics-based theories, as well as organisational theories,

that do not take into account the broader societal context of organisations. The ILT sees society as a "potentially contradictory interinstitutional system" (p. 240). This theory quickly gained momentum after 1991 (Townley, 1997; Wilhelm and Bort, 2013), a trend which accelerated especially in the later parts of the 2000s (Lounsbury and Boxenbaum, 2013).

### 5.3.1. Institutional logics

'Institutional logics' is a term that has become a "buzz-word," that is, its meaning has been "distorted" and "overextended" (Thornton and Ocasio, 2008, p. 99). There are different possible definitions of this term. As it is common in institutional work, the definitions of terms and their usage vary. Institutional logics dictate the goals and values that agents pursue in a societal context and specify what means for doing this are appropriate; thus, logics have both a culture-cognitive and a normative dimension (Scott *et al.*, 2000).

Thornton and Ocasio (2008) refer to three possible definitions of the term 'institutional logics:' Alford and Friedland's (1985), Jackall's (1988, 2010), and the definition of Thornton and Ocasio (1999). This thesis assumes the third definition, according to which institutional logics are: "the socially constructed, historical pattern of *material practices, assumptions, values, beliefs, and rules* [my emphasis] by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton and Ocasio, 1999, p. 804). Given this definition, calculative practices, i.e. CCG commissioning, are an assembly of institutional logics.

### 5.3.2. Dynamics and interplay amongst institutional logics

#### 5.3.2.1. Central/dominant institutional logics

Western societies, according to the ILT, are divided into several 'institutional orders' or into several "central institutions of the contemporary capitalist West" (Friedland and Alford, 1991, p. 232). The exact number of institutional orders varies in the literature. Some authors see five, while others see more, institutional or societal orders. The five institutional orders in Friedland and Alford (1991) are: the capitalist market, the bureaucratic state, democracy, the nuclear family, and the Christian religion. Thornton (2004), on the other hand, sees six main institutional orders: the market, the corporation, the professions, the family, the religions, and the state. In a more contemporary work, Thornton, Ocasio and Lounsbury (2012) add another, seventh, institutional order to this list – the community. Institutional orders are important because they all host societal-level institutional logics that are specific to them (Thornton, 2002).

An institutional order, for example the state, may be composed of several more narrowly defined institutional fields: education, healthcare, social care, national defence, transportation, commissioning, etc. What would be normal or acceptable as a practice within the boundaries of one institutional order or field might be inappropriate in another order or field, postulates the ILT (Friedland and Alford, 1991; Thornton, Ocasio and Lounsbury, 2012). Kneeling down and praying to God, for instance, would be acceptable within the religious order, but inappropriate at a secular business meeting within the market order. Thus, institutional logics are bound by certain normative (bahaviour-centred) boundaries.

Friedland and Alford (1991, p. 248) have determined that each of the institutional orders of contemporary Western societies is characterised by a 'central' or 'dominant' logic, i.e. by "a set of material practices and symbolic constructions … which constitutes its organizing principles and which is available to organizations and individuals to elaborate." Each institutional order has one or more 'central' logic(s) and organising principles (Glynn and Raffaelli, 2013; Thornton, Ocasio and Lounsbury, 2012) which affect actors' focus of cognition, relationships in society, practices, and meanings (Glynn and Raffaelli, 2013). Friedland and Alford give some examples of central logics within institutional orders: the central institutional logic of the state is the "rationalization and the regulation of human activity by legal and bureaucratic hierarchies," while that of democracy is "participation and the extension of popular control over human activity" (Friedland and Alford, 1991, p. 248). In a similar fashion, Kury provides the example of the logic of "maximizing shareholder value" as being the central logic to the financial markets' institutional order in the US (Kury, 2007, p. 376).

It might be debatable which exactly the dominant logic within an institutional order is: thus, Cloutier and Langley (2013) point to the fact that the early ILT's assumption that just *one* logic dominates a stable field is unjustified. So, there may be *several* simultaneously dominant logics within a, usually mature, field. Besides, to some academics, dominant/prevailing institutional logics often represent the interests of the most powerful institutional actors within an institutional order, while secondary/repressed logics represent "subordinated interests," interests that may become more pronounced and even "superordinate" with time (Scott *et al.*, 2000, p. 171).

A relevant example from history would be the changes to the prevailing monarchy logic in 18th century France, changes that were brought by the new logic of the bourgeoisie-led French Revolution in 1789. This Revolution established the First French Republic. The republic logic was not a prevailing logic up to 1789; yet, it has persisted up to this day, i.e. it became the dominant, 'superordinate' logic. Today, France is in its Fifth Republic.

In an example from a healthcare perspective, McDonald *et al.* (2013) view the 2004 reforms to UK primary care as,

> "intended to replace the dominant logic of medical professionalism with what some commentators have referred to (though not in an institutional context) as 'production line medicine'… The former is characterised by professional autonomy and discretion … [and] the use of reflective practice... The latter can be described in terms of guideline driven care, with standardised treatment protocols which leave little room for discretion" (pp. 4-5).

From an accounting perspective, dominant institutional logics have been studied for instance in the context of companies' voluntary adoption of the International Financial Reporting Standards (IFRS) (Guerreiro, Rodrigues and Craig, 2012) and in the context of US higher education publishing in the second part of the 20th century (Thornton, 2002). It has also been proposed that besides dominant logics, there are also 'retrenching' logics (Misutka *et al.*, 2013). The latter may impede innovation and lead to anomalies. These logics are understood to be triggered by cultural positioning, behavioural resistance, and feedback shaping and are examined by Misutka and colleagues in the setting of the Alberta oil sands case from 2008-2011.

#### 5.3.2.2. Shifts in dominant institutional logics

Scott *et al.* (2000) recount a series of shifts in dominant logics in US healthcare in the second half of the 20th century. 'Quality of care' was the first dominant logic, replaced by the 'logic of equity' emphasising equal access to healthcare. Later, the logic of equity was replaced by the 'market logic' with its emphasis on efficiency. The professional accounting, architecture, and publishing industries in the US have become settings for shifts in dominant institutional logics, as well (Thornton, Jones and Kury, 2005). In the 1980s, when US professional accounting firms incorporated management consultants in their practices, the structural overlap that resulted from this change shifted the dominant institutional logics.

This shift was accompanied by a change in the focus of attention from "overseeing the accuracy of clients' books to using exposure to accounting ledgers to identify consulting opportunities" (p. 129). The fiduciary logic of protecting the public interest in terms of financial opportunism, a logic that characterised the 1800s-1980s, slowly shifted and was replaced by the corporate logic of profit making (p. 132). In the spirit of the profit-making logic, "[accountancy] firms began negotiating treatments with their clients rather than dictating the standards, all to serve clients and protect their revenue base" (p. 134).[35]

In the early years of architecture in the US, the dominant logic was the aesthetics logic. This logic's ideal was 'design.' With the later arrival of new technologies that made possible the building of metal constructions (modern lifts and skyscrapers), a new logic replaced the

[35] Dutch mid-tier accounting firms, Lander, Koene and Linssen (2013) observe, have not experienced a shift in dominant logics, but a type of hybradisation of logics – these firms have selectively adopted certain commercial logic-related practices, while retaining their main commitment to the trustee logic.

aesthetics logic – the ideal of efficiency[36] (Thornton, Jones and Kury, 2005). As already mentioned earlier, a similar shift occurred in the US publishing industry. The 'editorial' logic ('personal capitalism;' see Thornton, 2004) of the 1950s-1960s succumbed to the 'market' logic ('market capitalism'). Üsdiken (2007) provides another example of shifts in logics that underpin an institutional field or sector: starting in the 1950s, the field of business education in the US started to give way to a new, dominant logic – this of science-based business education.

Over the last decade, institutional logics research has moved away from simply studying the effects of shifts from one dominant logic to another. It has moved towards studying the implications of plural logics and organisational responses to institutional complexity (Lounsbury and Boxenbaum, 2013). The study of shifts in dominant logics characterised mostly the early ILT research (what Daudigeous, Boutinot and Jaumier (2013) call the 'evolutionary or sequential' model of the theorisation of institutional logics). The authors give the example of the field of architecture where the aesthetics and the efficiency logics have been taking turns in dominance at various times in history.

#### 5.3.2.3. Multiple/co-existing institutional logics

The central institutions of the contemporary West, i.e. its institutional orders, are "potentially contradictory and hence make multiple logics available to individuals and organizations. Individuals and organizations transform the institutional relations of society by exploiting these contradictions" (Friedland and Alford, 1991, p. 232). So, multiple institutional logics, or logics pluralism (Glynn and Raffaelli, 2013) often exist together. It is possible that a single

[36] The emergence of a new logic, efficiency, in the early 20th century US healthcare field is studied in detail in Arndt and Bigelow (2006), while the emergence of the new logic of 'managed care' is examined in Nigam and Ocasio (2010).

institutional order (or an institutional field within an order) is inhabited by multiple logics. For example, the order of the state (or more specifically, the healthcare field within the state) hosts the following logics: the professional, business, governance, and other logics. Multiple or co-existing logics have been the object of many studies (Dunn and Jones, 2010; Greenwood *et al.*, 2010; Lounsbury, 2008; McDonald *et al.*, 2013; Waldorff, Reay and Goodrick, 2013), while the synonymous conception of 'constellations' of logics has been studied by Goodrick and Reay (2011) and Waldorff, Reay and Goodrick (2013).

Using archival sources from the 1900s and 2000s, Dunn and Jones (2010) identify two logics that have been persistently central to medical education – 'care' and 'science.' This study reveals that the plural logics of 'care' and 'science' in medical education are supported by distinct groups of actors with distinct interests. These logics fluctuate with time and create tensions as to how exactly to educate the future medical professionals – more like carers and less like scientists or vice versa.

#### 5.3.2.4. Competing institutional logics

Plural or multiple logics within institutional orders and fields do not always peacefully co-exist; instead, they may 'compete' with one another for dominance (Kitchener, 2002; Vit, 2011). Some scholars have proposed that institutional change may be triggered when actors develop "mechanisms of collaboration that support the co-existence of competing logics" (Reay and Hinings, 2009, p. 647). Thus, collaborative work fosters independence and separate identities among collaborators. Previous literature, in their view, has inadequately theorised institutional change as just the replacement of one dominant institutional logic by another.

Competing logics within orders and fields have been studied in the banking sector setting. Marquis and Lounsbury (2007) investigate how competing institutional logics facilitate resistance to institutional change by focusing on bankers' resistance to large banks' acquiring small, local banks. They explore the sources of actors' resistance to institutional change and "argue that the national banks' efforts to introduce a banking logic emphasizing efficiencies of geographic diversification triggered new forms of professional entrepreneurialism intended to preserve a community logic of banking" (p. 799). Competing logics have also been studied in the mutual funds sector: two competing logics (the trustee and performance logics rooted in two different locations, Boston and New York) were found to lead to variations in the way mutual funds established contracts with independent professional money managers (Lounsbury, 2007).

Logics are found to compete within the education sector, as well. Ezzamel, Robson and Stapleton (2012) analyse the competing 'logic of business' introduced in the UK by the ERA 1988, the 'logic of professions' (the teaching occupation), and the 'governance logic' (schools and local education authorities). These competing logics, together with the 1988 legislation, were found to have impacted upon the symbols of budgeting and budgeting practice variation in the schools studied.

In another study, a model is developed to predict organisational actors' preferred responses to competing logics (Pache and Santos, 2013). The authors categorise the actors in their study into three groups (novice, familiar, and identified) in terms of their level of adherence to each institutional logic examined and determine five types of responses that the actors may resort

to – ignorance, compliance, resistance, combination, and compartmentalisation. The model tries to predict which one of the five responses would be chosen by each actor.

#### 5.3.2.5. Conflicting institutional logics

Conflicting demands on individual and organisational actors stem from the collision of different, often countervailing, institutional worlds and worldviews (Pache and Santos, 2010). Conflicting demands imply the presence of conflicting institutional logics. Such logics have been studied in a variety of contexts – in Lloyd's reinsurance trading in London (Smets *et al.*, 2015), in sports management at a religious university (Nite, Singer and Cunningham, 2013), in Dutch mid-tier accounting firms (Lander, Koene and Linssen, 2013), and in UK healthcare (Macfarlane *et al.*, 2013), to name just a few. Within CCGs as well, highly conflicting logics are present. Given shrinking, in real terms, resources for the healthcare sector, GPs' referral activity has lately been more tightly scrutinised (McDonald *et al.*, 2013). Thus, GPs are "squeezed between patient demands and field expectations about what constitutes legitimate volumes of referrals" (p. 25).

Logics may conflict with, or complement, one another. Thornton gives the example of the countervailing editorial (professional) and market logics in the field of publishing which are mirrored from the societal level to lower levels of analysis:

> "[T]he society-level logics of the professions and of markets have parallel conventions in lower-order logics; the editorial and the market logic in the publishing industry are examples of such parallels ... The professions embody logics that conflict with corporations, and markets embody logics that are complementary to corporations. Therefore, the logics of the professions and the markets imply countervailing determinants of organization structure" (Thornton, 2002, p. 83).

In a study of Research & Development (R&D) collaboration projects between small and medium-sized enterprises (SMEs) and public universities in Denmark, Bjerregaard (2010) encounters the presence of conflicting logics, as well: businessmen and academics' conceptions of the time horizon that should be available for R&D projects is found to vary. "The public researcher attempted to extend the project period for the R&D work in order to ensure the research quality … whilst the SME partner initially tried to pull the project in the opposite direction towards fast commercialization and application" (p. 104).

What are the consequences of clashes of logics (conflicts) at the field level? Lander, Koene and Linssen (2013) see four possible outcomes of the clash among logics in the literature. First, elements of the new logic may get incorporated into the dominant logic; second, elements of both logics may become hybridised; third, a shift may occur from the old, dominant institutional logic to the newly introduced one; and fourth, both logics may permanently co-exist.

Smets *et al.* (2015) sees 'conflicting-yet-complementary logics' in the field of reinsurance. Conflicting logics, if combined effectively, may converge into a new artifact and produce constructive results. Thus, when institutional complexity and conflicting logics are present, organisational actors may act as 'bricoleurs,' a term borrowed from Lévy-Staruss, and combine different elements from different logics, to design new artifacts (Christiansen and Lounsbury, 2013). 'Bricolage' is the term for the artifact the bricoleur produces when he or she uses whatever materials are available in a given, closed environment. The empirics of this study come from a global brewery group that developed such a 'bricolage' artifact – a responsible drinking guide. The brewery combined elements of the normative social responsibility logic (drinking with moderation) and the market logic (profiting from selling

alcohol). By crafting a new artifact, the organisation experienced a possible identity change: "drawing upon extant organizational resources from different times and spaces [the brewery company made] … an effort to reconstitute [its] … collective organizational identity" (p. 200).

### 5.4. Institutional change in healthcare and institutional logics

Institutional change has been the object of many studies in the management and accounting literatures (for example, Cooper, Greenwood and Brown, 1996; Greenwood, Suddaby and Hinings, 2002; Leblebici *et al.*, 1991; McNulty and Ferlie, 2004; North, 1990). This change often comes in the form of reforms that may be radical or mild in nature. It may affect the public, private or voluntary sectors. Healthcare and other public sector fields have certainly not been exempt from institutional change (Macfarlane *et al.*, 2011; Scott *et al.*, 2000). Institutional change in the NHS in particular has been examined through the lens of various types of institutional and other theories (Checkland *et al.*, 2012; Macfarlane *et al.*, 2013).[37] According to Macfarlane *et al.* (2013), early neo-institutional theory research on the NHS considered how the healthcare field was changing as a result of coercive, normative, and mimetic influences (Currie and Guah, 2007; Currie and Suhomlinova, 2006). The purpose of this section is not to extensively review the literature on institutional change, but to make the point that such change in healthcare has often been studied in the light of institutional logics.

To reiterate, the HSCA 2012 brought radical institutional change to the healthcare field in England. Besides neo-institutionalism (NPM), the ILT has also proved to be a useful lens for

[37] Institutional theory, claim Greenwood and Hinings (1996), sees organisational behaviour as a response not only to market pressures, but also to pressures from institutions – regulatory agencies (the state, the professions, etc.). Pressures coming from social expectations and from leading organisations in the field also may require organisational responses.

the study of the plurality of norms and beliefs in institutional theories and the processes that underline institutional formation and change (Cloutier and Langley, 2013; McDermott, Fitzgerald and Buchanan, 2013), be it in healthcare or elsewhere. The introduction of institutional logics into institutional theory attempted "to move institutional thinking forward by incorporating an explanation for institutional change" (Greenwood *et al.*, 2008, p. 21).

These authors remind that Friedland and Alford's (1991) model of institutions proposed that modern capitalist societies are composed of 'central institutions' that are permeated by 'potentially incompatible' logics. Namely this logics' incompatibility is what provides the dynamics behind potential change: institutional actors may recognize opportunities for change thanks to their location 'at the interstices' of logics in conflict. Such an actor 'at the interstices' is the 'doctor in the lead' in the Dutch context (Witman *et al.*, 2011). Thus, doctors may 'bridge' the worlds of medical expertise and managerial acumen. Llewelyn (2001) called these medics, in the English context, 'two-way windows,' as we already saw in a previous chapter.

From the Canadian perspective, Reay and Hinings (2005) develop a theoretical model that attempts to bring more understanding to change in mature fields, such as healthcare. The authors investigate a large-scale, government-led reform in the healthcare field in Alberta, Canada via a qualitative case study to understand the process of field recomposition. Rather than try to explain the sources of institutional change, they investigate how a field may become reestablished after the implementation of a radical institutional change. The Alberta healthcare field experienced a shift from the dominant institutional logic – medical professionalism – to another institutional logic called 'business-like health care.' Since the government wanted change to occur at the field level, claim the authors, it implemented

legislation, so that the field's structure itself might change. Something similar happened with the HSCA 2012 reforms and the ensuing reorganisation of the NHS.

Due to different funding mechanisms, new actors were created, while others were rearranged in Alberta. Both the field structure and the institutional logic changed, so that the new structure and the desired new institutional logic might be consistent with each other, opine the authors. In another study (Reay and Hinings, 2009), the same authors see institutional change in Canada's healthcare as set within competing, co-existing logics. Their review of documents shows that the government and physicians espoused different logics. The documents from the Canadian physicians' association that were examined in the study accentuated the physician-patient relationship. It is clear from this study that physicians did not wish to be controlled by the government's logic of demanding more efficiency.

Institutional change, including this in healthcare, may come in a variety of shapes and forms. It may consist of: formation/birth of a new institutional logic or governance structure, deinstitutionalisation or dissolution of an existing logic or structure or reinstitutionalisation, during which an existing institutional logic or governance structure is replaced by a new logic or governance structure (Rao, Monin and Durand, 2003; Scott 2001). In a study of the implementation of business process reengineering in the NHS, McNulty and Ferlie (2004) suggest that change may be 'sedimented,' rather than 'transformational,' i.e. that former ways of organising behaviour may retain their resilience in current practices.

Besides 'sedimented' or 'transformational,' institutional change may be of other types, as well. Change may be 'convergent' or 'radical,' 'revolutionary' or 'evolutionary' (Greenwood and Hinings, 1996). Convergent change is about slight 'fine tuning' of the existing

organisation, while radical change is more about, as its name implies, ‘frame bending’ and transformation (*Ibid.*). In the case of CCGs, the institutional change involved is radical. Revolutionary and evolutionary change, further clarify the authors, are defined by the scale and speed of change. Evolutionary change in the healthcare field may occur slowly and gradually, whereas revolutionary change may happen swiftly and have wide-spread effects, just as it happened with the HSCA 2012.

Pouthier, Steele and Ocasio (2013) remark that institutional logics and collective identities, including professional identities, are closely inter-related: logics shape identities (Creed, Dejordy and Lok, 2010; Friedland and Alford, 1991; Greenwood *et al.*, 2011; Lok, 2010; Thornton, Ocasio and Lounsbury, 2012, etc.) and identities themselves mediate the influence of logics (Glynn, 2008; Goodrick and Reay, 2010; Wry, Lounsbury and Glynn, 2011, etc.).

Changes in the strength, content, and permanence of logics-identity relationships among ‘hospitalists’ (physicians who specialise in the provision of care in hospital settings) in the US are examined in Pouthier, Steele and Ocasio (2013). The term ‘hospitalist’ emerged in the 1990s. At first, the hospitalist identity was theorised in terms of the previously existing logic of ‘managed care.’ In the following decades, the authors share, the term became disassociated from managed care. They develop a process model of detachment or disassociation from an undesired identity. The trigger for this detachment process is found to be “a set of identity threats (Dutton and Dukerich, 1991; Elsbach and Kramer, 1996) and opportunities, which challenged the ability of hospitalists to maintain a positive identity in the eyes of other key stakeholders in the health-care field, and in their own estimation” (Pouthier, Steele and Ocasio, 2013, p. 205). Hospitalists were found to respond to identity pressures via ‘cultural

differentiation' and 'social realignment' with key stakeholders, such as hospital executives and 'quality of care' movements.

Hospitalists' identities in the NHS are enshrined in a complex web of macro-level service and policy (Eve and Hodgkin, 1997): some of them interact with politicians, local communities, managers, and, of course, patients. Hospitalists' leadership patterns and the resulting organisational outcomes, as well as the creation of new orders of disease worth, also shape identities and have attracted the attention in recent academic studies (Fitzerald *et al.*, 2013; Mason, 2014). In her study, Mason (2014) shows how commissioning practices in the post-HSCA 2012 world changed the valuation of public goods through the reframing of the notion of 'sickness and health.' In a situation of providing the 'most valuable' healthcare services, rather than a 'comprehensive' range of such services, clinicians doubtlessly face the identity challenge of being the ones deciding which health conditions in their areas are worth spending resources on (see Chapter 4).

In her study of clinical directors' (senior clinicians who have assumed managerial responsibilities over their colleagues) role simultaneously in management and health, Llewelyn (2001) opens up the debate on 'boundary' role identities and 'increased interchange' and communication between managers (with their logic of 'consequences') and clinicians (with their logic of 'appropriateness'). Mintzberg's (1987) three main activity groups that characterise managers – interpersonal, informational, and decisional – all apply to the role of clinical directors. CCG commissioners, as well, engage in these three types of managerial roles: they meet with the public, provide information to other parties, and make commissioning decisions.

## 5.5. Reasons for the choice of theory

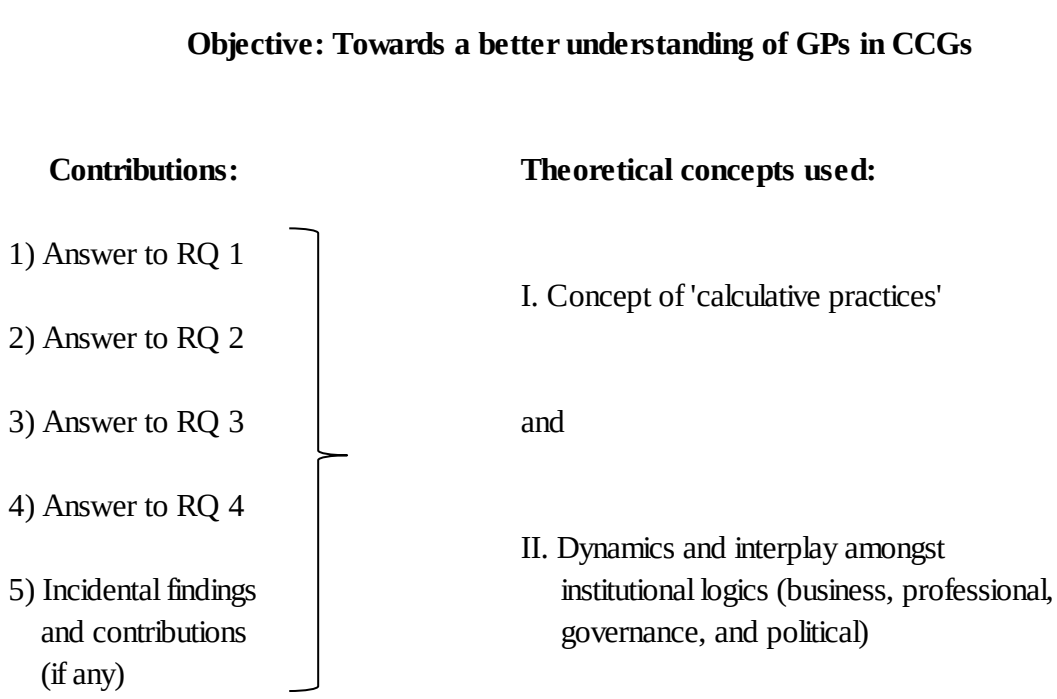
As it became clear from Chapters 1 to 4, a wide variety of factors influence the field of CCG commissioning – public sector ideologies (NPM and NPG), new legislature (the HSCA 2012), new governance arrangements and restructuring of the NHS, individual and party political worldviews and aspirations, medical and professional training and concerns, etc. The ILT, thanks to its concepts of institutional logics (business, governance, political, professional, and others) and dynamics/interplay amongst logics (co-existing, competing, conflicting, complementing logics, etc.) naturally feels like a very appropriate choice of theory for this research. The ILT does capture many of the issues discussed in Chapters 1 to 4 and seems to be very likely to help achieve the research objective from Chapter 1. This objective was to obtain a better understanding of GPs and other clinicians in CCGs. Miller's (1990, 2001) concept of 'calculative practices' is also very appropriate to use in the theoretical framework since, as we saw in Chapter 1 and section 4.5, commissioning is itself a calculative practice. NHS commissioners are expected to act like managers, accountants, statisticians, economists, and many more. This is to say, they are involved in a wide variety of calculative practices.

## 5.6. Theoretical framework used in this research

Coupled with Miller's concept of 'calculative practices,' the concept of 'institutional logics' and the dynamic interplay amongst these logics are chosen as the theoretical backbone of this study. Figure 4 depicts the theoretical framework of this study.

**Figure 4**

**Theoretical framework of this study**




The figure first presents the objective of this research, 'Towards a better understanding of GPs in CCGs.' On the left-hand side, it lists the four research questions (RQs) from Chapter 1. These RQs will be answered in Chapter 8. Below them, the figure lists any incidental findings and contributions (if any) that may transpire from the research data. These eventual incidental contributions will also be presented in Chapter 8. On the right-hand side are presented the theoretical concepts used – the concept of 'calculative practices' and the 'dynamics and interplay amongst institutional logics.' These institutional logics are: the business, professional, governance, and political ones since Chapters 1 to 4 either stated or implied that CCG commissioning interweaves these four institutional logics.

The business logic is present since NPM for example is business inspired and affects strongly CCG commissioning. Efficiency and cost savings in CCGs are both NPM and business

concepts. The professional logic is present since GPs and other clinicians involved in CCGs are medical professionals. The governance logic is present because GPs now have to govern and lead CCGs, statutorily. Finally, the political logic is also present since CCGs were instituted by a political agenda – this of the former Coalition government. The various worldviews and mindsets of the business, professional, governance, and political logics are embodied in 'material practices, assumptions, values, beliefs, and rules…" (Thornton and Ocasio, 1999, p. 804) – the very definition of institutional logics. The dynamics and interplay amongst these logics may turn out to be among these discussed in section 5.3.2 – central/dominant, co-existing, competing, conflicting, complementing, and so on.

## 5.7. Conclusion

This chapter introduced the theoretical framework of this research – Peter Miller's concept of 'calculative practices' and certain elements of the ILT. These elements mostly relate to institutional logics and the dynamics amongst various institutional logics – multiple, dominant, co-existing, conflicting logics, etc. Reasons for the choice of theory were also provided. The main reason was that given what was implied or stated in the preceding four chapters (the political and ideological embeddedness of CCG commissioning in broader contexts from Chapters 2 and 3 and the social or group identity aspects of commissioning hybrids from Chapter 3), several different worldviews or mindsets were found to affect GPs in CCGs. These worldviews are embodied in 'material practices, assumptions, values, beliefs, and rules…" (Thornton and Ocasio, 1999, p. 804) – the definition of institutional logics. Chapter 8 will discuss the research data from the theoretical framework perspective. Before that, Chapter 7 will present selected excerpts from the research data collected.

# CHAPTER 6
# RESEARCH PHILOSOPHY: METHODS AND METHODOLOGY

## 6.1. Introduction

Chapter 6 acquaints the reader with the research philosophy, i.e. the research methods and methodology, of this thesis. This chapter is vital to understanding of what specific tools and rationales will be used to answer the research questions from Chapter 1 and thus achieve the research objective. First, the ontological standpoint of this research is introduced – the interpretivist ontology – along with reasons for this choice of ontology. Second, the research methods of this thesis are introduced. These are: documents' content analysis, non-participant observation, and semi-structured interviews. It is also explained why these three methods have been chosen. Third, the research methodology or design is described and justified. Next, the data collection, selection (sampling), coding and data reduction processes, as well as the data analysis rationale are introduced. Some ethical consideration and reflexivity issues, as well as data validity, reliability, and research limitations, are also explained.

## 6.2. Ontology

Ontology is "a branch of philosophy that is concerned with the nature of what exists" (Blaikie, 2007, p. 13). In other words, ontology is concerned with the nature of reality. Moreover, Maylor and Blackmon (2005, p. 156) state that, "[o]ntology … helps us identify what we accept to be real and therefore what we can study – the objectivist focuses on physical evidence, while the subjectivist accepts that reality can be constructed by patterns of behaviour for instance." On the same page, these authors write that two differing

epistemological positions in business and management research are positivism (inspired by the physical sciences) and subjectivism (derived from the philosophy of the social sciences).

Since accounting, business, management, and organisation studies are all relevant to this particular research and since all of them are social sciences, the question behind the nature of reality in this research would be more specifically: 'What is the nature of *social* reality?' Research ontologies are also known as research 'paradigms' or research 'worldviews' (Hopper and Powell, 1985). Each research paradigm is founded on its own ontological assumptions. For instance, research paradigms, "implicitly or explicitly make different claims about what kinds of things do or can exist, the conditions of their existence, and the ways in which they are related" (Blaikie, 2007, p. 13).

Hopper and Powell (1985, p. 429) recognise that there is no such thing as a, "totally objective and value free investigation" and that, "certain fundamental theoretical and philosophical assumptions underlie any piece of research." These authors believe that researchers should make sure they are consistent with their own personal beliefs and underlying values concerning the nature of society and the sciences. They also hope that a greater tolerance and awareness of research inspired by alternative perspectives should be encouraged. In the absence of such an awareness, "there would be a danger that people become entrenched within well-defined and righteously guarded positions; unproductive claims and counter-claims may proliferate and constructive academic debate may be stifled" (p. 430). The above-mentioned study by Hopper and Powell builds upon Burrell and Morgan's framework of ontological types of research and creates a framework of accounting schools of thought and their own sociological paradigms. These paradigms are four: radical humanism, radical

structuralism, interpretivism, and functionalism. They are situated along the x-axis 'subjectivism-objectivism' and the y-axis 'regulation-radical change.'

'What is objectivity?' one might rightfully ask. There are various definitions of the term, one of which, this of Stokes (2011, p. 89), is: "A situation or an opinion is said to have objectivity when it is seen to be free and independent from particular prejudice, or partial *emotions* or sentiments. When someone or something displays these characteristics he, she or it is said to show *objectivity*." Subjectivity, on the other hand, "relates to points of, and opinions derived from, individual or group collectives' perspectives and experiences" (p. 123). Some of the most commonly used ontologies in the social sciences literature, besides interpretivism, are: positivism, the critical ontology, and critical realism (Bhaskar, 1978; Collier, 1994; Hallebone and Priest, 2008; Raihi-Belkaoui, 2004).

### 6.2.1. Interpretivism and reasons for this choice of ontology

The ontology of this research, as already mentioned, is the interpretivist ontology (Raihi-Belkaoui, 2004; Searle, 1995). If this ontology is assumed, "the goal of the research is not to explain human behaviour, but to understand it" (Maylor and Blackmon, 2005, p. 157). Interpretivism is subjectivist in nature. Subjectivism here is not considered a weakness. Some of the seminal social science pieces of work using the interpretivist paradigm are: Berger and Luckmann (1967) and Giddens (1984, 1987). The interpretivist ontology is a direct critique of the mainstream paradigm used in much of the early and present-day social science research – positivism (Chua, 1986; Hopper and Powell, 1985; Williams and Vogt, 2011). Interpretivism "holds that reality is made subjectively by (and sometimes through) our

knowledge" (Smyth, 2013, p. 3), i.e. reality does not exist independently of people's perceptions. We often construct reality via the so-called 'social construction' of reality.

Interpretivism, just like positivism, has also been the object of critique. The critical ontological approach for example critiques both positivism and interpretivism in that none of them really contributes to positive social change by and of itself. In some extreme variants of post-modernism and post-structuralism (two other ontologies), notes on the same page Smyth, interpretivism is critiqued because, "reality only exists in human knowledge and more particularly language (or discourse)," and not in people's perceptions.

Interpretivism emerged as an anti-positivist ontology in the 1960s and 1970s and is related to interpretation and hermeneutics (Hiley, Bohman and Shusterman, 1991). It was popularised by the sociologist Max Weber. It holds that reality is socially constructed via the creation of 'meanings' (Hallebone and Priest, 2008; Raihi-Belkaoui, 2004). What would be socially meaningful in one context, such as one culture, may be entirely meaningless in another. Thus, reality does not pre-exist the observer; it is created by the observer. This contextual aspect of interpretivism is in agreement with the ILT's idea that institutional logics are contextual (see Chapter 5).

The interpretivist ontology was chosen in this research because of its emphasis on subjectivity and interpretation, a fact which is believed by the researcher to contribute to a certain richness of interpretation that cannot be fully captured by positivism and other ontologies, both on the level of data and data interpretation. Such richness may be observed in several accounting studies, for instance in Ellwood (2008) and Rutherford (2003). In the former, Ellwood explains that accounting, while not 'real' (one cannot touch or feel it), "is

real in its consequences and can lead to biased decision-making, service closures and job losses" (p.399). She continues that the planned compliance of NHS trusts with IFRS may contribute to the modification and manipulation of the NHS accounting reality and the further construction of NHS meanings. Similarly, in this research, even though founded on meanings and interpretations that are partially based on DH (2010a) and the HSCA 2012, the consequences of CCG commissioning are real and affect the lives and wellbeing of millions of people in England, as well as the work of CCG clinicians.

### 6.3. Research methods: documents' content analysis, observation, and interviews

Both primary and secondary data are used in this research. Primary data are data that one has collected oneself, specifically for the research project, while secondary data are collected or created by others for their own aims or for commercial reasons (Maylor and Blackmon, 2005), but used in one's own research. Both primary and secondary data have their advantages and disadvantages. For example, primary data may take a long time to collect, transcribe, and organise and are often expensive and difficult to collect, while secondary data may save money, time, and effort. Primary data are supposed to better answer certain research questions than secondary data since they are specifically collected to answer these questions.

Research methods are tools for answering a research question. The same research question may be answered by using different methods. Examples of methods are: surveys or questionnaires, interviews, participant or non-participant observation, panels, action research, archival research, and many others (Dunleavy, 2003; Fisher, 2007; Hancock and Algozzine, 2006; Saunders, Lewis and Thornhill, 2009; Yin, 1984). In this thesis, a multiple-method

approach is used, as opposed to a 'mono method' (Horn, 2009). This kind of approach is also called 'data triangulation.' Triangulation may be used to collect various types of data (Gibson and Brown, 2009). A multiple-method approach is used here in the sense that three different research methods are used: documents'content analysis (secondary data), non-participant observation of meetings and conferences (secondary data), and semi-structured in-person interviews (primary data). Other research on healthcare commissioning in the NHS has also used some of these three methods (Checkland *et al.*, 2013; Coleman *et al.*, 2015).

Even though data triangulation may be used to test the trustworthiness of different sources of data, here some research questions will be answered by using certain methods, while other research questions will be answered by using other methods. Another circumstance for using data triangulation, according to Maylor and Blackmon (2005, p. 256), is "when you want to conduct your research in stages, and different methods are appropriate for each stage of your research." Thus, because CCGs were not operational yet when this fieldwork began (September 2012), CCG meetings could not be observed until after 1 April 2013. Data triangulation is used here because different methods help shed some light on possible answers to each of the research questions within the time and resources available for the research; for example, what managers, accountants, and clinicians say about clinicians' commissioning practices and professional identities (via interviews), how clinicians act in commissioning meetings and conferences (via observation), and what government documents say about what clinicians' practices should be (via documents' content analysis). During interviews, the research subjects may give personal accounts of their practices and engage in discourses about their identities (discursive data). Their behaviour may also be observed during interviews (behavioural data). Observational methods may be both bahavioural and

discursive in nature, as well. The three methods used here provide a richness of data that would have been compromised, had only one or two methods been used instead.

### 6.3.1. Reasons for the choice of methods

The choice of methods is dictated by the research questions and ontology assumed. The research methods should be appropriately chosen to help answer the research questions. Often, one research question may be answered using a wide variety of appropriate methods. The first research question (RQ 1) was, 'How appropriate is it for clinicians to be involved in acute care commissioning?' Documents' content analysis (Neuendorf, 2002; Krippendorff and Bock, 2009) will be conducted on the texts of DH (2010a) and the HSCA 2012. This analysis will help answer the first research question. More about the details of the documents' content analysis will follow in section 6.4.1. Official government documents, including laws, are a good source to consider when trying to understand the appropriateness of clinicians' involvement in acute care commissioning. Such documents are often readily available online and represent the government's official views on a topic of interest. Semi-structured interviews with clinicians and NHS managers and accountants will also be used to answer RQ 1. Non-participant observation of CCG meetings and NHS conferences will be used for this purpose, too (see Table 2).

**Table 2: Research questions and methods used to answer them**

| Research questions | Methods used |
|---|---|
| RQ 1: 'How appropriate is it for clinicians to be involved in acute care commissioning?' | Documents' content analysis – DH (2010a) and the HSCA 2012;<br><br>Semi-structured, in-depth interviews;<br><br>Non-participant observation of CCG meetings and NHS conferences. |
| RQ 2: 'What motivates clinicians to assume leadership roles in CCGs?' | Semi-structured, in-depth interviews;<br><br>Non-participant observation of CCG meetings and NHS conferences. |
| RQ 3: 'How involved are clinicians in CCG calculative practices?' | Semi-structured, in-depth interviews;<br><br>Non-participant observation of CCG meetings and NHS conferences. |
| RQ 4: 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' | Semi-structured, in-depth interviews;<br><br>Non-participant observation of CCG meetings and NHS conferences. |

It was determined that the researcher would have the time and resources (though limited) during the course of her Ph.D. to travel to the workplaces of NHS employees and independent contractors and interview them personally, as well as attend CCG meetings and NHS conferences where she could directly observe clinicians' behaviour. Non-participant observation helped the researcher see for herself how agents behaved, hear what they said, and observe how they spoke and acted.

In-person, semi-structured interviews are one of the most commonly known and used methods for doing qualitative research (Liamputtong, 2013). The reason for this, according to

the author, is that conversation is, “a fundamental means of interaction among individuals in society” (p. 51). Through oral communication, individuals may talk about their feelings, experiences, the world they live in (Kvale, 2007), and their self-perceived identities. The interview method has its strengths and weaknesses, just like any other method. It can help gather valid and reliable data that are relevant to the research questions asked (Saunders, Lewis and Thornhill, 1997a).

Let us elaborate briefly on the interview method of research. Interviews vary in level of formality and structure – there are structured, semi-structured, and unstructured interviews. Structured interviews were not used in this research. These interviews are based on pre-determined questions in an interview guide/schedule, without room for any deviation during the interview itself. Unstructured interviews were not used here, either. Such interviews are usually informal and help explore topics in greater depth than structured interviews. In this research, the researcher needed to ask questions on specific topics (for instance, calculative practices and clinicians’ professional identities in CCGs) that stemmed from the research gaps. This specificity provided a certain structure to the interviews. At the same time, some level of flexibility, digression, and depth of exploration was also desired. This would be the case if the interviewees responded too shortly to an interview question or if they said something interesting or unclear that the researcher wanted more details about. In such cases, the researcher wanted to ask additional or clarification questions that were not on the interview guide, to solicit a longer or clear answer.

Thus, this research uses semi-structured interviews, the middle ground between structured and unstructured ones. “In semi-structured interviews the researcher will have a list of themes

and questions to be covered, although these may vary from interview to interview," state Saunders, Lewis and Thornhill (1997c, p. 212). They also write:

> "This means that you may omit some questions in particular in interviews given the specific organisational context which is encountered in relation to the research topic. The order of questions may also be varied depending on the flow of the conversation … [A]dditional questions may be required to explore your research question and objectives given the nature of events within particular organisations" (*Ibid.*).

The interviews conducted for this research are in-depth interviews. In-depth interviews, highlights Liamputtong (2013), are usually face-to-face and one-on-one between the researcher and the research participant. Johnson and Rowlands (2012, p. 99) note that this particular method seeks to build, "the kind of intimacy that is common for mutual self-disclosure." The depth of self-expression in in-depth interviews is greater than that in other methods (for instance surveys) since the researcher may ask clarifying or follow-up questions if a point the interviewee makes is not very clear to the researcher. These questions usually solicit a more detailed answer that may help clarify ambiguities. Detailed answers were judged to be very important for this research. For instance, the interview subjects were encouraged to give specific examples from their own experience about the issues discussed.

The second research question (RQ 2) was, 'What motivates clinicians to assume leadership roles in CCGs?' and the third research question (RQ 3) was, 'How involved are clinicians in CCG calculative practices?' These two questions will also be answered by using data from semi-structured, in-depth interviews with NHS managers, accountants, and clinicians and data from non-participant observation of CCG meetings and NHS conferences (see Table 2). Some clinicians, managers, and accountants work in CCGs on a regular basis. Thus, they should be reasonably expected to know what motivates clinicians to assume CCG leadership roles. They should also most likely know how involved clinicians are in the calculative

practices of these new organisations. It seems like NHS clinicians, managers, and accountants are the right people to help find answers to RQ 2 and RQ 3. Therefore, this research looks at their *perceptions* of the level of involvement of clinicians in calculative practices. Direct observation of CCG meetings and NHS conferences should also be reasonably expected to help form some idea about clinicians' motivation and level of involvement. For example, during a NHS conference, a clinician may directly say why she chose to be a CCG Accountable Officer or may make a presentation and talk about what her clinical colleagues are doing in CCGs.

The last, fourth research question (RQ 4) was, 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' This question will also be answered based on semi-structured, in-depth interviews with NHS accountants, managers, and clinicians and observation of CCG meetings and NHS conferences (see Table 2). Clinicians and the people working with them in CCGs (managers and accountants) should be expected to know best how clinicians feel, or seem to feel, doing hybrid work, either through direct experience of these feelings (the clinicians themselves) or indirect experience (the NHS managers and accountants). Talking about clinicians' personal experiences with calculative practices in CCGs during interviews would be a good way to help answer RQ 4. Observing clinicians' behaviour (verbal and non-verbal) during CCG meetings and NHS conferences may also provide some helpful clues about how their professional identities may or may not be affected by hybridity and calculative practices. More information about the four CCG meetings and three NHS conferences attended may be found in Table 3. Appendices A, B, and C provide detailed information on the programmes of the three NHS conferences observed.

**Table 3**

**CCG meetings (anonymised) and NHS conferences attended**

| Events observed | Locations | Dates |
|---|---|---|
| *Commissioning Show 2013* | London | 25-26 June 2014 |
| *Commissioning Show 2014* | London | 12-13 June 2013 |
| *The Big Care Debate* (CCG 1's meeting with the public) | Location 1 | 18 October 2013 |
| *Hospital Directions 2013 Conference* | London | 26-27 November 2013 |
| *Health Forum meeting* of CCG 1 | Location 1 | 9 December 2013 |
| CCG 2's *Board meeting with the public* | Location 2 | 25 March 2014 |
| CCG 3's *Board meeting with the public* | Location 3 | 27 March 2014 |

## 6.4. Research methodology or design and its justification

This section elaborates on the research methodology, also known as research design, by explaining how, when, with whom, and where the research study was conducted.

### 6.4.1. Design of the documents' content analysis part of this research

As already noted, documents' content analysis is a method used toward the answer of the first research question, RQ 1. The content analysis of the two government documents (DH, 2010a and the HSCA 2012) involved reading thoroughly through their texts and finding sentences and paragraphs that conveyed the government's views (stated or suggested) on the appropriateness of clinicians to be involved in acute care commissioning. This is to say, 'Does the government think clinicians are fit to be acute care commissioners?' The researcher

also used keyword searches; for example, ‘GP,’ ‘commissioning, ‘consortia’ (CCGs were first announced in the white paper as ‘consortia,’ rather than as ‘groups’).

### 6.4.2. Design of the observational part of this research

Through the non-participant observation method, the talk and behaviour of clinicians (verbal and non-verbal) in four CCG meetings and three NHS conferences was observed directly by the researcher (see Table 3). The CCGs and their locations have been anonymised for confidentiality reasons (CCG 1, 2, and 3 and Location 1, 2, and 3, respectively). The number of meetings and conferences attended was judged to be adequate by the researcher given the time and resource limitations of this study.

Regarding RQ 1, before attending the meetings and conferences, the researcher wrote down what kinds of talk and behaviour (verbal or non-verbal) were expected to signal whether it was ‘appropriate’ or not for clinicians to be involved in acute commissioning; for example, do they speak the language of commissioning with ease, do they seem to be comfortable in these leadership roles, and do they seem to be overwhelmed? The list was not exhaustive. For example, a clinician might say during a conference presentation that GPs should not be given commissioning responsibilities at all since they went to medical school, not business school, i.e. they are not trained in business processes and calculative practices but in medicine. Also, the vocabulary used was determined to be important – would clinicians use with ease business and commissioning vocabulary and concepts, would it be difficult to spot who the managers and accountants and who the clinicians are in the room since all of them might use business concepts, such as: ‘revenues,’ ‘costs,’ ‘expenses,’ ‘assets,’ and ‘liabilities’? Non-verbal behaviour, such as confidence and poise, might also signal a level of ‘appropriateness’

in some situations. If clinicians shy away from speaking or seem indifferent at these meetings and conferences, then perhaps their level of involvement is not very appropriate.

Regarding RQ 2, prior to attending the meetings and conferences, the researcher wrote down what kinds of talk and behaviour would signal various possible motivations to assume leadership roles in CCGs. Such motivations may include, but are not limited to, the desire to help and make a difference in many people's lives, a genuine interest in health leadership, the desire to improve healthcare services, etc. Some indicative of these motivations talk and behaviour would be for example: "I have always wanted to use my medical expertise to redesign services on a large scale."

Regarding RQ 3, prior to attending the meetings and conferences, the researcher also wrote down what kinds of talk and behaviour (verbal or non-verbal) she might expect regarding clinicians' level of involvement in CCG calculative practices. For example, if a clinician mentioned that his medical colleagues have prepared a budget allocation report by themselves and have worked on it for several weeks, this might signal that clinicians are very involved in calculative practices in CCGs. If they say that they plan to delegate this job to someone else altogether, perhaps they are not so involved in CCG calculative practices. Again, this is not an exhaustive list.

Regarding RQ 4, prior to attending the meetings and conferences, the researcher also wrote down what kinds of talk and behaviour (verbal or non-verbal) she should pay attention to during the meetings and conferences. For example, would the clinicians wear name tags with the name of the CCG and their own name written on them? This might be a non-verbal clue that these clinicians have chosen to wear their CCG name tags as a sign of some level of

professional identification with hybridity and calculative practices. However, it may not necessarily signal a strong effect of hybridity and calculative practices on their professional identities in CCGs since it might as well be that clinicians have not chosen, but are expected to wear these name tags. With respect to verbal clues, perhaps speaking with pride or enthusiasm about CCG funds' allocation processes might possibly be a clue that clinicians do identify with hybridity to a great extent. It might as well be a clue that these clinicians are just showing enthusiasm, while in reality they may be indifferent or reluctant to participate in allocation processes.

### 6.4.3. Design of the interviews part of this research

Table 4 provides the interview guide, i.e. the questions asked during the interviews. The researcher tried to ask most of these questions of each interview participant. Not all questions were actually asked of each interviewee, however, due to time constraints, conversation flow, and relevance. Since the interviews were semi-structured, some additional questions not listed here were also asked of some interview participants, mostly for clarification purposes. The questions asked changed somehow during the fieldwork as time went on (some new questions were added and others deleted), for example to accommodate updated research questions or new knowledge on the side of the researcher. A contributing factor to this was the long time span of the fieldwork – about two years.

**Table 4**

**Interview guide**

**Ice breakers:**

1) Please tell me about your involvement in the NHS.
2) What was your involvement in commissioning before the most recent NHS reforms, if applicable?

**Interview questions:**

3) What is your involvement in the current commissioning system?
4) Do you think the reforms to clinicians' involvement in acute commissioning were necessary in this form and time? Why or why not?
5) In your opinion, how can the CCG system improve in the future?
6) What challenges have you experienced in CCG acute commissioning so far? Please provide some examples from your own (or others') experience.
7) What are the advantages of clinical involvement in commissioning? Please provide some examples from your own (or others') experience.
8) Do you think clinicians are in a good position to be the leaders of acute care commissioning? Why or why not?
9) Do you think clinicians are in a good position to handle duties, such as: priority setting, strategic planning, budget rationing, other accounting-related tasks, contract monitoring, etc.? Why or why not?
10) Do you see clinicians' professional identity change as a result of their involvement in CCGs? How?

**Concluding remarks:**

11) Anything else you would like to share?
12) Any personal contacts that you think might be interested in giving an interview for this research?

Table 5 shows how each interview question was expected to solicit answers to help answer RQs 2, 3, and 4.

**Table 5**

**Interview questions and related research questions (RQs)**

| Interview questions (from Table 4) | Related research questions |
|---|---|
| 1) | RQ 2, 3 |
| 2) | RQ 2 |
| 3) | RQ 3 |
| 4) | RQ 1 |
| 5) | RQ 1, 3 |
| 6) | RQ 1, 3, 4 |
| 7) | RQ 1, 3, 4 |
| 8) | RQ 1, 3, 4 |
| 9) | RQ 1, 3, 4 |
| 10) | RQ 4 |
| 11) | RQ 1, 2, 3, 4 |
| 12) | n/a |

Chapter 7 will present selected excerpts from the research interviews, together with observational data and documents' content data, in four general sections: data that help answer RQs 1, 2, 3, and 4, respectively. Generally, the interview subjects may be categorised

into two groups: 1) NHS clinicians and 2) NHS managers and accountants. Chapter 7 will present the chosen quotes from the clinicians under, 'Views from the clinicians' and the chosen quotes from the non-clinicians under, 'Views from the managers and accountants.' It was determined beneficial to interview both groups, as opposed to just clinicians, to have wider views on clinicians in CCGs. Besides, the response rate among the clinicians invited for an interview was rather low (about 8%). This is another reason why managers and accountants were also invited for interviews. Moreover, it would be interesting to see whether the two groups share the same or different views on the interview questions asked of them. Table 6 provides more details on the interview subjects (anonymised), their organisations, and the timing of the interviews.

**Table 6**

**List of interviews (anonymised) used in this research**

| Interview number | Entity (type) | Interviewee (type) | Job title | Date of interview |
|---|---|---|---|---|
| 1 | a (provider) | A (clinician) | Director of Clinical Finance | 19 Sept. 2012 |
| 1 | a (provider) | B (accountant) | Chief Financial Officer | 19 Sept. 2012 |
| 2 | b (provider) | C (manager) | Director of Business Development | 20 Sept. 2012 |
| 3 | c (provider) | D (manager) | Associate Director of Major Capital Developments | 25 Sept. 2012 |
| 4 | d (provider) | E (clinician) | Retired GP | 28 Feb. 2013 |
| 5 | f (commissioner) | F (clinician) | GP | 22 March 2013 |

| | | | | |
|---|---|---|---|---|
| 6 | g (commissioner) | G (clinician) | GP, CCG Board Member | 25 June 2013 |
| 7 | h (commissioner) | H (accountant) | Head of Financial Strategy | 5 July 2013 |
| 8 | i (provider) | I (manager) | Former Chairman | 29 July 2013 |
| 9 | i (provider) | J (manager) | Current Chairman | 29 July 2013 |
| 10 | i (provider) | K (accountant) | Director of Finance and Deputy Chief Executive | 29 July 2013 |
| 11 | h (commissioner) | H (accountant) | Head of Financial Strategy | 15 Oct. 2013 |
| 12 | j (provider) | L (clinician) | Former Nurse, current Educator in Public Health | 28 Oct. 2013 |
| 13 | k (commissioner) | M (clinician) | Retired M.D., current Health Forum representative of the local population to a CCG | 9 Dec. 2013 |
| 14 | l (commissioner) | N (manager) | Head of Service Development, former CCG employee | 19 Dec. 2013 |
| 15 | m (commissioner) | O (clinician) | GP and Accountable Officer | 23 Jan., 2014 |
| 16 | n (commissioner) | P (accountant) | Director of Finance and former Director of Finance of a SHA | 11 Feb. 2014 |
| 17 | o (commissioner) | Q (clinician) | GP and Chair and Clinical Lead | 28 Feb. 2014 |
| 18 | p (commissioner) | R (manager) | Chief Officer (Accountable Officer) | 5 March 2014 |
| 19 | h (commissioner) | H (accountant) | Head of Financial Strategy | 17 Apr. 2014 |

| | | | | |
|---|---|---|---|---|
| 20 | q (commissioner) | S (clinician) | Retired GP and CCG Governing Board member | 19 May 2014 |
| 21 | r (commissioner) | T (clinician) | GP and CCG Chair | 3 Sept. 2014 |

The NHS managers interviewed were six, the NHS accountants interviewed – four, and the NHS clinicians (mostly working or retired GPs) interviewed – ten. Twenty-one interviews were conducted. The intuitive assumption might be that clinicians would adhere mostly to the professional, medical logic and managers and accountants – to the business logic. Clinicians engaged, among other things, in self-categorisation (Hogg and Terry, 2000) and identity "self-positionings" (Morales and Lambert, 2013, p. 228) between two professional identities – managers/commissioners and clinicians. The managers and accountants, on the other hand, provided their views and perceptions of clinicians in CCGs.

### 6.5. Data collection and selection (sampling), data coding and reduction, and data analysis rationale

The research collection fieldwork took place in the period September 2012 – September 2014. Thus, this study is slightly longitudinal in nature. It covers the time before and after the CCG reforms became effective – 1 April 2013. Some data collection had already taken place prior to this date due to the timing of this Ph.D. (2011-2015).

It has been recognised that while in quantitative research sampling is usually random, in qualitative research one should try to select a sample that represents the concepts, rather than the population (Maylor and Blackmon, 2005). Sampling is a technique used with many

methods in order to reduce the amount of data that need to be collected down to a practicable amount. In other words, sampling makes research more manageable. Maylor and Blackmon recommend the use of either ‘theoretical’ or ‘purposive’ sampling where a maximum variety of responses, rather than uniformity of responses, is valued. Similarly, in this research, purposive sampling is used, as described next.

### 6.5.1. Data collection and selection (sampling)

Regarding the quote selection from the secondary data, as already mentioned, this stage involved reading through DH (2010a) and the HSCA 2012 and identifying instances that conveyed the government’s views on the appropriateness of clinicians to be involved in CCG acute care commissioning. To do the data selection from these online sources, the researcher used keyword searches. Only the most relevant parts of the documents were either cited directly or paraphrased in Chapter 7, the data presentation and analysis chapter.

Regarding the collection of observational data, the researcher took the following steps. She audio recorded with a Sony digital recorder some of the meetings and conferences attended, while hand-written notes were taken during all meetings and conferences. The verbal and non-verbal behaviour guidelines described in the research design section 6.4.2 were observed. Available conference brochures and pamphlets were collected during the conferences. A cloth bag full of conference and advertising materials was presented to each attendee at the entrance to the three NHS conferences in London. Materials were provided for free to all members of the public attending the four CCG meetings – mostly, printed agendas and reports which sometimes amounted to more than 100 pages.

Regarding the issue of which exactly CCG meetings and NHS conferences to attend (sampling), the researcher chose convenience, relevance, and importance. The three NHS conferences in London for example took place just an hour and a half away from the location of the researcher at the time – Colchester, Essex. These conferences were not only considered to be relatively nearby, but also very relevant and important. Many NHS leaders spoke at these conferences (see Appendices A, B, and C). Thousands of clinicians and NHS managers and accountants were in attendance, as well. Clinicians were given continuing education hours for their time spent at the three NHS conferences. As far as the selection of CCG meetings is concerned (sampling), this decision was guided by similar principles – ease of access and convenient timing. CCG governing board meetings with the public only take place about once every quarter.

Regarding the collection of interview data, twenty interview subjects (Interviewees A to T) gave twenty-one semi-structured interviews (see Table 6) of about 45 minutes each. The interviews were conducted in the interview subjects' offices, except in one situation when the interview was conducted via Skype due to the big geographical distance between the researcher and the interviewee. Appendix D provides more information on twelve additional interviews conducted by the researcher in the course of this Ph.D.; however, due to a change of topic (from NHS public-private partnerships to the current topic), these interviews were not used as data in this Ph.D. thesis. All interviews were recorded with a Sony digital recorder and transcribed verbatim using the Express Scribe software. This software was chosen since it allowed for the slowing down and fast forwarding of the MP3 recordings' audio.

Regarding the selection (sampling) of interview subjects, interview invitations describing the research topic, researcher's affiliation, approximate timing of the interview, and a list of sample questions to be asked were sent out by email or first-class mail to members of the governing bodies of CCGs in Essex, Suffolk, Norfolk, London, the Midlands, Cambridgeshire, Sussex, and other areas of England at a reasonable distance from the location of the researcher. Interview invitations were also sent out to GPs working in GP practices nearby. CCGs and GPs' contact information was found to be readily available online.

The invitations were sent out at intervals, just in case a large number of people from the last mailing batch responded positively to the invitation. The researcher tried to arrange an interview soon after an invitation was accepted. Most invitations did not result in an answer or an interview. After each interview, the researcher asked the interview subjects to provide some personal contacts (NHS co-workers) who might also be interested in an interview. A couple of these referrals did give an interview.

The acceptance rate among clinicians and non-clinicians was about 10% (20 individuals actually gave an interview, while about 200 individuals were invited for an interview). This low acceptance rate was perhaps due to the fact that CCGs were too new at the time. Perhaps, most individuals invited did not feel prepared enough to answer the sample questions from the invitation letters. Or, given that GPs and NHS managers and accountants have very busy schedules, it was probably very difficult for them to accommodate a 45 minute, in-depth interview. In fact, one GP responded that she could not participate in an interview due to her tight schedule.

### 6.5.2. Data coding

The interview transcripts were coded with the computer-assisted qualitative data analysis (CAQDAS) software MAXQDA10. This software allows the user to highlight text excerpts and assign to them a code by using a colour and a code description. The coding was done in two stages (Saldaña, 2013). The first stage involved 'structural' coding, i.e. coding according to research question category. There were four structural codes – one for each research question.

The second stage was more detailed and involved 'descriptive' coding. More than twenty descriptive codes were identified. For example, if a clinician said that being a hybrid had better helped her come to grips with her professional identity as a GP, this excerpt was coded as, 'RQ 4_high positive extent.' If she had said that she felt that her professional identity had remained the same before and after joining her CCG, the code would have been, "RQ 4_no effect.' Bear in mind that RQ 4 was, 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' Table 7 presents a sample list of structural and descriptive codes. Two levels of descriptive codes are sometimes used in Table 7. They are designated by the '_' sign. There were also about fifteen additional codes for excerpts that did not help answer any of the research questions. These excerpts came mostly from answers to interview question 11 (see Table 4), but also from answers to any of the other interview questions and from answers to spontaneous questions.

**Table 7**

**Partial list of structural and descriptive codes**

| Structural codes | Descriptive codes |
|---|---|
| RQ 1 | Very appropriate_they know best;<br>Inappropriate_they lack training;<br>Appropriate but not to this extent, etc. |
| RQ 2 | Interest in business processes;<br>Desire to make macro-level impact;<br>Prior experience in commissioning;<br>Monetary compensation, etc. |
| RQ 3 | Somehow involved_GPs don't commission alone;<br>Little involved_GPs delegate calculative practices;<br>More and more involved_GPs take business training, etc. |
| RQ 4 | Small extent_this is just temporary;;<br>High positive extent_CCG has changed me;<br>Positive extent_I think about commissioning a lot, etc. |

### 6.5.3. Data reduction

After coding but before analysing the interview data (Maylor and Blackmon, 2005; Crowther and Lancaster, 2009), data reduction was performed. Data reduction is the process of selecting, simplifying, and shortening qualitative data to a practical and reasonable size. Data reduction is necessary when a large amount of data is collected. Collis and Hussey (2009, p. 163) rightly observe that, "in some published studies, it is difficult to appreciate how the researcher structured and summarized hundreds of pages of qualitative data to arrive at the findings." Data reduction may be very challenging – too much data reduction takes away from the richness of the data and too little might leave little room for analysis.

Data reduction may be linked to some hard to avoid level of bias. The data reduction bias is a type of observer bias that is almost inevitable when only one researcher works on a study. Coding and interview segment selection may vary from one researcher to another. Due to the individual nature of this Ph.D., data reduction basis was inevitable. Crowther and Lancaster (2009, p. 195) also observe that data reduction is a subjective process:

> "[T]he very process of selecting and identifying chunks of data into patterns, inevitably means that the researcher's own often subjective view-points and ideas serve to shape and determine the data reduction process. One might argue, therefore, that at this stage the process is still entirely subjective and unscientific. However, so long as the reasons for, and thinking behind, the data reduction process are made clear by the researcher, then the validity and reliability or otherwise of this first stage of analysing qualitative data can at least be assessed and evaluated by others."

Subjectivity is not a weakness in qualitative research. It adds to the depth of analysis of such research, a depth that often lacks in quantitative research. In this thesis, the data reduction was done with the help of data segment 'weights,' tools available in the MAXQDA10 software. The higher the weight assigned to a segment of transcribed text during the coding stage, the more likely this particular segment was to be used, as a direct quote or paraphrased, in the data presentation chapter, Chapter 7. High weights were assigned to segments that either represented opinions shared by several interview subjects, or represented a unique, diverse view.

### 6.5.4. Data analysis rationale

Figure 5 visualises the data analysis rationale of this research. Figure 6 is an extension of Figure 4. Figure 5 adds cells in which to keep track of the various institutional logics that are entailed in the answer to each research question. The '…… logics' part is reserved for the type of logic (business, professional, governance or political) and the '…….. type of

dynamics' part is reserved for the nature of the interplay among these logics. The same applies to any incidental findings and contributions from the data. For example, if Chapter 7's data is conductive to saying that RQ 1's answer involves the professional/medical logic vs. the business logic, the first cell in Figure 5 will be filled in like this:

| Professional vs. business logic (conflicting logics) |
|---|

The cells from Figure 5 will be filled in Figure 6, which is a summary of this research.

**Figure 5**

**Data analysis rationale**

**Objective: Towards a better understanding of GPs in CCGs**

| | **Theoretical concepts used:** |
|---|---|
| | I. Concept of 'calculative practices'<br>&<br>II. Dynamics and interplay amongst institutional logics (business, professional, governance, and political) |
| **Contributions:**<br><br>**Answers to RQs:**<br><br>1) Answer to RQ 1<br>2) Answer to RQ 2<br>3) Answer to RQ 3<br>4) Answer to RQ 4 | 1) …… logics (….. type of dynamics)<br>2) …… logics (….. type of dynamics)<br>3) …… logics (….. type of dynamics)<br>4) …… logics (….. type of dynamics) |
| **Incidental findings and contributions (if any)**<br><br>List contributions here (if any) | 1) …… logics (….. type of dynamics)<br>2) …… logics (….. type of dynamics)<br>3) …… logics (….. type of dynamics)<br>4) …… logics (….. type of dynamics)<br>5) …… logics (….. type of dynamics) |

## 6.6. Ethical considerations and reflexivity

Saunders, Lewis and Thornhill (1997c, p. 109) give the following definition of 'ethics' in scholarly research: "In the context of research, *ethics* refers to the appropriateness of your behaviour in relation to the rights of those who become the subject of your work, or are affected by it." It is recognised, the authors state, that ethical considerations may emerge during all stages of the research process – planning, the seeking of access to organisations and individuals, data collection, coding, reduction, and analysis, data reporting, and the drawing of conclusions. Examples of lack of ethical behaviour in research practice would include: planning a research on a topic that the chosen population of study finds extremely offensive to discuss for religious, cultural or other reasons, being too forceful or too persistent in trying to obtain access to interview subjects in cases where multiple interview invitations have been received by the recipients but have been consistently ignored by them, claiming to have done interviews that have never been conducted in reality, and many others.

Ethical considerations were taken seriously during all the stages of this research, with a view of the rights of the research subjects and other people affected by this research (the readers of this thesis, for instance, who may draw certain conclusions from this work). The interview invitation letters and emails sent were as descriptive, as possible, not to be misleading. After reading the interview invitations, the interview subjects were in a position to give informed consent by participating in the described research. All interviewees were asked at the beginning of the interviews whether they gave permission for the interview to be audio recorded, i.e. the interviewees were given the right of choice (Myers, 2009, p. 48). Nobody refused to be audio recorded. If there had been refusals, notes could have been taken by the researcher instead.

It is believed that confidentiality is a vital part of research since it provides reassurance to the research subjects as to the fact that they will not be penalised or otherwise disadvantaged for participating in the study or sharing certain opinions. The research participants' right to confidentiality was observed by giving a signed and dated confidentiality agreement sheet to each interview subject at the beginning of each interview. This agreement stated that the researcher agreed not to disclose the names and employing organisations of the research subjects in this thesis and in any conference papers or publications that may result from it. In the case of the CCGs whose meetings were observed, these CCG names were also kept confidential. In the case where the job title of an interviewee was too unique (perhaps, the only such job title in the country), this job title was slightly altered, to protect the interviewee's confidentiality. In this respect, Hooley, Marriott and Wellens (2012, p. 35) note a concern with research participant reidentification:

> "Even though individuals' identities can be disguised through the use of pseudonyms, it may be relatively straightforward to re-identify individuals. The power of tools such as Google means that any direct quotation used in the dissemination of research findings can be easily traced back to its original context."

The ethical principles of 'beneficence,' 'respect,' and 'justice' (Mertens, 2012) were also observed during the course of this research. The very choice of topic in the planning stage of this research (the socially significant topic of NHS commissioning) is intended to 'benefit' English society due to studying the new and important issue of CCG commissioning. The interview subjects' right to decline or not to respond to an interview invitation was respected. 'Justice,' defined as, "the process of ensuring that the people who participate in the research benefit from the research" (p. 27), was also sought. The researcher plans to keep the promise

she made in the interview invitations by emailing a summary of the research findings to the interview participants upon the completion of this research.

Reflexivity is defined as, “an awareness of the researcher’s role in the practice of research and the way this is influenced by the object of the research, enabling the researcher to acknowledge the way in which he or she affects both the research process and outcomes” (Haynes, 2012, p. 72). Reflexivity may be theoretical. In this case, the researcher revises his or her, “theoretical assumptions and understandings” (p. 81), for example the theoretical framework in Figure 4, based on, “the new understandings gained during the process of research, which will then go on to inform new theoretical knowledge” (p. 82). The reflexivity informed theoretical framework through which this research intends to contribute to knowledge will be presented in Figure 6.

Another important type of reflexivity, methodological reflexivity, was also observed in the course of this research. Methodological reflexivity stands for the revision of methodology as the research unfolds (Haynes, 2012). “By considering the effectiveness, conduct and process of data collection, researchers may reinterpret and revise their methodological position to take account of such issues as ethics, power relations or the use of language” (p. 82). For example, with respect to the language used in the interview guide, the researcher altered some of the questions as the research transitioned from the pre-reform time span to the post-reform one.

### 6.7. Research validity and reliability

Research validity is, "concerned with whether the findings are really about what they appear to be about" (Saunders, Lewis and Thornhill, 1997b, p. 82). These authors refer to a 1991 study by Easterby-Smith and colleagues, according to which the question, 'Will similar observations be made by different researchers on different occasions?' may be used to assess the reliability of research findings. Given that the NHS is a big institution with 211 CCGs, each with very diverse populations, locales, practices, and outcomes, it is clear that the answer to the above question is probably, 'Maybe.' It is hard to compare a CCG from London or Manchester with a CCG from a small rural area in Norfolk on a like-to-like basis. However, in qualitative research, reliability is not such a highly treasured concept as it is in quantitative research. Qualitative research values mostly variability, depth of analysis, and subjectivity. In it, diversity, not consistency among populations (like in quantitative research), is valued more (Saunders, Lewis and Thornhill, 1997b).

According to the same source, there are four threats to research reliability: subject error, subject bias, observer error, and observer bias. Regarding subject error, one may find, claim the authors, that a questionnaire completed on different days of the week may generate different results. For example, a questionnaire filled out on Friday just before the end of the workday may show more optimistic attitudes than the same questionnaire filled out by the same person in the middle of the week when job duties often tend to be the most stressful. Regarding subject bias, one may notice that research subjects give the answers that they believe their bosses would like to hear, write the authors. Besides, introducing a, 'high degree of structure' to the interview guide would reduce the threat to reliability (*Ibid.*). Finally, observer bias is reduced when more than one researcher are involved in interpreting the

results. In this research, there had to be only one researcher for obvious reasons and thus, there was an unavoidable threat of observer bias. However, the researcher made a genuine effort to reduce this threat by trying to look objectively at the data and analyse them free of personal bias. For example, when two contrary views were presented (one of which coincided with the personal views of the researcher), the researcher quoted the two contrary views, not just the one she personally favoured.

### 6.8. Research limitations

Research limitations are an inherent weakness of any research, no matter what methods, methodologies or theories are used. This research also has its own research limitations. First, if different people had accepted the research invitations and given interviews, perhaps their answers to the questions from Table 4 would have been different from those of the people who actually gave an interview. Moreover, if the same people who were actually interviewed were asked the same questions at a different time or place, maybe their answers to the same questions would have varied, too (an example of the subject error discussed above). Second, if different CCG meetings or NHS conferences were attended, perhaps different observations would have been gathered. Thus, research data are time and context specific, a limitation to all research. Third, CCGs are new and highly complex entities that involve a multitude of actors and structures; therefore, only certain of their aspects and processes were studied here – GP hybrid professional identities, calculative practices, and acute care commissioning. Other important aspects of GPs in CCGs were not addressed in this research – work burnout (such as stress level on the job) or desire to continue serving as a CCG leader. Fourth, not all views expressed during the interviews were cited or paraphrased in this thesis, just a selection of the most representative, interesting, diverse, controversial and/or thought-provoking ones.

By no means does this mean that the views left uncited or unparaphrased were unimportant. Lastly, as any other qualitative research, this research assumes a certain degree of researcher bias in terms of the analysis and conclusions drawn.

## 6.9. Conclusion

Chapter 6 introduced the research philosophy of this thesis – the research methodology and methods. Reasons for the choice of methodology and methods were given. The ontology and the research design of this study were also discussed – interpretivism, data collection and sampling, coding, data reduction, data analysis rationale, ethics, reflexivity, validity, reliability, and limitations. This chapter was important because, among other things, it exposed the rationale for the data analysis and discussion (Figure 5) for Chapter 8. Now, Chapters 7 will present and analyse the reduced research data, so that the four research questions posed in Chapter 1 may be answered later in Chapter 8.

# CHAPTER 7
# DATA PRESENTATION AND ANALYSIS

## 7.1. Introduction

The research data presented and analysed in this chapter come from the primary and secondary sources mentioned in Chapter 6. To reiterate, the primary data consist of semi-structured interviews with NHS managers and clinicians (see Table 6). The secondary data consist of non-participant observation of CCG meetings and NHS conferences (see Table 3 and Appendices A, B, and C) and government documents (DH, 2010a and the HSCA 2012).

## 7.2. Data used to help answer RQ 1

Research Question 1 (RQ 1) was, 'How appropriate is it for clinicians to be involved in CCG acute care commissioning?' This section will present and briefly analyse selected secondary and primary data which will help answer RQ 1 later in Chapter 8.

### 7.2.1. Views from the documents

The views presented here are these of the Coalition government expressed in the white paper (DH, 2010a) and the HSCA 2012. The government's rationale for adding healthcare commissioning to the usual duties of GPs and other clinicians in England was first announced in the above-mentioned white paper. The white paper and the resulting legislation are expected to have a long-lasting and profound impact on the English NHS.

The white paper states that,

> "Doctors and nurses must … be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control … Of course, our massive deficit and growing debt means there are some difficult decisions to make … But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation" (DH, 2010a, p.1).

It also says:

> "The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia [the original name of CCGs]" (DH, 2010a, p. 4).

It also says that,

> "In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices. This change will build on the pivotal and trusted role that primary care professionals already play in coordinating patient care … Primary care professionals coordinate all the services that patients receive, helping them to navigate the system and ensure they get the best care (of course, they do not deliver all the care themselves). For this reason they are best placed to coordinate the commissioning of care for their patients while involving all other clinical professionals who are also part of any pathway of care … Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients' health or healthcare" (DH, 2010a, p. 27).

Based on the three quotes from the white paper above, one can see that the government at the time really trusted clinicians, the NHS frontline workers, in a time of deficit and growing national debt. It saw them as, 'best placed to coordinate the commissioning of care' for patients. Now, let us turn to the HSCA 2012.

The HSCA (2012, s. 25(1)) mandates that, "each provider of primary medical services … [be] a member of a clinical commissioning group." According to the same sub-section, each CCG must have a constitution of its own and a governing body. The main functions of the governing body are, "to ensure that the group has made appropriate arrangements for ensuring that it complies with … its obligations … and … such generally accepted principles of good governance as are relevant to it." A GP-led CCG may have its own employees and may also hire others (for instance, non-employees from CSUs) to provide services on its behalf.

The legislated duties of CCGs, according to the HSCA (2012, s. 26), are various in nature and cover a wide spectrum of issues. A CCG, among other things, needs to: promote the *NHS Constitution*, "exercise its functions effectively, efficiently and economically," improve the quality of services "in connection with the prevention, diagnosis or treatment of illness," obtain appropriate advice "from persons who (taken together) have a broad range of professional expertise," advocate public involvement and consultation, publish commissioning plans and annual reports on a regular basis and present the annual report to members of the public. The business emphasis of CCG duties is evident in the HSCA (2012, s. 27) which states that a CCG, "must ensure that its capital [and revenue] resource use in a financial year does not exceed the amount specified by direction of the Board [i.e. NHS England]."

According to Schedule 2 of the HSCA 2012, a CCG must have an Accountable Officer who is appointed by NHS England. One of his duties, according to this schedule, is to ensure that the CCG, "exercises its functions in a way which provides good value for money," another

requirement inspired by business reasoning processes. Schedule 2 also provides for an optional auditing provision: the "[the] accounts prepared … must be audited in accordance with the Audit Commission Act 1998 by an auditor or auditors"

Based on the above quotes from the HSCA 2012, one can see that clinicians were entrusted with a lot of important commissioning duties by the government. The HSCA 2012 is more technical and procedural in nature than the white paper and does not go into details about the appropriateness of choosing clinicians for these important roles the way the white paper does.

### 7.2.2. Views from the managers and accountants

In terms of appropriateness to be involved in CCG acute care commissioning (and commissioning in general), GPs were perceived by several managers and accountants as being not strategic enough. It was implied that being strategic was a key skill for a good commissioner. Interviewees H, N, and J shared the perception that GPs were not very strategic in CCGs due to the fact that their professional training was not business training, but one based on a medical doctor-patient, individual-level relationship.

Interviewee H said:

> "Hm, in theory it's a good idea [for GPs to be involved in commissioning] because they would be the clinical leaders of the system and all healthcare starts with primary care. In practice, it's extremely variable because the quality of primary care is extremely variable and hasn't really been addressed through the new contract" (Interview 7; **Quote 1**).

Interviewee H also shared:

> "No, they [GPs]'ve had no [business] training whatsoever other than some kind of corporate development support, but it's no way near enough. So, a lot of them don't really know how to run a legally-constructed public organisation

> and what the governance rules are, how boards should operate, how conflicts of interest should work, the roles of the Chair, the Accountable Officer, CFO ... So, quite a lot of them are quite inexperienced and it will take some time for them to gain that experience. And they also've got a tendency to do what are called 'silo gazing.' They look inward to their own organisation, not outward, at strategic level" (Interview 7; **Quote 2**).

Interviewee N said the following:

> "I think GPs … their professional culture is one of independence. So … managing large organisations is quite difficult for them. I also think there are gaps in their knowledge and skill in terms of some of the managerial aspects of commissioning. Hm, but on the positive side, I think they do bring, they certainly bring some practical experience to the discussion. And they tend to, they also, in some cases, bring some analytical skill, as well. But I don't think, generally, they are very strategic" (**Quote 3**).

Interviewee J expressed the following opinion:

> "I think they, the whole CCG lacks vision and strategy, so I think that's an area where management would help them develop. I think it was always going to be the case that the CCGs would have to have managers and a Chief Executive who is experienced and so on. And I think Andrew Lansley really in initiating the changes didn't make that plan. So, people got very concerned about GPs running a huge budget and never having any experience" (**Quote 4**).

From the four quotes above, one can see that some managers and accountants expressed skeptical views on the issue of how appropriate it is for clinicians to be involved in acute commissioning. They mentioned that clinicians lacked management training and skills, that 'they are not very strategic,' and engaged in 'silo gazing.'

Besides, GPs were perceived to be not 'all at one voice.' The interview data seemed to suggest that there was a lack of consensus among clinicians with respect to how to commission acute healthcare. Interviewees B, J, N, and R all agreed that GPs were not always in agreement with one another in terms of acute and other commissioning practices. Interviewee B shared:

> "And they are making collectively decisions about commissioning, I think they find amongst themselves … that would be really challenging because they haven't really had to think in that way collectively before. I think that those who are leading the CCGs are starting to find that particular challenge. They've got GPs who aren't all at one voice" (**Quote 5**).

Interviewee N disclosed that, 'not all the GPs [in his area] … [got] on [well] with each other [laughing]. So, they decided to have two groups' (**Quote 6**). Interviewee J mentioned:

> "Hm, one other thing is there is a general consensus, a general view, that CCGs are being run by GPs, represent GPs' views generally, and can get GPs to do things. That's not true. You know, the CCG struggles more to get the GPs to align to their commissioning intentions than they do to get acute hospitals to. So, we are very keen to introduce for example integrated care for the elderly but the GPs are not so keen. When the commissioners (the CCGs) commission a pathway, the GPs don't all buy into it. They do their own thing" (**Quote 7**).

Interviewee R shared:

> "[T]here's quite a lot of rivalry between practices. They are very competitive with each other … Or, actually, for micro-businessmen [they are] quite competitive between each other … But I find it causes me more problems managing … between them [GPs] … This does cause friction between them" (**Quote 8**).

It seems that even if it may be appropriate for clinicians to be involved in commissioning, *how* exactly they are involved and *how* exactly they commission are other issues that bring with themselves even more complexities – disagreements among clinicians, competitiveness, and sometimes friction.

### 7.2.3. Views from the clinicians

Interviewee A, a hospital medical specialist, shared:

> "[I]t's an experiment … And that's quite a high risk experiment, one of the higher risk things that the government have done. If it works, what it will allow is GPs, potentially, to redesign care pathways, so that patients always

> don't go to secondary care which is generally quite an expensive option. And so, if an elderly patient is having multiple falls, they often come to the hospital and spend a week in hospital, whereas they would be better managed in a non-hospital setting. So, the ideal is the people who know when it's best to design a pathway are in charge of it; whereas, previously there was a lot of inertia in the system because the GPs didn't really have much financial responsibility and therefore were doing what was the easiest thing which is to send the patients to hospital. Now they've got financial incentivisation, not necessarily personally, but because they have to live within a constrained budget, they might do something differently" (**Quote 9**).

Interviewee O, a GP, suggested that it was appropriate to build a 'synergy' between clinicians and managers in order to have a successful commissioning system:

> "Hm, I think … the big advantage of clinical commissioning is it says to the clinicians, 'You are responsible for the whole of your health system.' So, if it's not working, you are able to do things to put it right, you are able to take control, whereas previously in PCTs, it was not necessarily just the PCT that stepped back from engaging clinicians. It was sometimes the GPs and other professionals who stepped back from their responsibility. So, by putting it on the shoulders of the clinicians and saying, 'You use the tools that you need to sort it out' … and what we find is that it is a partnership between clinical leaders and expert managers and it doesn't work with one or the other on their own. It has to be that synergy" (**Quote 10**).

Interviewee O shared:

> "So, I would much rather have inherited the end-to-end responsibility of the PCT but with that requirement that it is the responsibility of the local clinicians to make it work. And then we would make sure that we have the managerial expertise in the organisation to discharge that responsibility. But we would then have been able to influence the whole system, whereas now we can only influence parts of it … [F]or example we don't commission general practice, we don't commission specialist services, we don't commission forensic services, things like that. And all of those have an impact. It's not, none of these exist in isolation, they all interrelate. The problem at the moment is that my priorities as a commissioner may not align with the priorities of the commissioners for the other system (parts of the system) but impact my population. So, public health going off to local government for example has created a big dis-connect in what was a very successful strategy between public health and health services' commissioning, where the PCT quite rightly had chosen to put more investment in public health than elsewhere. But what's happened is that then disappeared out of our control" (**Quote 11**).

Interviewee G, a GP, said:

> "When CCGs were formed, one of the key reasons for its formation was that NHS was running with cash starvation. And they had to find new ways to control the cost but at the same time make sure that the quality and services are well preserved and I think that giving it in the hands of clinicians addresses that focus and especially at our CCG level, the clinicians *are* in charge and they think more rationally, innovatively, to find the quality of care and to produce efficiency, so when there is like a war, people are at their best. So, when you have less money, to produce the same results, you have more innovation, and you think more differently to address those problems" (**Quote 12**).

Interviewee E, a retired GP, said:

> "But I mean most doctors will say, 'I am the clinician. I've been trained to treat people and care for people. Somebody else should be dealing with how all this is funded and how it might maximise the value of the service at the lowest cost level to the organisation … I think, probably two aspects of that, really. Doctors by and large have sort of common sense financial management you might get from running your own home. Doctors are not trained in financial management and therefore I think they probably have only a limited capability in these Clinical Commissioning Groups 'cause they are not used to dealing with, you know, multi-million pound budgets. I think most doctors see their skills as treating their patient population and knowing what the needs of their own patients, individual patients are, rather than knowing the needs of a wide population, you know, in a big city. I think the other thing that is starting to come out of this really is that if you have the GP as a service provider and also the GP as the purchaser of the services, you've got the GP trying to act in both roles. They are trying to provide the service at the coalface, if you like, for their individual patients. But that same GP may be involved in budget allocation. And I think there is a potential conflict of interest there that you are both a provider and a purchaser, the person who's deciding what sort of service provision needs to be bought from various health areas" (**Quote 13**).

In agreement with the managers and accountants' views from above, Interviewee E doubted the 'financial management' skills of clinicians. This interview was conducted only in early 2013, before CCGs became operational, so the reference to 'conflict of interest,' conflict which has been somehow mitigated later on, was a relevant issue at the time. Interviewee G was more optimistic about clinicians' aptness to commission well – in his CCG, 'the clinicians … *[were]* in charge and they … [thought] more rationally, innovatively.'

Interviewee A suggested that GPs would be careful commissioners due to the fact that now they were given more 'financial responsibility.' Interviewee O accentuated on the fact that a 'partnership' between clinicians and managers would be appropriate in commissioning and lamented the fact that now clinicians can only 'influence parts of it [the system],' unlike PCTs which could influence bigger parts of the system.

### 7.2.4. Observation of meetings and conferences

Some of the secondary data, i.e. data from the observation of CCG meetings and NHS conferences, gave some good clues as to the appropriateness of clinicians to be involved in acute care commissioning. The researcher observed a large variety of talk and behaviour at the *Commissioning Show 2013*, the *Hospital Directions 2013 Conference*, and the *Commissioning Show 2014*. During the *Big Care Debate* of CCG 1, the Accountable Officer who was a GP openly shared with the audience the challenges this CCG was facing – a growing elderly population, an increasing number of people with complex needs and long-term conditions, and a shortage of qualified medical personnel. He encouraged the audience to form groups of about eight people per table and write suggestions about what healthcare services they thought worked well in their local area and what services needed improvement. After discussing these issues in small groups, one person from each group summarised his or her group's concerns for everyone to hear. The notes of each group were then passed to the Accountable Officer who promised to personally read each one of them.

The *Big Care Debate* showed this GP-Accountable Officer in the light of a clinician and leader who was both financially and clinically competent and genuinely interested in finding out what the public thought about the healthcare services in his local area. This GP seemed to

be very well fit to be involved in acute and other commissioning. He used financial words, such as 'underfunded,' 'financial prognosis,' 'benchmarks,' 'demand,' etc.

The *Health Forum meeting* of CCG 1 was led by a retired GP. There were about twenty-five members of the public present. The most elderly person present was in his early 90s and was acknowledged during the meeting by the retired GP leader. This former GP wanted to hear views from the public on certain issues taking place in the local NHS trust, issues which were the object of close media attention at the time. He announced that he would make these views known to the local CCG. This GP displayed qualities of an outspoken leader, concerned medical professional, and visionary. He was well informed about the A&E challenges in the local area, the results of patient satisfaction surveys, and media news. He also responded to some business and finance-related questions from the members of the public with competence and ease.

Another meeting, CCG 2's *Board of governors' meeting with the public*, was attended by nine governing body members. The Chair of the board who was a GP participated very actively in the meeting. The meeting lasted for three hours. The Chair opened the meeting at 2:00 pm and presented the board members to the nine members of the public present. Then, the Chair summarised the declarations of conflicts of interest,[38] the items exempt from the *Freedom of Information Act 2000*, the minutes from the last board meeting from January 2014, and the action log. At about 2:30 pm, he welcomed any questions from the members of the public and answered some of them or invited members of the board to do so.

[38] The agenda of CCG 2's *Board of governors' meeting with the public* explained that if the Chairman and members had any pecuniary interest (direct or indirect), in any contract, proposed contract or other matter subject to consideration at the meeting, they had to disclose during the meeting this fact and not take part in the consideration or discussion on this contract, proposed contract or other matter, nor vote on any question with respect to it. There were a couple of declarations of potential conflict of interest.

Among the items from the minutes of the previous board meeting that this GP-Chair summarised were: a patient's story which was presented by the author in the form of a long poem, discussions about a commissioning report that was being prepared, and a performance report. Throughout the meeting, this clinician demonstrated excellent leadership skills and made use of business and accounting vocabulary with great ease. He used vocabulary, such as: 'deterioration in costs,' 'transformation funds,' 'fluctuating costs,' 'processes and controls,' and 'impact on anticipated savings.'

At yet another meeting, CCG 3's *Board of governors' meeting with the public*, twelve board members were present. Two of them (the Chair and the Director of Nursing and Quality) were clinicians – a GP and a nurse, respectively. The meeting started at 1:30 pm and finished at 6:00 pm. Similarly to the Chair of CCG 2, the Chair of CCG 3 led the first part of the meeting (from 1:30 to 2:25 pm). She introduced the board members in attendance to the ten members of the public present, read the apologies of the absentees and the declarations of interests report, gave a summary of the minutes from the last board meeting, talked about matters arising from the last meeting, gave the Chair's update, and finally introduced the Accountable Officer who gave an update on some CCG governance issues.

Later during the meeting, the Chair presented the minutes from the last CCG Audit Committee meeting from January 2014 and used terminology, such as: 'internal audit tender,' 'CSU KPIs [Key Performance Indicators],' 'financial position,' 'new financial ledger,' 'risk report,' and 'counter-fraud progress report.' It was observed that the GP-Chair was well fit for her role. She facilitated the discussion of various issues with great ease and answered clearly and informatively several questions from the public regarding the workings of the CCG.

## 7.3. Data used to help answer RQ 2

As outlined in Chapter 6, interview excerpts and observational data from CCG meetings and NHS conferences will be used to help answer RQ 2. This research question was, 'What motivates clinicians to assume leadership roles in CCGs?' Before clinicians' motivation is discussed, it would be helpful to see who the clinicians involved in CCG leadership roles are, i.e. to look into their background – training and work history, both in medicine and previous forms of commissioning, if any.

### 7.3.1. Clinicians' backgrounds, i.e. training and work history

Several of the GPs interviewed (Interviewees O, Q, S, and T) shared that they had extensive prior experience in commissioning from earlier NHS commissioning reforms, such as the voluntary GP fundholding and PBC. One GP shared:

> "Hm, so, I trained … as a doctor and I qualified in 1996 and I … did my pre-registration house officer jobs and their surgical rotation … through to 2008. Then, I passed my membership in the Royal College of Surgeons exams. Due to some health problems, I decided to change career and train as a GP. So, then did a GP vocational training scheme … for another two years and qualified in 2000 and then came over to [county] to work as a GP. Sorry, then I had a year … as a GP registrar in [town] in [county]. Then, I came over in 2001 to [county] to work. And in 2002, I became a Partner in practice in the [town] area. By two thousand and, I think 2003, I started doing some part-time work with the [county] Strategic Health Authority, as it was at the time, supporting the Connecting for Health Programme (the National Programme for IT as it was at the time). And … they gradually increased my commitment there until … in 2006, I was doing two days a week work there and that work gradually evolved into supporting Practice Based Commissioning and, hm, I continued that work for a couple of years till the SHA [Strategic Health Authority] dissolved in 2008, I think. Hm, and during that period I'd also become the leader for the [town] Practice Based Commissioning Group. In 2009 … Yes, it's been a very interesting journey. And then, during that period of around 2010 when the government was setting out its new strategy around the *Health and Social Care Bill*, we consolidated with the [town] Clinical

> Commissioning Group, which had been the neighbouring Practice Based Commissioning Group, to form a single group … I certainly spent quite a lot of time contributing to national policy and thinking around clinical leadership. I wouldn't claim that I influenced that hugely since these things are complex and difficult to influence and a lot of people have input into them, but certainly we were pushing in that direction for a very long time. So, during this time (in about 2007, I think, maybe 2008) I became the, one of the two clinical commissioning champions for the NHS Alliance, which is a national membership organisation that was formed around the time fundholding was introduced and through that I networked with a lot of like-minded people across the country but also got involved in a lot of work with the Department of Health and with, you know, kind of shaping thinking and working with think tanks and policy fund organisations to contribute to the thinking about how clinical leadership could be a positive contribution" (Interviewee O; **Quote 14**).

Another GP said:

> "I started off, I did, hm, went to school in [county], went to [university], did a natural sciences degree, which is mainly chemistry, and left and joined the [military body] for, it was a total of 16 years, but the first eight years I was flying and I left, went to medical school and then went back in as a doctor for the next six years, so … there was a gap in between. And then 12 years ago, I left the [military body] and came to [town] as a GP. So, 12 years ago, I joined the NHS as a General Practitioner. And through that I got involved first in Practice-Based Commissioning and then – Clinical Commissioning Groups. So, effectively we had a Practice-Based Commissioning Consortium in [name] CCG for the past 7-8 years … We were quite a cohesive team … so we've always been recognised as being one of, if you like, the leaders as far as CCGs in [part of England]" (Interviewee Q; **Quote 15**).

Yet another GP said:

> "So, I should probably just tell you to start with that, hm, I stopped doing general practice about 18 months ago, but I carried, I carried on doing the commissioning work, OK? So, I don't do clinical work anymore, but I am just doing this work. OK? … So, I was a GP for over 20 years in [town] and, hm, for probably the last, hm, 15 years I've been involved in, with all the various NHS, hm, reforms and whatever, in some way. So, initially in the Primary Care Groups and then in Primary Care Trusts, I've been involved in linking up with the practices in [town] and the … area to working together to deliver the sort of the national agenda. So, so, so, working in the NHS as a GP and then working alongside that in a commissioning role … Well, since, yeah, it would have been since 97, I think, when the Labour Party came in and then that was the demise of fundholding and the beginning of Primary Care Groups. So, I don't know if you know the history going back, but I was involved in them, really" (Interviewee S; **Quote 16**).

Interviewee T, also a GP, shared his experience:

> "So, I qualified in 1988, [city] Medical School, and did a range of hospital jobs which you are required to do in order to fulfilled GP training. Then, I did a year as a GP, as a trainee back then (there wasn't a Registrar back then) and then I did a year of research in epidemiology based mainly in [city], but then I came back, we came back to [town], and I've been a GP since then. Did a little bit of locum work for about 8 or 9 months and then became a Partner about 18 or 19 years ago in the practice that I am at now. So, I've been a GP there ever since. I was full time to start with. Currently, my clinical work is one and a half days and I, my other sort of main involvement's been a bit of work with the Local Medical Committee (the LMC). I've done that for quite a number of years and I still do a little bit of that but I do a lot less of that now because of the CCG involvement. The CCG involvement's been, well it's grown, and it's now three days a week" (**Quote 17**).

Another GP who was retired at the time of the interview said:

> "Well, I've retired, I retired ten years ago but I started working for the NHS as a junior doctor in 1963 and I retired in 2003. OK? … My specialty, before you are a consultant, you work generally in everything but when I was appointed a consultant in 1975, it was a consultant in general medicine, diabetes, and endocrinology. So, the general medicine is taken as being something that everyone does, but my specialty interest was diabetes and endocrinology" (Interviewee M; **Quote 18**).

Another GP shared the following:

> "OK. I will start off saying that I started working in the NHS in 1987. I started off with being a hospital doctor, working in oncology, radio-oncology and I spent about five years doing patients' cancer treatment, chemo-therapy and radio therapy treatment. Then, in 1991, I changed my course, became a GP and since then I am a GP in [city]. Since 1992 till now it's about 20 odd years. But I am also a Board member of the CCG and I've been a Board member of previous organisations like the PCT and the PCG. Since 2002, I have been involved in NHS management. And my current role is that I am the Clinical Safety Officer for the CCG and the Innovative Lead for the CCG and I have four or five of my programmes that I lead on. Most of them are cardio-vascular, MSK [musculo-skeletal] but it's all based around a teaching concept and training concept which is the 'three T concept' … In the PCTs, in the previous system, I have always been a Board member of the PCT, as well. For three or four years in between I wasn't in medical management but most of the years I've spent in it" (Interviewee G; **Quote 19**).

Yet another GP said:

> "So, I graduated from [city] Medical School in the year 2000 and I did my first jobs at [city] Teaching Hospitals and [religious denomination] District General Hospital in …. [town] and I did three and a half years as a surgical trainee at various places – [religious denomination] Hospital, [city] Hospital in [city] again and I did general surgery, urology, neurosurgery, orthopaedics, Accident & Emergency medicine and then I changed to general practice training after doing six months paediatrics at [religious denomination] Hospital. I moved to [town] and I worked at [name] NHS Trust and I did psychiatry, gynaecology, for a number of years, and training in a GP practice. Then, I finished my GP training in 2007 and then moved to the [name] Practice in the centre of [town] as a GP Partner and I worked there for five and a half years and then recently this year I moved to … Scotland and from the beginning of last month, I am working at the medical practice here as a GP … Yeah, so during my career I've had quite a lot of medico-political experience, as well. When I was a GP trainee, I was the regional representative on to the British Medical Association [BMA] Board for GP registrars where I used to go to kind of meetings in London and also to the kind of Annual Conference for junior doctors and to the BMA. And I was also the registrar representative on the Local Medical Committee [LMC]. When I became a GP, I carried on their kind of property from the LMC and last year I had about six months of being the Medical Secretary of [town] LMC and I've been to the LMC conference several times. So, I knew quite a lot about kind of the politics of primary care and things like that" (Interviewee F; **Quote 20**).

From the seven quotes above, it becomes clear that many of the clinical interviewees who had assumed leadership roles in CCGs had had a long and diverse experience working in medicine. General practice, as well as medical specialisations, were both mentioned. Interestingly, a *continuity of involvement* from various kinds of prior commissioning – GP fundholding and PBC – was often observed. These clinicians became naturally and seamlessly the CCG leaders of their respective geographical areas. This is to say, these clinicians were recycled through the commissioning system, most likely thanks to their prior commissioning experience, experience which many of their clinical colleagues perhaps lacked at the time.

### 7.3.2. Why did clinicians assume leadership roles in CCGs?

Now that clinicians' training and work history were presented, what can be found out about their motivation to assume leadership roles in CCGs?

#### 7.3.2.1. Views from the clinicians

In terms of why he undertook a CCG leadership role, Interviewee F was found to like the politics of medicine – Interviewee E said about another interviewee whom he knew as a former colleague, "I think he [Interviewee F] volunteered to be there [in a commissioning leadership role], yeah, 'cause he quite likes the politics of medicine" (**Quote 21**).

When asked why she got involved in a CCG leadership role, Interviewee S responded:

> "I think that, probably along with a lot of people, just doing full time general practice is just too head banging. It's just too dreadful [laughing]. So, you need to find something else to do … to help keep your enthusiasm going … to help deliver on … I think I thought I wanted to do it on a bigger scale than just in a [GP] practice. So, I think that was partly what it was – to have a more … of a public health type, more of a population-type impact than just in an individual practice" (**Quote 22**).

Interviewee T expressed the following view:

> "Under our Constitution [of our CCG], we have: four GPs on the governing body are elected by the GPs across the city and then four GPs are elected by each one of four localities (elected or selected by those localities). So, four of them are elected city-wide and four of them are elected within the localities. That was, that is a sort of historical arrangement because we had these localities before, with a strong identity, and they wanted their representative to be there. I am one of the locality GPs. To be, to be Chair, under our Constitution, you are elected by, those eight, one of those eight GPs is elected by the other GPs. So, the GPs choose who the Chair, the GPs on the governing body through that electoral, elections process, choose who's gonna be the Chair. So, I put my name forward 'cause nobody else did … Well, I had, I've had some experience of this type of work through LMC work and through the work that was going on before CCGs were invented. And I've probably done

> more of it than any of the other GPs. So, so, there's a little bit, that I had probably more experience than others but there's also, just continuing to be interested in doing it, more interested actually than I thought I would be. So, that's been, you know, sort of a, almost a personal discovery … I do have, I am interested in that. And I am interested in how … organisations generally [are run]. So, that can be any kind of organisation ... Hm, I am also quite attracted to the fact that you can shape services in the NHS for patients, hm, (How do I put it?) at a different level in the organisation, rather than just in the consulting room where you do it for one patient within the existing framework. You can actually change the framework and in that way, make things better for the patient, but of course you don't just do it for the one patient. You do it for lots and lots of patients. So, there's the opportunity to make a difference for lots of patients though using that organisational structure" (**Quote 23**).

Interviewee Q shared, "Well, I was elected (officially) but there was no other applicant because that's what I've been doing, effectively; we just moved, seamlessly, from what we were doing before into this [CCG commissioning]. So, officially, yeah, there was an election" (**Quote 24**).

From the above, Interviewees S and T seemed to be motivated by the idea of making a difference on a more macro level than the micro level of a doctor-patient one-to-one professional encounter. They wanted to help shape national policy and thus help many patients. Moreover, being involved in something other than clinical practice seemed refreshing to Interviewee S. It kept her 'enthusiasm going.' Interviewee T was found to have joined a leadership role in his CCG as the CCG Chair because of his prior experience and personal interest in how organisations were run. Interviewee Q was 'moved … seamlessly' into a CCG leadership role also thanks to his prior experience in commissioning – perhaps, his prior experience was his motivator.

#### 7.3.2.2. Views from the managers and accountants

Interviewee H, an accountant, brought up the issue that perhaps some GPs might be assuming CCG leadership roles because of the monetary compensation involved:

> "The new GP contract came in 2004-5 or whatever it is. There hasn't really been a coherent effort to, to level the playing field around the quality and rationing of both access to primary care and the sort of services that primary care offers. And that's a real problem. So, essentially it means that you have some interested good GPs and some really bad GPs and the problem is they all want pay. So, it doesn't matter what they do; they all want pay at their practice profit rates. So, £150-200 an hour is what they charge to take part in meetings" (Interview 7; **Quote 25**).

Interviewee E, a retired GP, shared the following with respect to the latest GP contract:

> "They [GPs] are independent contractors, yeah. And some would say very expensive to employ 'cause when they renegotiated the new GP contract, GPs seemed to come out of it very well because they had substantially increased salaries … Hm, probably [this happened] eight years ago or something like that. Yeah, the Labour government negotiated a new contract for General Practitioners for the British Medical Association and basically the amount of on-call that GPs have to do was dramatically reduced. But they seemed to end up with a significant increase in salary. So, it was a good deal for the GPs but it wasn't a good deal financially for the running of the National Health Service … The British Medical Association negotiated a very good deal for general practice" (**Quote 26**).

Interviewee R, a manager, shared:

> "But I find it causes me more problems managing between, between them [GPs]. You know, one practice is, is fed up cost, I mean, some of the GPs are very social, socially conscious when it suits them. You know, they are very, very socially minded, whereas, there's some that are a bit more business minded and this does cause friction between them. Yeah, I have had a few interesting tussles. But I think people, I think if anything casts a negative light on CCGs, it would be public perception about GPs doing it for the money. And I think, you know, as I say, for an ordinary person in the street, looking in on that, I can fully understand why they might feel like that. It is a bit like herding cats, I'm telling you. They are an interesting bunch" (**Quote 27**).

While the two clinicians above (Interviewees S and T) expressed idealistic views with respect to clinicians' motivation to assume leadership roles in CCGs, two of the managers and

accountants (Interviewees H and R) expressed more worldly and skeptical views related to the monetary motivation.

#### 7.3.2.3. Observation of meetings and conferences

What did the CCG meetings and NHS conferences prompt in terms of clinicians' motivation to join CCG leadership? The *Big Care Debate* and the *Health Forum* of CCG 1 shed some light on this question. The *Big Care Debate* was led by a GP who was also the Accountable Officer of CCG 1. He and other members of staff from the CCG addressed an audience of more than 100 members of the public. Due to the remote location of the meeting from the local town, the CCG had arranged for the free transportation for those members of the public who had no means of transportation. This showed the concern of the CCG to hear views from vulnerable and less privileged members of the public. Perhaps, this concern with helping their local populations was a motivation to assume these leadership roles? Also, at the *2013 Commissioning Show*, one clinician said that if he and other clinicians were not interested in helping people lead better and healthier lives, those clinicians would not be there, i.e. at the *Commissioning Show*.

## 7.4. Data used to help answer RQ 3

This part presents data that will help answer RQ 3, 'How involved are clinicians in CCG calculative practices?'

### 7.4.1. Views from the managers and accountants

When asked what exactly clinicians did in CCGs in terms of business, accounting, and other financial activities, i.e. calculative practices, Interview H (Interview 19) shared that they were involved in budgeting and managerial accounting allocations, as members of a team. However, to his knowledge, clinicians were not involved directly in any financial accounting practices:

> "They are not [involved], not at all [in financial accounting-related practices]. It's all contracted out to CSUs; however, I am aware in [city A] of eight CCGs are now, they've given notice on their CSU contract and are bringing their services back in but as a shared service" (**Quote 28**).

Interviewee H added later in the same interview: "But, I mean, GPs wouldn't have any knowledge of accounting, in the same way that the management teams of the old PCTs didn't, either. It's the Finance Director that might have accounting knowledge, but that's it" (**Quote 29**). When asked how clinicians were involved in calculative practices, such as budgeting and cost accounting, Interviewee R responded:

> "I think it's probably variable. They all have a reasonable insight into accounting practice, you know, but some of them have a deeper insight than others … [I]f you are a Senior Partner in a practice, you probably know more about the numbers and you probably know more about accounting practice than if you are just a jobbing salaried GP. If you are a Practice Manager, you actually might even come from a financial services background (a lot of them do), you probably have a good understanding of the numbers. I think it's quite variable, actually. It is variable" (**Quote 30**).

She also added from her personal experience:

> "You know, accounting conventions just drive me nuts, but … you intuitively understand the numbers. I just had an earlier meeting with a provider (with the Director of Finance) in the room and I think he's gone away not very happy 'cause I knew the numbers better than he did and he is the Director of Finance. Only because I made it my business to go through and understand because what I was trying to do was, 'What are these numbers telling me by way of a story?' So, yeah, yeah, whether they [clinicians] would be familiar with accounting techniques, I think, is a different question. All of them would have a reasonable financial orientation" (**Quote 31**).

Interviewee I shared that in his commissioning experience, GPs were sometimes helped by advisors from CSUs. According to him, the clinicians involved in CCGs were not left alone in dealing with the rigorous demands of commissioning:

> "There is an issue, quite a serious issue, about the capacity of GPs to provide capacity, the experience of GPs in relation to financial, contracting, Human Resource, and others. 'What is the extent to which a GP has the experience of running a business?' That's essentially the question and as a solution to that question the Commissioning Support Units is a fairly obvious solution … I think that this is the only way forward under the current circumstances" (**Quote 32**).

Interviewee H (Interview 19) shared that he knew from personal experience that some GPs were withdrawing from their commissioning leadership posts:

> "[T]he NHS is very, very complicated, particularly in terms of how the activity and financial flows happen and it takes a great deal of commitment and time to do it. So, I don't blame GPs for deciding (some of them), starting to decide that it's not really the sort of thing they want to do" (**Quote 33**).

Clinicians were not left alone in commissioning, as Interviewee I shared; yet, there seemed to be some instances of clinicians' disinvolvement from commissioning leadership.

### 7.4.2. Views from the clinicians

Interviewee O, a GP, pointed out his involvement with a large variety of other parties. This involvement required a 'vast array of skills,' calculative and non-calculative:

> "So, if I look at the drivers on me, as the leader of the organisation, I've got: the expectations of my practices, the expectations of my elected practice members, the expectations of my staff, the expectations of the local public, the local media, the politicians at, at least, four or five different levels of local government, then we've got the regional expectations in the Health Service, the expectations from social care, we've got the national expectations from NHS England, then we've got the Department of Health and the Secretary of State's expectations laid separately on top of those, then we have the expectation of the national political debate and then we have trends in national and international healthcare and everything that that brings with it … That's a, that's a complex environment. And in all of that I've got to do Delivery for Today, Awareness for the Future, Transformational Change … communication, public engagement, you know, a vast array of skills and that is a challenging environment to be in and therefore you have a funnel of people who are capable of doing it down to a very small number, a bit like you do with medicine and law where you have to be highly capable, skillful, and dedicated to survive in those environments" (**Quote 34**).

When asked what he did on a day-to-day basis for the CCG in terms of business-related (i.e. calculative) activities, Interviewee Q answered:

> "[T]he Chair of a CCG is almost a pure leadership role … so there isn't, if you like, a list of daily tasks or, you know, I don't have, in terms of reference, I don't have a team as such. What I have to do is fill in the gaps, act as liaison with outside agencies, try and preempt any problems. If there are problems, try and troubleshoot them, again mainly by liaison with outside agencies. Hm, obviously ensure that the team is happy, that they've got the right level of support, that the Chief Executive is managing the organisation in the right way, so … it's a very ill-defined job. If you asked me to write down exactly what I did on a piece of paper, I don't think I would be able to. But that's very much the nature of leadership" (**Quote 35**).

When asked the same question, Interviewee S responded:

> "OK, so all general practices are in fact businesses, OK. So, they all have some knowledge and awareness of how their business runs, so I think that, I would say that if you are going to be a Partner in general practice, you do have some awareness about, about budgets and how you run, how you run a

> business, really. Hm, so I would think that you are not coming from 'no knowledge at all.' Certainly, there has been some training available for people to look at NHS budgeting and whatever, if people wanted to take advantage of it" (**Quote 36**).

Interviewee O shared:

> "So, what I am learning, what my colleagues are learning is what is our added value as clinicians in discharging those functions well. So, I don't attempt to do the accountancy for the CCG, but I do now know how it's done and I do pay attention to the result of it as the leader of the CCG, but also as a local clinician because I know we have to make that money work effectively for us" (**Quote 37**).

Interviewee Q accentuated on the fact that clinicians were the leaders of the new commissioning system:

> "[A]s Chair of the Board, I mean, clearly, I don't do the, you wouldn't do the operational budget setting but, actually, the high-level strategy is clearly, you know, something that I'd lead a team on, developing that … I mean, actually, one of the things that I've put in my personal development plan this year for my appraisal is to get greater insight into the accounting processes … Hm, you know, because I see that as a definite educational need in this role, so I plan to spend some time with the Finance team and actually go through, watch them, go through with them in their preparation of the end-of-year accounts, so that I can understand it from, you know … which would certainly allow me to perform this role a bit better" (**Quote 38**).

Interviewee T shared that the clinicians in his CCG were involved 'to a limited extent' in business- and accounting-related practices, i.e. calculative practices:

> "Yeah, to a limited extent ... We have been visiting practices to look at their activity against a nominal budget which has been assigned to each practice in the city. We've actually asked the GPs in the practices to look at their activity compared with what the budget, the nominal budget if you like, actually shows that they do. So, there is that level of awareness of budgetary issues. Hm, at sort of the other end of the scale, if you like, we always, at the governing body every month have a financial statement introduced by the Chief Finance Officer for us all to have a look at, line by line. It amounts to, I don't know, 10-15 pages and, you know, the spreadsheets and the summary and so on ... And so, the GPs around the table are invited to comment on these, if you like, at a summary level. So, there's the practice-level activity going on right through to the summary level across the entire CCG. So, yes, GPs are involved, the most definitely involved, in all of that. Those are more or less routine things that are going on" (**Quote 39**).

Interviewee T continued:

> "There's also, every year we put together our commissioning intentions ... We decide what sort of things the service should be like and then with the help of the Finance Department, we have a comment, if you like, about how much resource we invest into each of our new commissioning plans. So, there's an input but it's from the body, it's not from individual GPs, it's from the body of GPs and those around the table. So, it's a corporate view but of course it's informed by the GPs' view. The GPs are in the majority of our governing body, so it's a majority GP view about what we should do, but of course it is very much held by the financial team helping us to do that. We might say, 'We think that should be more and that should be less.' And then there's a discussion about how we make that happen. So, yeah, there's a variety of inputs into the finance that goes on in the governing body. We don't of course do any of the technical parts of public sector accounting. I don't think any of us have tried to get involved in that. There's not really any reason why we shouldn't do it if we were interested. We could start taking a really in-depth interest in it. But I think we all view it in a way, as I said, as a tool and enabler to do the things that we think we need to do to make the service better, rather than an interest in itself in its own right, we think of it as a means to an end, not the other way around" (**Quote 40**).

Interviewee O, just like Interviewee I above, shared that in his CCG, clinicians were not responsible for doing all parts of the commissioning cycle themselves. They were assisted by others:

> "You don't do it [accounting-related and other calculative practices] yourself. But it's still your responsibility. So … I don't have enough years left in my life to learn all those skills. But I've got a team of very skilled people who do that, who are the managers … Yeah, the employees of the CCG or the Commissioning Support Service or whoever we get in to help us to do it. So, there's a difference between the accountability and responsibility for doing it and having all those skills yourself" (**Quote 41**).

The quotes above provided evidence to the fact that clinicians were indeed involved in many calculative practices within CCGs – 'GPs are involved, the most definitely involved, in all of that,' as Interviewee T shared. However, this was not done as an end to itself, as the same interviewee said, but 'as a means to an end.' Clinicians were said to be involved mostly in leadership, managerial accounting (not financial accounting) teamwork, including the

allocation of budgets, and high-level strategy setting. They turned out to have a basic understanding of accounting-related practices and were also found willing to obtain a more in-depth accounting and finance training to do their jobs better.

It also became clear from the data above that clinicians did not commission alone, but were aided by CCG employees and CSUs. Yet, clinicians *were* the ones responsible for commissioning. Clinicians are the agents collectively and ultimately accountable for billions of pounds of CCG budgets each year.

### 7.4.3. Observation of meetings and conferences

Similar findings to the ones above were obtained from the observational data. At one of the commissioning shows, several clinicians discussed their CCG's work with the Winter Pressures Fund and how they distributed the funds across their locale. Other clinicians talked about how they tried to define the words 'health outcomes' for patients and how to measure outcomes – a calculative practice. Again, clinicians seemed to be involved in CCG calculative practices to a significant extent and more than before the reforms; yet, they were not alone in this involvement.

## 7.5. Data used to help answer RQ 4

This part of the chapter will present data in support of the answer to RQ 4, 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' Both interview and observational data will be used here. Who are GPs in the NHS? These are independent contractors of the NHS who work in small businesses. They are not NHS

employees like specialist medical consultants in hospitals, for example. Because of this, GPs are considered to be business people.

### 7.5.1. Views from the managers and accountants

Interviewee R shared the following:

> "I think we need to acknowledge that GPs are businessmen. So, it isn't that they are not business-like and managerial. It's … compared to the commissioning business though, they are in micro-businesses; so, they are business-like and they are, you know, financially aware, but in a small business setting as providers. And I think, a bit of the struggle I have in the commissioning side of the business is thinking large, you know, thinking big. So, if you went along, let me try and give you an example, if you said to a practice, 'You know, what do you want us to do differently around commissioning services for you?' they'll probably say, 'Oh, well, we want counselling in the practice, you know. Five grand, it will cost about 5K.' Whereas, I want them to tell me, 'What are the really big ticket things that you want to change? Are, you know, are there any big-ticket items you want to change? Because you, Mr. GP in your practice, are now part of an organisation that controls £300 million worth of resources, not 5,000!' So, there's something about the scale, the perspective, that is not quite, you know … it's quite a struggle to get them to think about… 'You control 250-300 million quid, guys'" (**Quote 42**).

The professional identity of clinicians therefore is changing – from a micro-level identity of less hybridity and micro-level calculative practices to a more macro-level identity, one of more hybridity and macro-level calculative practices. Interviewee R also added:

> "It isn't that they are not good leaders, but they are used to leading something different. So, if they are at Senior Partner in a practice, that's a leadership job of running a small business; it's not the same as being a leader of a commissioning organisation. So … the doctors, they are individual practitioners. That's how we train doctors – we train them to be individual practitioners, making their own judgements … their own, scientific knowledge, intuition, we train them as individuals, but what we've done is we now expect them to be corporate people" (**Quote 43**).

These two quotes are particularly telling. They convey the message that medical doctors have

been trained to use their individual, independent professional judgement on a small-scale level, while the neo-liberal hybridity and CCG calculative practices have now pushed them toward a much larger-scale level of business commitment than they are used to. Now, they are expected to be 'corporate people.' Their professional identity is perhaps also changing as a result.

Interviewee N talked about how management, and by implication commissioning, was generally viewed in the NHS:

> "Yeah, I think the GPs genuinely try to become what they are as a commissioner … But I think they also … the NHS is interesting, I think, in terms of how it views management, generally. It generally doesn't have a very high opinion of managers. It believes, they are putting it bluntly, that being a clinician is good and being a manger is bad [laughing] … And I think they probably don't value, don't always value, management as a profession in its own right. I think they see, I think they think anyone can be a manager. Hm, I am generalising, but I think there is a view that anyone can be a manager and that generally management is about managing budgets and signing leave cards and, you know, it's about, about not the most important things. The patient care would be seen as the most important thing. And, you know, I think, I think on the whole a lot of politicians would take the view that we shouldn't be too worried about the money, that patient care is what's important to us … The two are linked" (**Quote 44**).

He continued his reflections by next talking about the values of the clinicians involved in commissioning. Identity is generally considered to be based on values and beliefs:

> "And I would say these particular GPs who are actively involved [in CCGs], they would tend to be in the minority and would actually, probably would value management a bit more and probably would be very concerned about the money, particularly now that they are responsible for it, because in the past GPs did not feel responsible for the money. They could write any number of prescriptions or send people for any number of hospital appointments and it didn't affect them in any way in terms of their budget" (**Quote 45**).

Interviewee P acknowledged the fact that clinicians were not managers, nor accountants. Still, in his opinion, both clinical and managerial 'qualities' were needed of successful commissioners:

> "I do think that primary care clinicians have got a big role to play and I am happy with them leading it … What I do expect of the primary care clinician (and the advantage of putting them in the leadership role) is to be responsible for the commissioning decisions that they take. And that's not dissimilar to what I expect from a clinician in a hospital. They are making resource decisions all the time … based on clinical need and clinical practice. What you need is to have those two things aligned … And actually, because I don't expect a clinician to be an accountant any more than a clinician would expect me to be a doctor, the best bit is the marrying up of those qualities and attributes in an appropriate organisational form" (**Quote 46**).

The managers and accountants quoted in this section tended to see hybridity as a matter of "values" (Quote 45), "qualities" (Quote 46) and "attributes" (*Ibid.*). Clinicians are now making new types of large-scale resource allocation and de-commissioning decisions. Only clinicians can speak for themselves in terms of their professional identity or professional self-understanding; so, let us now turn to some views expressed by clinicians themselves.

### 7.5.2. Views from the clinicians

Interviewee Q shared a similar view to the one of Interviewee R with respect to GPs traditionally being businessmen and businesswomen on a micro, not macro, level:

> "I think it's especially difficult if you just come from general practice where you have an organisation that you can understand from top to bottom almost … you can have the control of pretty much everything. To come into a larger organisation [a CCG] where you have to have systems and processes you trust and you can't … possibly have an oversight of everything" (**Quote 47**).

Interviewee S noted that having 'managerially competent clinicians' and 'clinically competent managers' was a good perspective to have in healthcare:

> "[A] long time ago … I went to a meeting where people talked about managerially competent clinicians and clinically competent managers and I think that actually works really well. If you've got people who can understand the drive of what the clinicians want and then can put that into place, those are very good managers. And if you've got clinicians who understand some of the limitations of what managers can do, then that would serve you well, too. But

> if you don't have that, then you end up with everyone being unhappy 'cause you can't deliver anything" (**Quote 48**).

Some interviewees signaled that there was a lack of interest among clinicians in undertaking commissioning leadership roles:

> "Well, they [GPs] are not particularly interested in it [commissioning]. Nobody, you know, as part of your training this isn't part of what you learn … When you sign up to do general practice, this isn't part of what you sign up to do. You sign up to provide healthcare to people in primary care. You don't … sign up for this. This is a government initiative. It's not what we learned at medical school … Hm, I think, certainly locally, we are finding that a number of people who are towards the end of their work as clinicians have been doing this [commissioning], I mean, our governing body is quite heavily towards the end of their working period … rather than new people coming through and we've had to work quite hard to try and see if people are interested and involved. And that's partly just from a time point of view, I think, and they are making the time commitment" (Interviewee S; **Quote 49**).

Others seemed to welcome the commissioning challenge as an opportunity. The words, "When you sign up to do general practice, this isn't part of what you sign up to do … This is a government initiative" (Quote 49) speak to the fact that perhaps clinicians don't identify strongly with their new hybrid responsibilities. Commissioning has been imposed on them from the top down. The GPs who are at an earlier stage of their careers are perhaps too hesitant to embrace too many new to them tasks, including commissioning.

Interviewee Q shared, "It is a … challenge, I think, inevitably, you know, trying to do two things part time, having 2-3 quarter-time jobs" (**Quote 50**). No matter what the challenges, Interviewee O noticed a deep change in his professional identity due to his hybrid role:

> "[A]bout the change in … [my] identity … absolutely yes! It [CCG commissioning] has changed my identity fundamentally. So, although I remain a practicing clinician locally, I see myself as a system leader for the local health service and I think that's a really profound, important change. And hopefully, what my colleagues see is if they are not the leaders of the system, they certainly have a contribution to making the whole system work well and the responsibility to ensure that it happens. And they do that either by coming

> and participating in some of that leadership (which you know a number of them do) or by allowing us to do it as their representatives. I think that, you know, the kind of mandating process by the [GP] practices is really quite important to us. Even if they are not actively participating, they are permitting and that's quite an important contribution, as well." (**Quote 51**).

Interviewee T, when asked whether he had experienced a deep identity change or just a superficial role change, shared:

> "It's about half way between the two. I do feel like I would walk away from it sometimes and do the clinical role again, more full time, but at the same time I do spend a lot of my own time thinking about the issues that we are trying to deal with. It's not just in meetings and then I leave the office and forget about it. It's not like that at all. So, it's quite interesting. Some of it is just a role change and you could quite easily see the role could change back … There is something more than that, actually. It's a bit more [thinking]. For example, the leadership aspect of the role is a completely brand-new one and if you don't identify with it to some extent, then that's a, potentially, could be a difficult aspect of the job. So, that's, a relatively, obviously, relatively fundamental thing, really, in terms of identity, self-identity … It's not a superficial thing. I think you have to … you have to care about what it is that you are trying to do. At times, it's stressful. So, you have to actually have a degree of an emotional investment, I think. Otherwise, you just don't bother doing it" (**Quote 52**).

The last six quotes expressed a variety of views on clinicians' hybrid identities as doctors and commissioners. The clinicians were both skeptical and optimistic vis-à-vis the hybrid role identity of GPs as commissioners and clinicians. Interviewee O for instance had experienced 'a really profound, important change' in his professional identity because of this dual role.

### 7.5.3. Observation of conferences and meetings

The observational data seemed to confirm the fact that the dual medical-commissioning identity was present indeed. In the CCG meetings, it would have been difficult to know who exactly the managers and the physicians in the boards were without seeing the name tags of the board members and the abbreviation 'Dr.' Both groups spoke the same language of

business and healthcare. Perhaps, the fact that clinicians spoke just like managers meant that CCG clinicians had acquired a new identity? At the NHS conferences, there were many clinicians who spoke with conviction, pride and enthusiasm about their CCGs' new achievements. They talked about their challenges with concern. These feelings of pride, enthusiasm, and concern were also perhaps indications of the presence of a new identity. Otherwise, why invest emotionally in CCGs, as Interviewee T said?

### 7.6. Conclusion

Chapter 7 presented and briefly analysed excerpts from the primary and secondary data collected in the course of this research. The data presented were the result of the data coding and data reduction processes described in Chapter 6. Sometimes, the quotes from the interviews were not shortened too much. They were intentionally kept long, so that to provide a richer basis for analysis and discussion. Shortening a quote excessively would take away from its contextuality, if was believed. The interview data was quoted according to two groups – 1) the clinicians and 2) the managers and accountants. The next chapter will concentrate on a further discussion of the primary and secondary data, given the theoretical framework from Figure 4 and the data analysis rationale from Figure 5. Chapter 8 will answer the four research questions posed in Chapter 1 and delineate the contributions of this research.

# CHAPTER 8
# DISCUSSION

## 8.1. Introduction

Chapter 8 provides a further discussion on the data presented and analysed in Chapter 7. As already mentioned, this research is an elaboration of an existing theory, the ILT, and Peter Miller's concept of 'calculative practices.' It aims to increase understanding of the research subjects – clinicians in CCGs. This discussion chapter weaves together the information already presented in the previous chapters and may be seen as the culmination of this research. First, this chapter answers the four research questions originally asked in Chapter 1 – RQs 1 to 4. It is important to note that the answers given are not the only possible answers to these research questions. This is due to the qualitative nature of this research and the interpretivist ontology that was assumed, an ontology which is based on subjectivity and personal interpretation. Second, this chapter lists in a table format some additional data, findings and contributions. These contributions are contributions to current policy/legislation and practice. They came up incidentally from the research data. Many of the interview quotes supporting these unforeseen in the beginning of the research contributions came from the unstructured part of the interviews, for instance from answers to interview question 11 (see Table 4).

## 8.2. Answer to RQ 1

The first research question (RQ 1) was, 'How appropriate is it for clinicians to be involved in CCG acute care commissioning?' This question will be answered based on documents' content analysis and the interview and observational data from section 7.2.

First, according to the two government documents examined – the white paper (DH, 2010a) and the HSCA 2012 – the answer to RQ 1 would be that it is *very appropriate* for clinicians, mostly GPs, to be involved in CCG acute care commissioning, a set of calculative and other practices, as we saw in Chapters 1 and 4. In section 7.2.1, family doctors were found to be 'best placed' for commissioning, according to the white paper. This document stated that doctors and nurses had to use their 'professional judgement about what … [was] right for patients' and that trusting these professionals would 'drive up standards.' Besides, GPs were seen as 'the healthcare professionals closest to the patients.' GPs 'coordinate all the services that patients receive, helping them to navigate the system…' By mandating a membership in a CCG for all GPs in England via the HSCA 2012, the Coalition government once again expressed the idea that it was highly appropriate for clinicians to be involved in acute care commissioning. The government did not loosen its stance on commissioning by possibly allowing GPs to opt out of membership. In this way, it reinforced its idea that clinicians were very appropriately placed to commission care. By ensuring that a CCG's 'capital [and revenue] resource use … [did] not exceed the amount specified by direction of the Board…' (examples of calculative requirements), the Coalition government pledged its faith in the calculative abilities of CCGs. Moreover, CCGs should provide 'good value for money' and its accounts should be 'audited,' according to the HSCA 2012.

Second, according to the managers and accountants interviewed, the answer to RQ 1 would be *less straightforward* than according to the two documents examined above. The answer would perhaps be that it is *questionable* whether clinicians should be involved in acute care commissioning. The reasons for this conclusion are that in section 7.2.2 GPs were seen by several managers and accountants as having 'no [business training than some kind of

corporate development support,' as 'quite inexperienced' in commissioning, as involved in 'silo gazing,' as not 'all at one voice,' and as 'very competitive' with one another. Interviewee H saw this involvement as good in theory, but not so much in practice (Quote 1). Thus, based on the interview data, the managers and accountants interviewed did seem to share the view that it is challenging and perhaps *not very appropriate* for clinicians to be involved *in leadership roles* in CCG acute care commissioning.

Third, according to the clinicians quoted in section 7.2.3, the answer to RQ 1 would be that *it is not very clear whether it is appropriate* for clinicians to be involved in acute care commissioning. This is to say that there were views that evoked either perceptions of appropriateness or inappropriateness of involvement. For example, Interviewee A in Quote 9 suggested that it would be appropriate for clinicians to be involved in acute care commissioning because more "financial responsibility" was now placed in their hands than before; because of this, now they thought more carefully before referring a patient to expensive acute care. Interviewee O also spoke about clinicians' responsibility for the "whole … health system" (Quote 10) and emphasised the fact that partnerships between "clinical leaders and expert managers," not just clinicians, were important to CCG commissioning. Clinicians, therefore, were found to not be alone in commissioning. Interviewees O and E, respectively, spoke about the challenges that made clinicians' involvement difficult – the disintegration of commissioning ('[N]ow we can only influence parts of it [commissioning]') – and the lack of management training among GPs ('Doctors are not trained in financial management and therefore … have only a limited capacity in these Clinical Commissioning Groups').

Fourth, based on the observation of CCG meetings and NHS conferences in section 7.2.4, the

answer to RQ 1 would be that it is *very appropriate* for clinicians, mostly GPs, to be involved in acute care commissioning. The observational data spoke to the fact that many of the clinicians who had assumed leadership roles in the CCGs observed and many of the clinicians who attended the three NHS conferences were the right people to be involved in commissioning: they talked about financial numbers and budgets with great ease, they made use of accounting and business vocabulary and answered both finance- and business-related questions from the public with remarkable competence. It would have been hard to know for example who the managers and the clinicians in the boards of governors were, had their names and titles not been written down on plates in front of them.

The conclusions from the three methods seem to be divergent. The government and the researcher tended to lean toward appropriateness, while the people directly affected by CCG commissioning – the NHS managers, accountants, and clinicians – had more diverse views. The managers and accountants tended to be the most skeptical ones. Maybe because the government and the researcher were not directly involved in commissioning on a day-to-day-basis, they tended to be more idealistic and perceived the involvement as very appropriate. From the interviews, the traditional professional/medical logic to which GPs have always adhered seemed to be perceived as both *in conflict* (Quotes 1, 2, 3, 5, 7, 8, and 13) and *in harmony* (Quotes 9, 10, 12, and the observational data) with the new macro-level CCG governance/leadership logic and the neo-liberal business logic (see Figure 6).

### 8.3. Answer to RQ 2

The second research question (RQ 2) was, 'What motivates clinicians to assume leadership roles in CCGs?' This question will be answered based on the interview and observational data from section 7.3. Before presenting the data on motivation, Chapter 7 discussed clinicians' backgrounds, i.e. training and work history, in section 7.3.1. It became clear that there was a continuity of involvement in CCG commissioning by the same medics who had been involved in prior forms of commissioning.

First, according to the clinicians quoted in section 7.3.2.1, the answer to RQ 2 would be that among the things that motivate clinicians to assume leadership roles in CCGs is a variety of factors: a liking for the "politics of medicine" (Quote 21), a desire to keep one's "enthusiasm going" (Quote 22), and a desire to volunteer because "nobody else did" (Quote 23) and a desire to make a positive difference in many patients' lives. All these motivators appear to be others-centred, rather than self-centred. Most clinicians appeared to have joined their CCG leaderships out of a genuine desire to contribute to the improvement of health services in their geographical areas.

Second, according to the managers and accountants quoted in section 7.3.2.2, the answer to RQ 2 would be that what motivates clinician-leaders is the monetary compensation. Interviewee H mentioned a "£150-200 an hour … to take part in meetings" (Quote 25). Interviewee R said that GPs were "socially conscious when it … [suited] them" and that there was a "public perception about GPs doing it [commissioning] for the money" (Quote 27). The clinicians interviewed presented more idealistic views on their sources of motivation, while the managers and accountants expressed some more skeptical views. Of course, the

money motivator and the large-scale social good motivator are not necessarily mutually exclusive. They may walk hand in hand, as long as they are reasonable and help toward the common good of the NHS.

Third, based on the observation of CCG meetings and NHS conferences in section 7.3.2.3, the answer to RQ 2 would be that what motivates clinicians to assume leadership roles is *probably a sincere concern* to hear views from a diverse body of the public, including the frail and vulnerable. One CCG had arranged for the free transportation of those without means of transportation who wanted to attend the CCG meeting. The clinicians observed at the meetings and conferences also showed that they really cared. Perhaps, they were motivated by a desire to contribute to the wellbeing of their local populations?

The conclusions from the three methods seem to be divergent, just like in RQ 1's case. The managers and accountants expressed some skeptical views about the motivation of GPs (the good monetary compensation), while the clinicians and the researcher saw less self-centred motivators. If the money motivator was indeed a factor, most likely the clinicians would not have confessed this in an interview out of confidentiality or discreetness. In the UK, personal money matters are usually considered a taboo.

The professional logic was found to be *in harmony* with the governance and business logics, according to the clinicians (Quotes 21, 22, 23, and 24) and the researcher's observation, since their motivations were found to be mostly positive and altruistic in this new governance, professional, and economic arrangement, the CCG. The business logic (personal profit) was found to be taking the upper hand via the governance logic, according to the managers and accountants (Quotes 26 and 27). The governance logic was mentioned here because CCG

leadership (a governance structure) was conductive to this private gain. It would be wrong to claim that the business logic was found to take the upper hand over the professional logic since a doctor may be highly paid and still care well for patients. In sum, the professional, business, and governance logics were found to be *in harmony but sometimes in disbalance* (see Figure 6).

### 8.4. Answer to RQ 3

The third research question (RQ 3) was, 'How involved are clinicians in CCG calculative practices?' This question will be answered based on the interview and observational data from section 7.4.

First, according to the managers and accountants cited in section 7.4.1, clinicians were involved *partially and to various degrees* in CCG calculative practices. Interviewee H said that clinicians were not involved at all in financial accounting practices, such as the preparation of financial reports and accounts since this task was "contracted out to CSUs" (Quote 28). Clinicians were found to be more involved in budget allocations and other management accounting activities than in financial accounting ones. They worked as members of a team where calculative practices would be the realm of Finance Directors (Quote 29). In Interviewee R's view, the picture was "variable" (Quote 30), i.e. some GPs were more involved in calculative practices (for example, GP Practice Managers) than others. Interviewee I saw CSUs as "the only way forward under the current circumstances" (Quote 32). Even though clinicians were found not to be left alone in CCG calculative practices and received a lot of help from experts, some of them had decided to withdraw from their CCG leadership due to the complexity of how "activity and financial flows happen" (Quote 33).

Second, according to the clinicians cited in section 7.4.2, clinicians were also involved *partially* in CCG calculative practices. Interviewee O for example shared that he did not "attempt to do the accountancy for the CCG, but … [he did] know how it … [was] done and … [he did] pay attention to the result of it as the leader of the CCG" (Quote 37). Interviewee Q said, "I don't do the … operational budget setting but, actually, the high-level strategy" (Quote 38). Interviewee T mentioned in Quote 39 that clinicians were involved "to a limited extent" in CCG calculative practices. They were welcome to comment on the financial statements, line by line, as presented by the CFO. This interviewee continued, "We don't of course do any of the technical parts of public sector accounting … There's not really any reason why we shouldn't do it if we were interested" (Quote 40). He saw calculative practices as an "enabler," as a "means to an end" (*Ibid.*). Interviewee O brought up the point that even though calculative practices in CCG were performed mostly by non-clinicians, the responsibility and accountability still belonged to clinicians (Quote 41).

Third, according to the observation of meetings and conferences in section 7.4.3, clinicians were also *somewhat* involved in CCG calculative practices: at some of the conferences attended, clinicians talked about their involvement in various calculative practices – Winter Pressures Fund allocations, health outcomes measurement, and others. This involvement appeared to be on a macro, leadership, and strategic level, rather than on a technical, operational level. For example, clinicians did not appear to be involved in the bookkeeping for the Winter Pressures Fund; instead, they were the ones who were involved in decisions on channelling this fund to the neediest departments of their health locales.

As Llewellyn (2001, p. 596) put it, "[N]ew cross-boundary tasks of budgeting, rationing, performance review and risk management have emerged." Doubtlessly, GP-commissioners are not just low-level, operational managers (Fauré and Rouleau, 2011; Staehle and Schirmer, 1992) or middle managers in healthcare commissioning (Buchanan *et al.*, 2013; Checkland *et al.*, 2013). They have higher-level, strategic responsibilities. It also looks like the job of the GP-commissioner is an 'extreme' job (Buchanan *et al.*, 2013, p. 646), a job that requires long hours and working with "conflicting priorities, being required to do more with fewer resources, [and] responding to regulatory bodies." Perhaps, Clark (2012, p. 437) is right in foretelling that, "the era of strong general management may be replaced by one where non-clinical managers and clinicians work in partnership to optimise the different expertise, experience and values to achieve high quality, productive and patient-focused care."

In summary, based on the three methods, one can conclude that clinicians are *partially and somehow involved* (Quotes 37, 38, 39, 40, and the observational data) in the calculative practices of CCGs. They are involved *to various degrees* (Quotes 30, 31, and 33). They are also involved on a macro, strategic level, not so much on an operational level. Clinicians are greatly aided by CCG employees and CSUs (Quotes 28, 32, and 41). Therefore, the dynamics between the professional, business, and governance logics here are *in harmony* thanks to the great cooperation of different agents in CCGs (see Figure 6).

### 8.5. Answer to RQ 4

The fourth research question (RQ 4) was, 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?' This question will be answered based on the interview and observational data from section 7.5.

According to the managers and accountants (see section 7.5.1), the answer to RQ 4 would be that hybridity and calculative practices affect clinicians' professional identities in CCGs *to a large extent* – from a micro-level identity towards a more macro-level identity. These are clinicians' identities perceived by others (the managers and accountants). GPs in the English NHS are businessmen and businesswomen "in micro-businesses … [and are] business-like and … financially aware, but in a small business setting as providers" (Quote 42). Traditionally, they have thought on a smaller scale, while now they have to get used to "thinking big" (*Ibid.*). GPs "are used to leading something different" and now "we expect them to be corporate people" (Quote 43). Thus, their micro-level business identity as small business owners is seen by outsiders as changing towards the more macro-level business identity of CCG commissioners. One's identity is closely linked to one's values and beliefs. Interviewee N shared that in his opinion, "these particular GPs who … [were] actively involved [in CCGs] … would tend to be in the minority and would … probably … value management a bit more and probably would be very concerned about the money…" (Quote 45). Interviewee P shared that he did not "expect a clinician to be an accountant any more than a clinician would expect … [him] to be a doctor, the best bit … [was] the marrying up of those qualities and attributes…" (Quote 46). Thus, certain foundations of one's identity – values and beliefs, such as the belief in the usefulness of management – reinforced the new macro-level professional identity of some GPs commissioners.

According to the clinicians (see section 7.5.2), the answer to RQ 4 would be that hybridity and calculative practices affect clinicians' professional identities in CCGs *to various degrees*. The focus here is not identifying oneself with a particular CCG, i.e. organisational identity (Hatch and Schultz, 2004; Kenny, Whittle and Willmott, 2011; Wetherell and Mohanty,

2010; Whetten and Godfrey, 1998), but identifying oneself with a profession/occupation – commissioner *and* clinician. How deep is GPs' identity change – fleeting, ephemeral, and shallow (just another role to play) or deep and stable? Given the discussion on the evolution of identity studies in Chapter 4, the identity change of clinicians in CCGs tends to be perhaps still in the making because it is still relatively early into the reforms.

Some clinicians thought of their hybrid roles as commissioners and medics as just a superficial role change imposed externally on them by the government, while others thought of it as a deep identity change, not just a role change. For instance, Interviewee Q talk about a shift in control – before the reforms, GPs felt like they had "control over pretty much everything [in their GP practices]" (Quote 47). Now, in CCGs, they could not "have an oversight of everything" (*Ibid.*). CCGs are much more complex in terms of activities and calculative practices than a GP surgery. Thus, the identity of GPs is probably becoming more versatile, while control over 'everything' is weakening. Interviewee S alluded to a superficial role change due to hybridity: "When you sign up to do general practice, this [commissioning] isn't part of what you sign up to do … This is a government initiative" (Quote 49). She continued by saying that her CCG's governing body was "quite heavily towards the end of their working period … rather than new people coming through…" (*Ibid.*). This lack of interest among young clinicians may be a sign that they do not strongly identify with a new commissioning role. This reform has been imposed from the top down and hence, this lack of enthusiasm may be indeed present among some clinicians.

Opposite views were expressed by Interviewees O and T. Interviewee O responded: "[CCG commissioning] has changed my identity fundamentally" (Quote 51). He added that, "[e]ven if they [some GPs] … [were] not actively participating [in commissioning], they … [were]

permitting [other GPs to lead commissioning] and that's quite an important contribution" (*Ibid.*). Interviewee T felt "about half way between the two [between a just role change and a deep identity change]" (Quote 52). He felt like walking "away from it [commissioning] sometimes and do the clinical role again, more full time, but at the same time … [he did] spend a lot of … his own time thinking about … [commissioning]" (*Ibid.*). He mentioned that he didn't just think about these issues in the office and forget all about them at home. "Some of it is just a role change … There is something more than that, actually" (*Ibid.*). Interviewee T thus felt that his hybrid role and the commissioning, calculative activities he was involved in did change his professional identity in ways deeper than just superficial.

The clinicians in the study didn't seem to see clinicians' identity as put at risk, "destabilized" (Kornberger, Justesen and Mouritsen, 2011, p. 514) or debased, but as enabled by the CCG reforms. So, the usual focus of the literature on 'identity threats' (Dutton and Dukerich, 1991; Elsbach and Kramer, 1996) was not found to be present here. None of the clinicians interviewed saw himself or herself as less of a medic and to the detriment of his or her professional identity or status. Rather, a new 'identity opportunity' (Pouthier, Steele and Ocasio, 2013), not an 'identity threat,' was sensed from the optimism with which many interviewees talked about their clinical input in CCG commissioning.

Based on the observation of meetings and conferences (see section 7.5.3), the answer to RQ 4 would be that hybridity and calculative practices affect clinicians' professional identities in CCGs *to a noticeable extent*. This is so because while observing the CCG meetings and NHS conferences, it was clear for the researcher that clinicians talked like more than just clinicians; they talked like project managers or administrators. They discussed adhering to guidelines and protocol and it was generally hard to discern who the real managers and the

clinicians were in the room. Identity is a very personal thing, so whether the clinicians present were playing just a role and wearing just another hat or whether they felt a true change in their self-concept deep inside was difficult to know for sure.

In the future, even more changes to the roles and responsibilities of GP commissioners are expected (Holder *et al.*, 2015; Naylor *et al.*, 2013; NHS England *et al.*, 2015). Speaking of the recently announced 'co-commissioning' initiative of some parts of primary care between CCGs and NHS England, more changes are immanent. In co-commissioning, there will be a significant expansion of GP roles within CCGs. Clinicians may face enhanced conflicts of interest (Holder *et al.*, 2015). One of the findings from the case study approach undertaken in this last source is that clinical involvement in CCGs is at risk of being unsustainable, given the "waning levels" (p. 4) of GP leaders' engagement in CCGs. Besides, this study noticed a problem with the recruitment and retention of GP leaders in CCGs, as well as time and capacity constraints. Many GPs will soon reach the end of their CCG appointments and may get attracted to posts within provider organisations, claims the source. A good example of this is the recent move of the Clinical Chief Officer of the North-East Essex CCG, Dr. Shane Gordon, to serve as the Chief Operating Officer of the Colchester Hospital University FT (Welikala, 2015a).

It is unclear what will become of commissioning hybrid identities in the future. GP-commissioners are becoming '1$^{st}$ order policy recipients' and '2$^{nd}$ order change agents' of institutional change (McDermott, Fitzgerald and Buchanan, 2013). They receive policy from central government and have to make it work on a local level. Their 'dispersed' or 'distributed' and 'encompassing' leadership may involve "leaderism [which is] a new form of privileged agency" (O'Reilly and Reed, 2011, p. 1079).

To sum up the above, *it is ambiguous* whether GPs in CCGs are experiencing a deep identity change or a shallow role change due to their hybridity and exposure to calculative practices. The extent of the effect of hybridity and calculative practices on their professional identities is hard to know exactly since identity is very personal and difficult to observe from outside. Yet, there is plenty of evidence that this extent is rather high (Quotes 45, 51, 52, and the observational data). Even though Quote 49 mentioned just a role change (since this is just a fleeting government initiative, in Interviewee S's opinion) and even though Interview H mentioned about CCG clinicians stepping down, similar quotes were relatively rare. The business logic here seems to take up a new shape (from a micro to a macro level) since GPs now have to "think… big" (Quote 42). They are still business people but a different kind of business people. The professional logic (traditional medical identities) seems to be metamorphosing as well thanks to the new governance logic (CCG leadership duties) and the reshaped business logic. Thus, these three logics are *in flux; their boundaries are metamorphosing* (see Figure 6).

### 8.6. Contribution to policy and legislation

Now that the four research questions have been answered (hopefully, a meaningful contribution to knowledge and understanding of GPs in CCGs), this research will try to make a further contribution – to policy/legislation. This contribution is incidental to this research and transpired mostly from the unstructured part of the interviews; for example, from responses to the question about what else the interviewees wanted to share that was not already asked of them during the interviews (see Table 4).

The terms ‘policy’ and ‘legislation’ are not synonymous. Legislation is a statutory law passed through Parliament (the House of Commons and the House of Lords) that applies to the whole country (or parts of it), while policy is not voted by Parliament. Policy is organisation-specific; it may be issued by a specific department, such as the DH, or by an organisation. Policy has a much lower authoritative status than legislation (Partington, 2014; Norton, 2013). Table 8 summarises the three key contributions to policy/legislation that arose from this research.

**Table 8**

**Contributions to policy/legislation**

| Contribution to policy/legislation number | Nature of the contribution to policy or legislation | Relevant quotes from the data |
|---|---|---|
| 1 | The research data suggest that legislation should be very carefully crafted in the future since it is harder to undo legislation compared to policy. | **Quote 53**: “I think Andrew Lansley wanted to make sure that his reforms could not be undone, so I think (as you probably know that there are different ways of getting things done) he has, what he has done is, a lot of the reforms have been done using primary legislation which is very hard to undo. If you make something, you know, if you take something through Parliament and create primary legislation, it takes a lot to undo that, whereas getting GPs involved and making these reforms happen in a softer way is easily changed by policy as opposed by change to legislation. So, I think he’s done what he’s done because he’s made it very, very difficult, if not impossible, to change” (**Quote**) (Interviewee K).<br><br>**Quote 54**: “It’s a law. Extraordinary! It’s an amendment to the NHS Act [of 2006], the Health Reform Act” |

| | | |
|---|---|---|
| | | (Interviewee H).<br><br>**Quote 55**: "[S]peaking as somebody who works in the system, I think that we could have achieved greater and better GP involvement in commissioning without actually making these structural reforms that we did. So, I think … the objective could have been achieved without actually such wide-ranging reforms" (Interviewee K).<br><br>**Quote 56**: "[I]f you'd asked me two years ago 'Does commissioning need reforming?' I would have said, 'It needs improving.' PCTs were very heavy on administration, very low on innovation and creativity or partnering. And so I would say the clinical input to commissioning needed to be increased at that time. So, I don't think it needed reform but I think it needed improving. Obviously, Andrew Lansley decided it needed reforming … but I think the reforms that he has developed are correct in principle but we can argue about how effective they are in practice. So, in summary, PCTs could have been smaller and more clinically focused and more innovative than they were when Andrew Lansley was viewing the situation. Did they need wholesale reform? I would have thought not" (Interviewee J).<br><br>**Quote 57**: "Could you have done it in a different way? Yes, you could have taken a Primary Care Trust and you could have structurally altered it, so it took far more managerial recognition of the views of its primary care clinicians. Could have done that, but that wasn't really the nature of the beast. The nature of the beast was: reduce bureaucracy, get more clinicians involved in the decision-making process, put them in charge of the money (the rhetoric could have said) and basically get rid of a load of |

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|---|---|---|
| | | administration and management … so that locally clinicians were front and centre of the commissioning process" (Interviewee P).<br><br>**Quote 58**: "Do I think they [the commissioning reforms] were necessary? No. And one of the reasons I don't think they were necessary was because the Primary Care Trust was beginning to become a mature organisation. So, it's quite a new organisation itself, but it was beginning to operate effectively as an organisation. So, at the point where the changes happened, it caused a lot of upheaval. And there are other ways of involving clinicians without completely changing the system" (Interviewee N). |
| 2 | Simplicity, rather than complexity in policy/legislation design, seems to create better receptivity by organisations. In addition, CCG commissioning loses its strategic scope by overdoing the localism agenda and fragmentation. | **Quote 59**: "[W]e have a kind of complicated system in England, really … An example would be in [town X], if the local authority set up a service like re-enablement to support people coming out of hospital, if you have a local commissioning group that covers [county Y], those [county Y] residents wouldn't be able to use that service. They would have to talk to [Y] County Council. And [Y] County Council would be talking to a different local commissioning group, so it gets very complicated. So … I think that kind of thing is an unintended consequence of allowing GPs the right to determine their own boundaries" (Interviewee N).<br><br>**Quote 60**: "[T]he NHS is very, very complicated, particularly in terms of how the activity and financial flows happen and it takes a great deal of commitment and time to do it. So, I don't blame GPs for deciding (some of them), starting to decide that it's not really the sort of thing they want to do" (Interviewee H).<br><br>**Quote 61**: "So, I would much rather |

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| | | have inherited the end-to-end responsibility of the PCT but with that requirement that it is the responsibility of the local clinicians to make it work. And then we would make sure that we have the managerial expertise in the organisation to discharge that responsibility. But we would then have been able to influence the whole system, whereas now we can only influence parts of it … [F]or example we don't commission general practice, we don't commission specialist services, we don't commission forensic services, things like that. And all of those have an impact. It's not, none of these exist in isolation, they all interrelate. The problem at the moment is that my priorities as a commissioner may not align with the priorities of the commissioners for the other system (parts of the system) but impact my population. So, public health going off to local government for example has created a big disconnect in what was a very successful strategy between public health and health services' commissioning, where the PCT quite rightly had chosen to put more investment in public health than elsewhere. But what's happened is that then disappeared out of our control" (Interviewee O).<br><br>**Quote 62**: "So, when I was here before [under the PCT system], I had all this money. So, if I took an example of … commissioning for coronary heart disease, I had all the money for smoking cessation, I had all the money for primary care doctors, if they get in prescribing … I had all the money for (when you go into hospital, you get your echo, your cardiac catheterisation) and all the money for heart/lung transplant. So, if you had a coronary heart disease problem, we commissioned the whole array of services end-to-end. Now, |

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| | | smoking cessation's public health and council, primary care's NHS England, hospital care and rehabilitation – the CCG, complicated care (tertiary care) is NHS England. Three separate organisations now commissioning that. And that's complicated, I think, compared to what it used to be. But, you know, we live with it" (Interviewee R).<br><br>**Quote 63**: "[I]t's a variable picture. It's too early yet to see very clearly. We are only six months into the reforms but at the moment the evidence we've got is that there is instability in the system through the sheer number of CCGs, I mean, there's over 200 nationally and quite a few of them are significantly financially challenged. So, if you look at London, for example, out of 32 CCGs … 9 or 10 of them have significant financial challenge. So, and nationally between 25 and 30% of CCGs are in a spot of financial trouble. And they are gonna find it difficult to work their way out of that. So, the problem, the structural problem with the reform, is that CCGs are not big enough to act as the place for strategic change and yet they have obstacles in front of them to working strategically with their neighbouring CCGs. So, they are accountable to their management bodies, for example. So, I can think of very real situations where you've got neighbouring CCGs, one of whom is rich and the other one poor, and the rich one does not want to work strategically with the poor one because it fears having their money taken, a risk share" (Interviewee H).<br><br>**Quote 64**: "What I am absolutely sure [of] is we have too many CCGs … But I think you need to bring CCGs together" (Interviewee P).<br><br>**Quote 65**: "The money and the need |

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| | | to commission certain things or some of the decisions around commissioning need to be done at scale. But you can do that without removing the clinical leadership piece. That's the big keep" (Interviewee P). |
| 3 | The partnership between clinicians and managers is a sensible idea and should be fostered in the future. | **Quote 66**: "[W]hat we find is that it is a partnership between clinical leaders and expert managers and it doesn't work with one or the other on their own. It has to be that synergy" (Interviewee O).<br><br>**Quote 67**: "And actually, because I don't expect a clinician to be an accountant any more than a clinician would expect me to be a doctor, the best bit is the marrying up of those qualities and attributes [managerial and clinical] in an appropriate organisational form" (Interviewee P).<br><br>**Quote 68**: "[A] long time ago … I went to a meeting where people talked about managerially competent clinicians and clinically competent managers and I think that actually works really well" (Interviewee S).<br><br>**Quote 69**: "[A]s Chair of the board … I don't do the, you wouldn't do the operational budget setting but, actually, the high-level strategy is clearly, you know, something that I'd lead a team on, developing that … I mean, actually, one of the things that I've put in my personal development plan this year for my appraisal is to get greater insight into the accounting processes … Hm, you know, because I see that as a definite educational need in this role…" (Interviewee Q).<br><br>**Quote 70**: "I read a paper in the *BMJ* [*British Medical Journal*], I think it might have been, a few years ago which was looking at risk tolerance and risk management behaviours in the different groups, I mean managers vs. doctors, and they do have a |

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| | | different approach to risk management … So, doctors tend to be much more risk tolerant than managers. Managers tend to manage risk by, by planning, by consultation, by collective decision making, whereas doctors would manage it through autonomous decision making, you know, reference to their own knowledge, sometimes reference to external sources of knowledge, but by and large shoulder the decision making on an individual basis, whereas managers tend to do it on a group basis. And I think that characterises some of the difference in style. And that's why this bit is such an important partnership between managers and doctors because sometimes the managers stop me from making rash decisions on an individual basis and sometimes I cut through some of their bureaucracy and obfuscation that group behaviour provides. So, it's quite a good tension" (Interviewee O). |

The first contribution to policy/legislation in the above table consists of the following: the research data suggest that legislation should be very carefully crafted in the future since it is harder to undo legislation compared to policy. Six relevant quotes from the interviews are presented in Table 8 in support of this first contribution.

Primary legislation consists of statutory laws, i.e. bills that have passed through Parliament, such as the HSCA 2012. Legislation may be primary (acts of Parliament which were proposed bills before becoming acts) or secondary (statutory instruments and regulations). According to Partington (2014, p. 42), secondary legislation, "is not subject to the full parliamentary scrutiny that a bill faces" and "[t]he process of amending legislation is usually done by passing a new Act that alters an Act already on the statute book. Thus amending

legislation must take its turn in finding a slot in the legislative programme" (p. 43).

As illustrated in Table 8, using policy, rather than legislation, to institute change is preferable, according to many research subjects since legislation cannot be altered by simple policy change, but only by new legislation. Moreover, the creation of new legislation is a lengthy and expensive route to reform. In support of this first contribution to policy/legislation, Timmins (2013, pp. 37-38), a source recommended by Interviewee K, purports:

> "Crucially, this would all be laid down in legislation, and in a way that, without further legislation, would tie the hands of both the current health secretary and his successors … So it had all to be put into legislation to nail it down, to ensure that the next secretary of state could not just come along and change it without fresh legislation. "The evidence of the past was very clear," Lansley says. "That because of the nature of the [existing] legislation, you change the secretary of state and you can change the policy on virtually everything in the NHS.""

In support of this first contribution, Ham *et al.* (2015, p. 9), a publication by the King's Fund, write the following regarding the recent top-down NHS reforms: "The implication of these decisions [the HSCA 2012] was that the NHS would be required to undertake major structural change even though the programme for government – and, indeed, Conservative politicians when in opposition [during the New Labour government] – had promised to avoid this." This fundamental restructuring expressed in "root and branch changes" was done at a time when "funding pressures began to bite," while it would have been more reasonable, the source states, if "existing arrangements" had been used instead (*Ibid.*).

Thinking of Miller's theoretical work mentioned earlier in this research, one may see CCG commissioning as indeed a 'technology' of government (Miller, 1990), i.e. a set of "calculations, procedures and mechanisms" (p. 317). Technologies are used by the state to make the programmatic aspect of government "operable in principle" (*Ibid.*). This

programmatic aspect is the "abstract aims" (*Ibid.*) that the state had in mind when it legislated the latest commissioning reforms – excellent health outcomes, patient-centred services, cost effectiveness, etc. By legislating the reforms, the government reinforced these abstract aims and made the reforms very hard to undo. Even though many interviewees perceived the large scale of the commissioning reform as not very necessary (Interviewees K, H, J, P, and N), CCG commissioning, a technology of government, was imposed on the NHS from the top down. The political logic shattered the arena of commissioning in a powerful, gargantuan way and *moulded the governance logic*, so that the medical/professional logic became more business-like.

The second contribution to policy/legislation that this research puts forward is: simplicity, rather than complexity in policy/legislation design, seems to create better receptivity by organisations. In addition, CCG commissioning loses its strategic scope by overdoing the localism agenda and fragmentation (Table 8). Support for this second contribution comes not only from the interview data, but also from the practitioner literature. Partially in an effort to enhance the strategic scope of CCG commissioning, three CCGs were recently announced to be joining one another in the first CCG merger since CCGs became statutory bodies – the Gateshead, Newcastle North and East, and Newcastle West CCGs (West, 2014). Another example from the recent past of an effort not to overdo the localism agenda is the recently signed agreement on the Manchester devolution project (Williams, 2015). This article states:

> "A memorandum of understanding, which was leaked in draft form two days ago, has now been signed by 12 clinical commissioning groups, 15 NHS providers, 10 councils, NHS England, the chancellor George Osborne and health secretary Jeremy Hunt … The agreement covers the entire health and social care system in Greater Manchester, including primary care and social care, mental health, acute and community services, and public health."

This agreement represents an effort toward the local integration of these services. The devolvement of financial responsibility to local level has always been about both financial freedom and constraints (Laughlin *et al.*, 1994). Yet, as suggested by the research data, local freedom and constraints should not overshadow the national strategy for the NHS. Both local vision and national strategy are equally important, as Interviewee S shared. This second contribution may be seen as *an aspiration towards more simplicity and complementarity* in the interrelationship among institutional logics, be they the business, professional, governance or the political one.

The third contribution to policy/legislation consists of the following: the partnership between clinicians and managers is a sensible idea and should be fostered in the future (Table 8). Even though Bååthe and Norbäck (2013) write about clinicians and managers as having different mindsets or identities (physicians 'cure' and managers 'control') the interview data seemed to suggest that a partnership between the two groups was essential. The above authors call this partnership 'organisational development work.' Fitzgerald *et al.* (2013) also note a link between distributed/dispersed leadership and service improvement outcomes, thanks to the collaboration of managers, clinical hybrids, and other actors.

An online survey from January 2015, entitled *Change Challenge*[39] and administered by the *Health Service Journal*, *Nursing Times*, and *NHS Improving Quality*, aimed to identify how the NHS could achieve change, while challenging top-down leadership. More than 1,500 people from within and outside the NHS participated in the first stage of the survey and made more than 7,000 contributions, the source claims. Many of the contributions to the *Change Challenge* addressed the often times strained relationship between NHS physicians and

[39] Available at: <https://changechallenge.clevertogether.com/> [Accessed 1 March 2015].

managers. For instance, a clinician posted a comment that mangers, mostly at the senior level, should come to the hospital wards and see for themselves what it was like to work there. This clinician wrote that he/she would welcome his or her NHS trust's Chief Executive to come on a shift with him or her. Maybe then, continued the clinician, this executive would truly understand the pressures on the frontline and maybe then things might progress better.

Box-ticking and targets are commonly used tools for performance evaluation (Townley, 1997), consultant appraisal for medical licence revalidation (McGivern and Ferlie, 2007), and hospital appraisal. Box-ticking tends to be a process that may alienate clinicians from the managers who performance-manage them perhaps against too unrealistic standards. Managers have often been accused of not knowing the real pressures on the frontline. Also, the negative effects of the sometimes "clumsy use of performance management systems" (Arnaboldi, Lapsley and Steccolini, 2015, p. 1) have been observed in the public sector. This clumsy use may cause additional tensions between clinicians and managers.

The dual role of the commissioning GP hybrid is central to the working harmony between the two camps – clinicians and managers. Recently, some distinguished NHS leaders called for more respect for NHS managers in the upcoming at the time elections campaign via an open letter (HSJ News, 2014):

> "In our experience, NHS managers are as dedicated to the service as any other group of staff. We find it regrettable, therefore, that they are so often the subject of ill judged criticism and made scapegoats when concerns arise. This is both unfair and damaging to the interests of patients since successful joint working between managerial and clinical staff is an essential ingredient of good care."

The letter was signed by Dr. Mark Porter, Chair of Council (BMA), Dr. Maureen Baker, Chair (Royal College of GPs), Alan Milburn, former Secretary of State for Health, and

several other signatories. In line with the expectations of the neo-liberalist literature on de-centralisation and governing 'at a distance' (Pollitt, 2005; Rubin and Kelly, 2005), clinicians, and not mangers, were the Coalition government's chosen actors to entrust with commissioning duties. Perhaps, because managers in PCTs were perceived by the government as people who were doing a poor job with the NHS (consistent with the quote above), their commissioning duties were taken away and placed in the hands of GPs. This was probably done because of the overall culture of mistrust in NHS managers. Clinicians initially did not welcome the changes: Timmins (2013) writes that the Royal College of GPs and the Royal College of Nursing were both strongly opposed to the proposed at the time commissioning reforms. Later, coerced by the new law, GPs embraced their new roles as CCG commissioners – some directly as leaders, others indirectly as contributors.

To nurture a good working relationship, it is a wise idea to start the relationship as early as possible and have an open communication. Ahmed-Little (2013) gives the following example of establishing a good working relationship between NHS clinicians and managers from the very start of their careers, a real-life example which may turn out fruitful in the future:

> "North Western deanery has adopted this [collaborative, my note] approach with its medical leadership programme. Junior doctors can now apply for formal leadership development alongside NHS management trainees. Eight junior doctors in a room of 230 management trainee graduates has [sic] influenced the group dynamic to everyone's benefit. False preconceptions are challenged there and then, not years later when it is often too late to change a habit."

The *complementarity and peaceful coexistence* of the four logics this research has been talking about may be seen as the embodiment of this third contribution to policy or legislation (see Figure 6).

## 8.7. Contributions to practice

In the recent literature on qualitative research in accounting and management (Humphrey, 2014; Ter Bogt and Van Helden, 2012), the importance of academic rigour (theorisation) and the practice relevance behind qualitative research are both outlined as vital tools for the understanding of social reality. The interview data collected in the course of this research led incidentally to some ideas on how to improve the practices or activities that CCGs engage in. Thus, the data prompted several contributions to current CCG practice, two of which are examined in more detail below. Current CCG practices, i.e. meaningful and relatively well established and coherent activities, should be subject to constant improvement. The two contributions in Table 9 below are aimed to help improve current CCG practice.

**Table 9**

**Contributions to practice**

| Contribution to practice number | Nature of the contribution to practice | Relevant quotes from the data |
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| 1 | Living within the limits of a constrained budget incentivises clinicians to do things differently and, hopefully, better than in the past. Moreover, CCGs and other NHS entities should not be overly averse to taking risk and, occasionally, making mistakes. | **Quote 71**: "When CCGs were formed, one of the key reasons for its formation was that NHS was running with cash starvation. And they had to find new ways to control the cost but at the same time make sure that the quality and services are well preserved and I think that giving it in the hands of clinicians addresses that focus and especially at our CCG level, the clinicians are in charge and they think more rationally, innovatively, to find the quality of care and to produce efficiency. So, when there is, like, a war, people are |

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| | | at their best. So, when you have less money, to produce the same results, you have more innovation, and you think more differently to address those problems" (Interviewee G).<br><br>**Quote 72**: "…whereas, previously there was a lot of inertia in the system because the GPs didn't really have much financial responsibility and therefore were doing what was the easiest thing which is to send the patients to hospital. Now they've got financial incentivisation … because they have to live within a constrained budget, they might do something differently" (Interviewee A).<br><br>**Quote 73**: "It's about the bureaucracy, the kind of hoops that you need to do before you can really do practical things. They say, just like the police, they have to tick 200 boxes for a five-minute incident. So, they have the contact with the criminal for five minutes but they spend two hours writing about it. The same thing is happening with the doctors ... So, whatever you do, it takes a lot longer to implement it because of several layers of ... it's called governance, too many layers of governance. So, there are people governing you from five, ten different organisations, so you still do not have the independence to actually … because they are afraid that you may make the wrong decision but you have to learn from making the wrong decision in the first place or you don't make any decision at all … Then, how can you change anything? And if someone knew exactly that that's the right decision, nobody knows if it is the right decision because they do not have the experience of doing it in the first place. You have not allowed people to do something new, then how can you have the information about it?" (Interviewee G). |

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| 2 | The NHS should further train the clinicians involved in CCGs in business, accounting, leadership, and other management skills, so that they may better understand large-scale business mechanisms, strategies, and processes. | **Quote 74**: "It's [A CCG is] a business [laughing]. Frankly, it comes down to it, doesn't it? You know, if I were the GP, right, and somebody came to me; so, it all depends on how this business process works. So, I am a GP and I go to somebody and I say, 'I would like, I'd like to offer an additional service. I am going to buy a piece of kit. I'm going to train myself up on it to an accredited standard and I'd like to offer you an additional service.' And somebody says, 'That's marvelous and we'll do that.' OK? Now, that's part of your investment decision to make that call and the issue is: to keep that running, you need to do it well. That's a different set of business processes, so me as a commissioner saying, 'GP, I'd like you to run this service.' And then the GP then responds, 'OK, I need to buy a machine. I've got to train myself up. I want a three-year contract. Because if I get a three year contract, that gives me more payback on my machine.' It's about understanding business process, you know. If you strip away the words 'health,' 'clinicians,' it's a business transaction. You would not enter into a business transaction not having a clue about how you recover your investment or not understanding the market and your income stream … Well, it is complex, but I mean, the actual business processes aren't that complex. We make them complex 'cause we throw a lot of words in it that people don't mean and we don't allow ourselves to recognise some of the more obvious economic disciplines" (Interviewee P).<br><br>**Quote 75**: "No, they [GPs]'ve had no training whatsoever other than some kind of corporate development support, but it's no way near enough" (Interviewee H).<br><br>**Quote 76**: "Certainly, there has been some training available for people |

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| | | [clinicians in CCGs] to look at NHS budgeting and whatever, if people wanted to take advantage of it" (Interviewee S).<br><br>**Quote 77**: "I mean, actually, one of the things that I've put in my personal development plan this year for my appraisal is to get greater insight into the accounting processes … Hm, you know, because I see that as a definite educational need in this role … which would certainly allow me to perform this role a bit better" (Interviewee Q). |

The first contribution to practice from the above table consists of the following: living within the limits of a constrained budget incentivises clinicians to do things differently and, hopefully, better than in the past. Besides, CCGs and other NHS entities should not be overly averse to taking risk and, occasionally, making mistakes. This is so because mistakes are a normal part of risk taking. Without risk taking, no change will ever materialise. Even though healthcare is a sector with a high potential for harm to the end user, so are also many other industries which take charge of people's lives and safety – the automobile industry, the airlines industry, the pharmaceutical industry, and many more. In today's economic climate of scares resources, taking well-calculated risks should be something normal, even in healthcare, and should not be feared. Table 9 presents four relevant quotes in support of this first contribution to practice.

An opinion that supports this contribution comes from an anonymous commentator from the online survey, the *Change Challenge*, mentioned in section 8.6: "[T]he end result of being over-risk averse, especially in a culture of fear, is that patient safety is compromised and

more mistakes are made.[40]" Another anonymous commentator wrote a post entitled, 'Fear of failure in a blame culture' which says that this fear "is a key barrier to change within organisations. The front line is not empowered to make improvements." This posting generated an impressive 37 'likes' from other participants in the survey.

Another supporting comment to the first contribution to practice comes from an article on the recent, very controversial discontinuation of the private company Circle's franchise of the Hinchingbrooke Health Care Trust in Cambridgeshire (Welikala, 2015b). This was the first of its kind franchise by a private company of a NHS trust. Because costs exceeded an agreed-upon limit (£5 million), Circle withdrew contractually from the agreement. Several commentators to Welikala's online article commented that they also felt like withdrawing from their poorly performing NHS hospital contracts but they couldn't – the public sector simply did not have similar withdrawal privileges to those of the private company Circle. A commentator then responded:

> "The NHS cannot continue to do what it has always done and expect things to improve by some automatic process. All sorts of approaches need to be developed and tried. Not all will be successful, in fact most won't. But if we took the approach of "no guarantee so no attempt" we wouldn't be using modern pharmaceutical products or surgical techniques. well [sic] done for the attempt, for recognising when it had failed and reverting to a different model. Whether others have a go at this model [franchising to a private company] or not is a matter for them. I hope someone tries something" (Anonymous, 9 January 2015, 11:20 am, *Ibid.*).

Common sense dictates that too much risk aversion is not conductive to discovering new, and perhaps better, ways of doing things. Some recent research has found that the new CCGs have a desire to do things differently than the previous commissioners (Coleman *et al.*, 2015). Hopefully, this desire to experiment and innovate will ultimately improve CCG practices. Coming back to excessive risk aversion, Pope and Burnes (2013) call this aversion

[40] Available at: <https://changechallenge.clevertogether.com/> [Accessed 30 March 2015].

organisational ‘silence’ and ‘selective moral disengagement.’ These two phenomena, in the authors’ view, hinder the NHS from becoming a ‘wise’ organisation that listens and learns along the way.

*A healthy pressure from the business logic on the medical/professional logic* is a good idea: living within limited resources brings out the best in people, as this contribution showed. The professional logic should accommodate calculated risk taking, to avoid creating a ‘culture of fear’ and to nurture innovation. Thus, *flexibility in logics is desirable*.

The second contribution to practice proposed here (see Table 9) is the following: the NHS should further train the clinicians involved in CCGs in business, accounting, leadership, and management skills, so that they may better understand large-scale business mechanisms, strategies, and processes. According to the four quotes in support of this second contribution, such training would help clinicians become better CCG leaders.

Among the first articles to address the topic of clinicians’ business training within CCGs were Currie *et al.* (2012) and Devlin (2010). The previous chapter showed that clinicians were not alone in commissioning, but were still the ones accountable and responsible for it. In the parlance of *HSJ News*, maybe, clinician-commissioners are a less ‘tainted’ type of manager than the pure NHS manager who performance manages the hard-working, understaffed, and overly-stressed NHS clinicians to whom was assigned the impossible task to meet ever-rising demand with ever-dwindling resources. In this spirit, HJS News (2014) states:

> “A popular suggestion [in the *Change Challenge* online survey] was that the words “manager” and “management” should be banned as they were “alienating” and had “tainted” connotations. Instead, managers could be replaced with “team leaders” who “lead from the front.””

The rationale for the symbiosis of family doctor and commissioner transpired from the white paper that first announced the CCG reforms: "The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia [which later became known as CCGs]" (DH, 2010a, p. 4). As already mentioned, the Coalition government perceived PCT managers as expensive people who were doing a sub-standard job with the NHS and its finances. Therefore, 'Who could be better than GPs in handling PCT mangers' jobs than GPs?' probably thought the government. After all, "90 per cent of patient contact with the NHS takes place in general practice.[41]" Clearly, the proximity of GPs to patients, i.e. their situation within the field, or their frontline worker status, similarly to this of head teachers and school governors in education (Laughlin *et al.*, 1994), is what earned GPs their status of commissioning hybrids. It is still relatively early to know how the commissioning practices of these hybrids would differ from these of PCT commissioners, as evoked by several interviewees. Yet, many differences are already widely evident – more engagement with the public is taking place, an enhanced dialogue with various external parties is being heard, and an increased clinical input in decision making is present. Additional management, accounting, and leadership training would doubtlessly help these new hybrids to better understand large-scale business issues.

Training clinicians in the economic disciplines and their calculative practices is nothing but a spreading of the business logic into what used to be the realm of the professional/clinical logic (clinicians' skills set). It looks like some clinicians (Quote 77) were keen to learn new

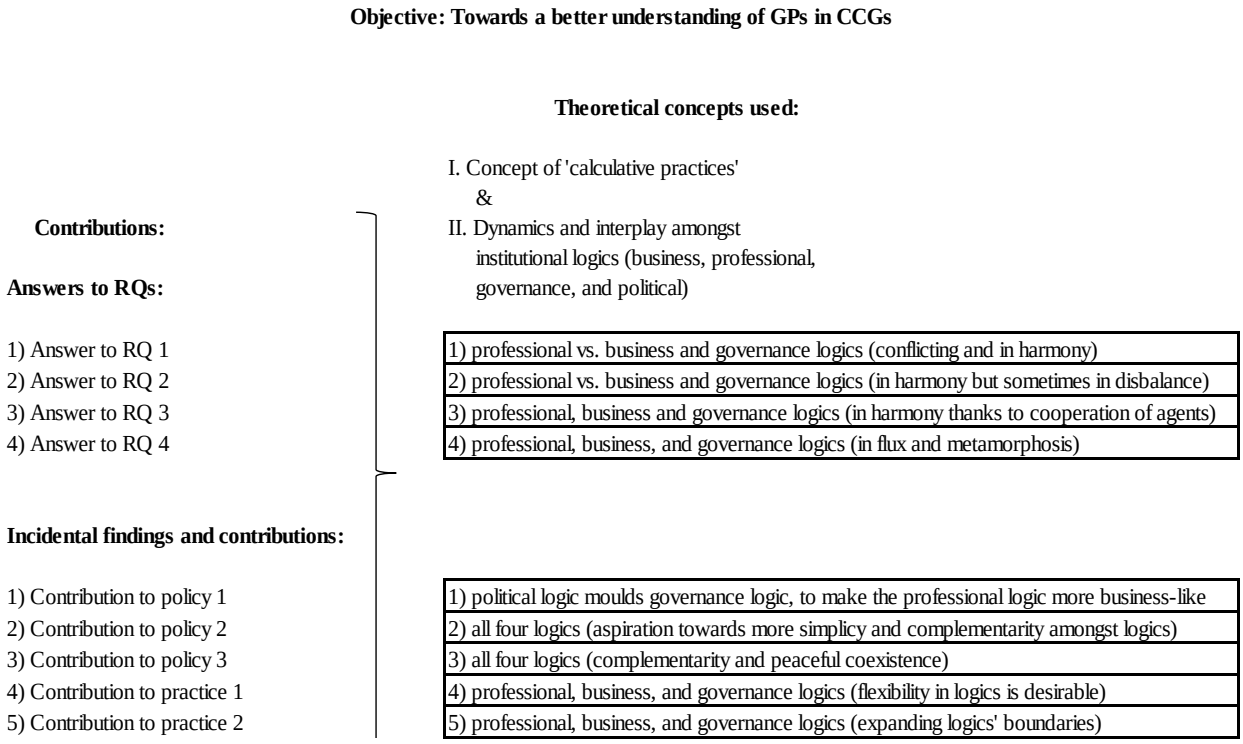
[41] Available at: <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf> [Accessed 20 April 2015].

skills and thus become better CCG leaders. This way, *the expanded boundaries* of the business logic would improve governance and leadership (the governance logic).

Figure 6 is a summary of this research and an extension of Figures 4 and 5.

**Figure 6**

**Summary of this research**




Some interviewees even expressed the view that the latest NHS reforms were an orchestrated attempt by the government to give the impossible task of ‘fixing’ the NHS to the inexperienced in large-scale business processes GPs and thus put the whole blame for the immanent NHS failure on them. This is a perceived ulterior motive of the Coalition government. Thus, the only viable remaining solution would be to privatise the NHS. Interviewee F opined:

> "My cynical opinion is that the whole exercise [of CCG commissioning] is part of the government's wider agenda to privatise primary care in England. After years of generating bad press and public hostility towards GPs in the press, commissioning initially seemed like a change of heart from the powers that be, but … the whole exercise is doomed to failure. The government itself could never get away with privatising primary care, but if they can say, 'Well, we gave the responsibility to GPs and look what a mess they've made of it,' then they may be able to bring in the private sector and potentially remove the independent contractor status of GPs and turn them into more manageable NHS employees (something I'm sure they've wanted to do for decades anyway)" (**Quote 78**).

'More manageable NHS employees' resonates with a Miller-inspired concept – this of the 'calculative agent.' The boundaries of who should be such a calculative agent have changed in order to help privatise the NHS, would claim this interviewee.

When asked at the end of the interview what else he wanted to add, Interviewee A shared:

> "The other thing that I think would be quite interesting is there's very clearly, I think (particularly with the new Minister) gonna be a drive to provide a bigger amount of health care from independent [i.e. private] providers and not the NHS. And it's never a lot of examples of independent providers is more expensive. Not necessarily less value for money but more expensive. So, we got examples locally where the audiology service which is provided mostly from this hospital and could easily be provided in community settings is likely to increase the cost of providing audiology services because to attempt into the market, the independent providers, you have to make it look attractive and so we had the same experience in elective orthopaedics. Well, undoubtedly, there was a problem and the local NHS wasn't delivering elective orthopaedic care in a timely or effective manner. And an independent provider was asked to provide it for five years and they did so but at a considerable extra cost … It actually, that particular example through a negotiated process that we've taken, the NHS has taken that service back and we are in our first year of providing that and if all goes according to plan, we'll be able to do it at significantly less than the independent provider was proving it for" (**Quote 79**).

Interviewee A continued:

> "And so, there are areas where I think independence [i.e. privatisation] *will* add value – diagnostic services is probably one, where pathology services could potentially provide better value for money, imaging (X-Rays and ultrasound) … They are, it's gonna become very blurred I think. So, money

> will go to a non-NHS provider to look after NHS patients. And then it becomes a significant issue about – is it more expensive to start with and what happens to all the profit that normally gets reinvested? Because elective orthopaedics is highly profitable and if you leave the care of all the trauma patients within the NHS and the profit from the elective service goes to the independent provider, there's a health economy problem … I am not sure it's all bad … And I am certainly not against having independent providers. You can set a benchmark for what services should cost because it does make others, you know, if our Imaging Department for example are aware that there may be a moderate amount of competition from an independent provider, it does challenge them to make sure they are providing us with a cost-effective service within the NHS. I am not sure it's all bad … I am not sure that it's very transparent and it needs to be. But that's quite difficult because independent providers wouldn't release information about cost of services. They just hide behind confidentiality and other agreements. So, transparency in the market is quite difficult" (**Quote 80**).

Interviewee H shared the following with respect to an eventual NHS privatisation:

> "So, I think there will be parts of the NHS that will be opened up to the market and … we seem to be designing institutional failure into the system. And the lesson from the last 20 to 30 years is that the government uses institutional inefficiency and failure as a rationale for privatisation … Did you know, if you look at the rail industry, did you know that the private sector franchise holders receive four times more in taxpayer subsidy than British Rail did before privatisation and that fares for passengers are many times more expensive? … So, we've got the most expensive rail fare in Europe! So, where is the evidence that privatised public institutions are cheaper, more effective, and more efficient? So, again, the electricity industry simply loads risk onto the consumer, so the consumer pays more. That doesn't sound like a very good model. I think we are still suffering from an ideological perspective that the Tory party have had since the days of Margaret Thatcher that because something is owned by the state and run by the state, that it is inherently bad value for money. There's no evidence that I can think of to conclusively prove that to be the case … I think that's [the privatisation of the NHS] inevitable. I can't see that that wouldn't happen but we are having that conversation with the people of this country on health. Hm, so I think it's inevitable, given the increasing demands on the healthcare system that some kind of copayment system *must* be introduced at some point because the NHS is not affordable within the resources that have been allocated" (Interview 11, **Quote 81**).

Interviewee M offered the following view:

> "The aim basically is to try and make healthcare less expensive. They [the government] know the answer to that – you could make it less expensive if you make patients pay for some of the services. And to do that, you've got to hive off some of the NHS to private companies … It will be less expensive for

> the government. It will be more expensive for patients. Now, as you probably know, when the NHS was formed, it included dental services, included eye testing (ophthalmology) … So, within a few years, if you wanted false teeth, you had to pay for them. If you wanted glasses, you had to pay for them. Whereas in 1948 when it [the NHS] was started, you could get glasses, you could get false teeth, you could get virtually everything. You were getting your prescriptions free. Now they've already (in England) they've already started paying for prescriptions. In Scotland, they don't pay for it. They've got a different financial arrangement and of course this will happen as time goes on. It is very easy to think, 'What else can we make patients pay for?' Well, maybe if you go to A&E. You can get them pay for that. So, if you go to A&E, you pay £20. Who knows where it's going? But, it's the thin end of the wedge. It's the privatisation of what was a social service" (**Quote 82**).

A supporting claim for the above views (Quotes 78-82) is one by a leader of Unite, the largest trade union in Britain, Len McCluskey, who was heard saying that, "no fewer than 230 Conservative MPs (out of 303) … [had] some sort of link with private health companies" (White, 2015). With the benefit of hindsight, it is hard to say whether the private sector will always want to enter the NHS realm, given the fiasco of Circle with Hinchingbrooke. As Interviewee A said in Quote 80, there would be a "health economy problem" if only highly profitable services get privatised.

### 8.8. Conclusion

Chapter 8 provided a further discussion on the research findings from Chapter 7. This was done in light of the gaps identified in Chapter 1, the literature review, the theoretical framework in Figure 4, and the rationale for data analysis in Figure 5. This chapter provided some possible answers to the four research questions (see sections 8.2, 8.3, 8.4, and 8.5) and added five more contributions (three contributions to policy/legislation and two contributions to theory) that were incidental to this research. The empirical and theoretical findings from the whole research were summarised in Figure 6. Now, let us turn to the final chapter of this thesis, Chapter 9, which will briefly conclude this thesis.

# CHAPTER 9
# CONCLUSION

## 9.1. Summary of this research

The objective of this research was to contribute to knowledge and understanding by exploring the professional identities of GPs in CCGs and their level of involvement in commissioning calculative practices. Four research questions were asked in Chapter 1 and answered in Chapter 8. These questions were: RQ 1, 'How appropriate is it for clinicians to be involved in acute care commissioning?;' RQ 2, 'What motivates clinicians to assume leadership roles in CCGs?;' RQ 3, 'How involved are clinicians in CCG calculative practices?;' and RQ 4, 'To what extent do hybridity and calculative practices affect clinicians' professional identities in CCGs?'

The answers to these four research questions hopefully helped fill the eight research gaps identified in Chapter 1, at least partially. Gap 1 was the shortage of academic studies on the new CCG commissioning compared to such studies in the practitioner literature. Gap 2 was the lack of studies on how the people directly involved in CCGs, such as GPs and other clinicians, personally felt about clinicians' involvement in commissioning. Given that some commentators after CCG commissioning was first announced were very skeptical about GPs' role in commissioning, this gap was particularly important to fill. Gap 3 was the lack of studies of CCGs from a calculative practices perspective. Gap 4 was the shortage of accounting studies on healthcare commissioning, compared to education commissioning studies in England. Gap 5 was the shortage of agency studies in CCG commissioning. Gap 6 was the lack of studies on the motivational factors thanks to which clinicians undertake active

roles in CCGs. Gap 7 was the lack of studies on the level of involvement of clinicians in CCG calculative practices. Finally, Gap 8 was the scarcity of studies on hybrid professional identities in CCG commissioning.

This research also presented five additional, incidental contributions to current policy/legislation and practice. These contributions were followed by more research data that alluded to the, what some interviewees saw as, the immanent privatisation of the NHS. Figure 6 summarised this whole research by giving the spotlight not just to the answers to the research questions and the incidental contributions, but also to a number of theoretical observations and findings (depicted in cells).

An important foundation of CCG commissioning is the purchaser-provider split that was introduced in Chapter 3. Hybrid GP-commissioners and this whole research would not have existed in the absence of this split. "The division of the health service into purchasers and providers has been a cornerstone of governments' health policies for three decades. However, recent months have seen its value called into question by high profile figures within the NHS" (Clover, 2013). According to this source, the *Health Service Journal*/Capsticks Hospital Chief Executives' Barometer survey asked the leaders of English hospital trusts to rate how useful the purchaser-provider split was to their health economies. The survey was administered in the early days of CCG commissioning. The average rating of all 45 respondents was 3.1, with 1 being 'not at all useful' and 10 being 'very useful.' No respondent gave more than an 8 rating. A chief executive of a FT wrote in this survey that while leaders of FTs and trusts wanted to focus on delivering the best services to their patients, they were often, "frustrated by the amount of time they … [had] to spend

negotiating contracts with commissioners and navigating the added complexity this brings" (*Ibid.*).

In a 2013 interview with the *Health Service Journal*, Sir David Nicholson said that NHS England was already "thinking about the possibility of mutual [organisations and] social enterprises, and also about whether the straightforward commissioner-provider split … [was] the right thing for all communities" (West, 2013). He also called on the service to look more closely at the U.S. healthcare organisations, Geisinger and Kaiser Permanente which serve as both an insurer and provider for a defined membership. He added, "We need to be much more creative about those sorts of models of integration, which go beyond simple provider integration" (*Ibid.*).

So, what is the future of CCG commissioning? If indeed the English NHS moves to an insurance-based system like the one in the U.S., the duties of CCG commissioners, whether these commissioners are clinicians or not, will most likely transfer to health insurance companies and/or providers. Perhaps, the early signs that the English NHS is moving toward a U.S.-inspired insurance-based model are already here? It is probably too early to speculate whether or when this will happen since the HSCA 2012 is a piece of law and, as we saw, legislation is hard to undo. Hard but not impossible.

### 9.2. Implications for future research

It is recognised that this research may be extended in the future, so that it may cover other important issues besides the professional identities and calculative practices of commissioning hybrids in acute care commissioning. The data already collected may be used

for future, in-depth studies on issues repeatedly brought up by the research interviewees: the localism agenda of NPM, the changing work identities and practices of non-clinicians involved in CCGs, the new duties of local authorities, the new Health and Wellbeing Boards, NHS England, and many more. Another area of future research may be to examine the contemporary state of commissioning in other public sector fields, not just in acute healthcare, such as social care and infrastructure, to list just a few. Besides, the issue of the eventual privatisation of the English NHS and how the purchaser-provider split might be implicated by it may also be addressed in the future.

It is hoped that the reader enjoyed reading this thesis and that the topic of the socially important CCG commissioning will grab the attention of many more scholars to come.

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# Appendix A

***Commissioning Show 2013*** **programme**

**PROGRAMME**

**12 June, 2013**

**Streams: CCG Business and Clinical Commissioning Support**

**Stream Chairs: Dr. Amanda Doyle and Dr. Phil Moore, respectively**

| | |
|---|---|
| 9:00 – 9:15 | Morning plenary sessions: Opening and welcome from **Dr. Charles Alessi**, Chairperson, NAPC and NHS Clinical Commissioners |
| 9:15 – 9:50 | Keynote address: **Rt. Hon. Norman Lamb**, Minister for Care and Support |
| 9:50 – 10:00 | NHS e-Referrals Launch: **Beverly Bryant**, Director of Strategic Systems and Technology, NHS England and **Dr. Masood Nazir**, GP Lead, CCIO, NHS England |
| 10:30 – 11:00 | HSJ Debate: Who is responsible for the delivery of QIPP – NHS England, CCGs or CSUs? |
| | Debate chair: **Dave West**, Chief Reporter, HSJ |
| | **Andrew Kenworthy**, Director of the Commissioning Support Unit Transition Programme, NHS England |
| | **John Wilderspin**, Managing Director, Central Southern CSU |
| | **Dr. Sam Everington**, Chair, Tower Hamlets CCG and NHS England Representative |
| 11:00 – 11:30 | Commissioning an informed anticoagulation service for the patient |
| | **Dr. Ameet Bakhai**, Consultant cardiologist, R&D Lead, Barnet and Chase Farm NHS Trust |
| | **Dr. Matthew Fay**, GP, Westcliffe Medical Practice, Shipley |
| 11:30 – 12:00 | Networking and exhibition visit |
| 12:00 – 12:30 | How can CCGs achieve financial balance in their first year? |
| | **Paul Baumann**, Chief Financial Officer, NHS England |

| | |
|---|---|
| 12:30 – 13:00 | How out of hospital care can help you meet the QIPP agenda? |
| | **Jacqui Lyttie**, Commissioning adviser, JSL Consulting |
| | **Richard Jackson**, Director of Operations, Bupa Care Services |
| | **Stephen Cook**, Director of Pharmacy, Bupa Home Healthcare |
| 13:00 – 14:00 | Procuring commissioning support services: A consultation on supporting CCGs and other buyers |
| | **Bob Ricketts**, Director of Commissioning Support Strategy & Market Development, NHS England |
| 14:00 – 14:30 | Commissioning for long-term conditions: Do we know what commissioners actually do? |
| | **Dr. Judith Smith**, Director of Policy, Nuffield Trust |
| 14:30 – 15:00 | A new primary care pathway for DVT treatment |
| | **Dr. David Russell**, GP and **Andy Reay**, Pharmaceutical Adviser |
| 15:00 – 15:30 | How to make a success of CCGs' critical relationships with NHS England? |
| | **Dr. Johnny Marshall**, NHS Clinical Commissioners |
| | CCGs and member practices – a shared fate? |
| | **Dr. Minesh Patel**, Clinical Chair, Horsham and mid-Sussex CCG |
| 15:30 – 16:00 | CCGs post-Francis: How to avoid another Mid Staffs and make quality the priority in 2013? |
| | **Dr. David Paynton** (MBE, FRCGP, DMS), National Clinical Lead, Centre for Commissioning, Royal College of General Practitioners |
| 16:00 – 16:30 | The CQC's new strategy for 2013-16 – its impact on CCGs |
| | **Dr. Paul Bate**, CQC Director of Strategy and Intelligence and Former Health Advisor, No. 10 Policy Unit |
| 17:00 – 17:45 | Keynote address on Labour's vision for integrated health and social care: **Rt. Hon. Andy Burnham**, MP, Shadow Health Secretary. Followed by a live interview with **Alastair McLellan**, Editor, *HSJ* |

**PROGRAMME**

**13 June, 2013**

**Streams: CCG Business, Long-Term Conditions, and Clinical Commissioning Support**

**Stream Chairs: Julie Wood, Dr. Rowan Hillson, MBE, and Dr. Charles Alessi, respectively**

| | |
|---|---|
| 9:00 – 9:15 | Morning plenary sessions: Welcome by conference chair **Dr. Mike Dixon**, Chair, NHS Allianceand Interim President, NHS Clinical Commissioners |
| 9:15 – 10:00 | Head-to-head debate: Can CCGs solve the urgent and emergency care crisis? |
| | **Dr. James Kingsland**, National Clinical Lead, NHS Clinical Commissioning Community and **Prof. Tim Evans**, Lead Fellow, Royal College of Physicians Future Hospital Commission, NHS |
| 10:00 – 10:30 | Networking and exhibition visit |
| 10:30 – 11:00 | No health without mental heath |
| | **Rebecca Cotton**, Acting Deputy Director, Mental Health Network |
| | **Dr. Caroline Dollery**, Mental Health Commissioners Steering Group, NHS Clinical Commissioners |
| 11:00 – 11:30 | Practical examples of improving productivity and efficiency |
| | **Dr. Umesh Kumar Roy**, CCG Board Member, Innovation Lead and Chair for Improving Cardiovascular Outcomes – Leicester City |
| 11:30 – 12:00 | Networking and exhibition visit |
| 12:00 – 12:30 | The Big Conversation: What are the key priorities for CCGs post-authorisation? |
| | **Dr. Stephen Richards**, Chief Clinical Officer, Oxfordshire CCG, |
| | **Dr. Andrew Coward**, Chair, NHS Birmingham South Central CCG and |
| | **Dr. Helen Tattersfield**, Chair, Lewisham CCG |
| 12:30 – 1:00 | Networking and exhibition visit |
| 1:00 – 1:30 | Procuring Commissioning Support Services: A consultation on supporting CCGs and other buyers |
| | **Bob Ricketts**, Director of Commissioning Support Strategy & Market Development, NHS England |

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|---|---|
| 14:00 – 14:30 | Moving beyond authorisation – the legal and governance challenges CCGs must address in their first year<br><br>**Giles Peel**, Adviser, Clinical and Healthcare Risk, DAC Beachcroft,<br><br>**Robert McGough**, Partner, DAC Beachcroft |
| 14:30 – 15:00 | Commissioning to prevent Atrial Fibrillation (AF) Related Stroke<br><br>**Dr. Matthew Fay**, GP, Westcliffe Medical Practice, Shipley |
| 15:00 – 15:30 | Integrated responsibility: Patient centred commissioning<br><br>**Dr. Steve Kell**, Chair, Bassetlaw CCG and Co-Chair, NHS Clinical Commissioners Leadership Group |
| 15:30 – 16:15 | Keynote Debate: What do CCGs need to do to avoid major re-organisation in three years' time?<br><br>Chair: **Dr. Mike Dixon**<br><br>Confirmed panel members: **Rt. Hon. Stephen Dorrell**, MP, Chair of the House of Commons Health Select Committee, **Prof. David Haslam**, CBE, Chair Designate, NICE and National Professional Adviser, CQC, **Ben Page**, Chief Executive, Ipsos MORI, **Sir Robert Naylor**, Chief Executive, University College London NHS Foundation Trust, **Dr. David Bennett**, Chair and Chief Executive, Monitor. |

Source: *Commissioning Show 2013* programme. London ExCel Building, 12-13 June, 2013.

# Appendix B

***Hospital Directions 2013 Conference*** **programme**

**PROGRAMME**

**27 November, 2013**

**Presentations attended in Theatres 1/2/3**

| | |
|---|---|
| 09:00 – 09:30 | What will the hospital of the future look like? |
| | **Mike Farrar**, Chief Executive, NHS Federation |
| 10:00 – 10:40 | 'Operation Onion – peeling back the layers' for lasting change |
| | **Samantha Jones**, Chief Executive, West Hertfordshire Hospitals NHS Trust |
| | **Michael Van der Watt**, Medical Director, West Hertfordshire Hospitals NHS Trust |
| 10:50 – 11:35 | Kaiser Permanente's hospitals' journey: Achieving the triple aim |
| | **Gregory A. Adams**, Executive Vice President, Group President and Regional President of Northern California, Kaiser Permanente |
| | **Alide Chase**, Senior Vice President of Medicare Clinical Operations and Population Care, Kaiser Permanente |
| 11:55 – 12:40 | Benefits of tele-health in secondary care |
| | **Katy Lethbridge**, Healthcare & Health Technology Sector Specialist, Medvivo |
| 13:30 – 14:10 | New approaches to improving performance and creating a system of consequences |
| | **David Dalton**, Chief Executive, Salford Royal NHS Foundation Trust |
| 14:35 – 15:10 | Financial challenge – moving towards sustainability |
| | **Bob Alexander**, Director of Finance, NHS Trust Development Authority |
| 15:45 – 16:30 | The role of the private sector in the NHS |
| | **Michael Watson**, Chief Operations Officer, Circle Partnership |
| | **Stephen Collier**, Group CEO, BMI Healthcare |

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| | **John Myatt**, Strategic Development Director, Serco Health |
| 16:50 – 17:30 | Clinical engagement in hospital finance – the Brighton experience |
| | **Philip Thomas**, Clinical Chief of Finance and Consultant Urologist, Brighton and Sussex University Hospital NHS Trust |

**PROGRAMME**

**28 November, 2013**

**Presentations attended in Theatres 1/2/3**

| | |
|---|---|
| 09:30 – 10:00 | Opportunities abroad – NHS expertise and Gulf States demand |
| | **Simon Shooter**, Partner, Bird & Bird |
| 10:00 – 10:40 | Delayed discharges are all down to social care … or are they? |
| | **Richard O'Driscoll**, Discharge Transformation Manager, Cambridge University Hospital Foundation Trust |
| 11:05- 11:45 | The worst of both worlds? Resource allocation compromises inequality |
| | **Prof. Sheena Asthana**, Professor of Health Policy, University of Plymouth |
| 11:55 – 12:40 | **Linda Mussell**, Child Protection Information System (CP-IS) Clinical Engagement Lead, Health and Social Care Information Centre |
| | **Dr. Emyr Wyn Jones**, Clinical Lead – National Implementation Summary Care Records Service, Health and Social Care Information Centre, HSCIC – Information sharing between health care settings |
| 13:40 – 14:15 | Progress towards sustainability in estates |
| | **Martyn Jeffery**, Director of Estates, Royal Free London NHS Foundation Trust |
| 14:30 – 15:10 | The importance of clinical leadership in the future of the NHS |
| | **Mark Newbold**, Chief Executive, Heart of England NHS Foundation Trust |
| | **Karen Payne**, Head of Operations, NHS Leadership Academy |

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| 15:45 – 16:20 | QIPP – changing our business model in a changing world<br><br>**Rob Forster**, Director of Finance and IM&T, Wigan, Wrighton and Leigh NHS |
| 16:20 – 17:05 | Health IT and the Francis Report – how IT systems can help address the key findings<br><br>**Dr. Paul Shannon**, Consultant Anaesthetist in the NHS and Medical Director at CSC |

Source: *Hospital Directions 2013 Conference* programme. London ExCel Building, 27-28 November 2013

# Appendix C

***Commissioning Show 2014*** **programme**

**PROGRAMME**

**25 June, 2014**

**Stream: CCG Business**

**Stream Chair: Dr. Steve Kell, Chair, NHS Bassetlaw CCG,**

**Co-Chair, NHS Clinical Commissioners Leadership Group, and GP, Bassetlaw**

10:25 – 10:55 Key challenges and opportunities for CCGs in year two

Speaker(s):

**Ros Roughton**, National Director, Commissioning Development, NHSE

**Dr. Sam Everington**, OBE, NHS Clinical Commissioners Leadership Group; GP and Chair, Tower Hamlets CCG

11:00 – 11:30 CCG finance update and Q&A with expert panel

Speaker(s):

**Dean Westcott**, Chief Financial Officer, West Essex CCG; member, NHSCC Leadership Group

**Dr. Tim Moorhead**, Chair, Sheffield CCG; member, NHSCC

11:30 – 12:00 Integrated care for commissioners

Speaker(s):

**Matt Murphy**, Managing Director, EMIS

**Hasib Aftab**, Head of Informatics and IT, Camden CCG

12:00 – 12:30 CCGs' role in co-commissioning primary care

Speaker(s):

CCG Business Chair **Dr. Steve Kell**, GP and Chair, NHS Bassetlaw CCG; Co-Chair, NHS Clinical Commissioners Leadership Group; GP, Bassetlaw

12:35 – 13:05 Introducing point of care medicines optimisation support into NHS Lincolnshire East CCG

Speaker(s):

**Dr. James Howarth**, GP Chair, NHS Lincolnshire East CCG

**Dr. Fermin Blanco-Mayo**, GP

13:05 – 14:00 Networking & exhibition visit

14:00 – 14:35 Commissioning for value-based outcomes – how to actually do it

Speaker(s):

**Dr. Neil Bacon**, CEO & Founder, iWantGreatCare, Ltd.

**Dr. Nikki Kanani**, GP, Vice Chair CCG, Quality Lead FMLM, Exec NAPC

**Dr. Ombarish Banerjee**, Clinical Lead for MSK, Bexley CCG

**Dr. Rupert Dunbar-Rees**, Founder and Director, Outcomes Based Healthcare

14:35 – 15:05 Workforce challenges, opportunities, issues and anxieties

Speaker(s):

**Dean Royes**, Chief Executive, NHS Employers

15:05 – 15:35 Networking & exhibition visit

15:35 – 16:10 Alcohol in safer hands: A joint working project opportunity for CCGs

Speaker(s):

**Dr. Joe McGilligan**, Chair, East Surrey CCG & Co-Chair, Surrey Health and Wellbeing Board

16:10 – 16:40 Tackling the A&E crisis – two high-impact solutions commissioned by CCGs

Speaker(s):

**Clare Lyons-Collins**, Out of Hospital Mental Health Lead, Hammersmith and Fulham CCG

**Mike Pinkerton**, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust

**Dr. Steve Reid**, Clinical Director for Psychological Medicine, Central and North West London NHS Foundation Trust

16:40 – 17:10 Networking & exhibition visit

17:10 – 17:45 Keynote debate: What whole-system innovations are most likely to help end the A&E crisis within five years?

Chair: **Dr. Charles Alessi**, Chair, National Association of Primary Care, NHS Confederation and Lead for Preventable Dementia, Public Health England

Speaker(s):

**Dr. Anita Donley**, Clinical Vice President, RCP

**Sir Bruce Keogh**, National Medical Director for NHS England

**Clifford Mann**, President, The College of Emergency Medicine

**Göran Henriks**, Chief Executive of Learning and Innovation, Jönköping County Council, Sweden

**PROGRAMME**

**26 June, 2014**

**Stream: CCG Business**

**Stream Chair: Dr. Phil Moore, GP, Central Surgery Surbiton, Deputy Chair, Kingston CCG and Member of leadership Group of NHSCC**

09:00 – 09:15 Keynote address by **the Rt. Hon. Andy Burnham**, Shadow Secretary of State for Health

09:15 – 09:55 Keynote debate: Is whole person care another NHS reorganisation?

Chair: **Alistair McLellan**, Editor, *Health Service Journal*

Speaker(s):

**Andy Burnham**, Shadow Secretary of State for Health

**Dr. Charles Alessi**, National Association of Primary Care, NHS Confederation and Lead for Preventable Dementia, Public Health England

**The Rt. Hon. Stephen Dorrell**, Former Chair of the House of Commons Health Select Committee

**Cllr. Steve Bedser**, Cabinet Member for Health and Wellbeing, Birmingham City Council

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|---|---|
| 09:55 – 10:25 | Networking & exhibition visit |
| 10:25 – 10:55 | Integrating services for the frail elderly in Kingston – a blueprint for the Better Care Fund |
| | Speaker(s): |
| | **Dr. Phil Moore**, GP Central Surger Surbiton, Deputy Chair, Kingston CCG and Member of Leadership Group of NHSCC |
| 11:00 – 11:30 | Collaborative commissioning – getting it right |
| | Speaker(s): |
| | **Giles Peel**, Head of Governance Advisory Practice, DAC Beachcroft |
| 11:30 – 12:00 | Networking & exhibition visit |
| 12:00 – 12:35 | Tackling common tensions in the CCG/NHS England Area Team relationship |
| | Speaker(s): |
| | **John Wicks**, Interim Chief Officer, Warrington CCG |
| | **Moira Dumma**, Area Team Director, Cheshire, Warrington & Wirral Area Team, NHS England |
| 12:35 – 13:05 | Tips for procuring excellent commissioning support |
| | Speaker(s): |
| | **Dr. Shane Gordon**, Chief Officer, NHS North East Essex CCG |
| 13:05 – 14:35 | Networking & exhibition visit |
| 14:35 – 15:15 | Commissioning for value based outcomes: Is the NHS capable or not? |
| | Speaker(s): |
| | **Prof. Paul Corrigan**, Former Advisor to Prime Minister Tony Blair and Commentator on Health Policy |
| | **Saffron Cordery**, Director of Policy and Strategy, Foundation Trust Network |
| | **Dr. Steve Laitner**, GP, Freelance Health Consultant |
| 15:05 – 15:40 | Networking & exhibition visit |
| 15:40 – 16:15 | Preventing another ‘Bournemouth and Poole’ – lessons from experience |
| | Speaker(s): |
| | **Catherine Davies**, Executive Director of Cooperation and Competition, Monitor |

**Gerard Hanratty**, Partner, Capsticks

**Sharon Lamb**, Partner, Capsticks

Available at:
<http://www.healthpluscare.co.uk/page.cfm/action=search/searchid=42/filterShowCatID_10=,108/filterentryDateRange=,26%20Jun%202014> [Accessed 22 August 2014]

# Appendix D

**List of interviews (anonymised) conducted in the course of this Ph.D. but not used in this research**

| Interview number | Entity (type) | Interviewee | Job title | Date of interview |
|---|---|---|---|---|
| 22 | s (provider) | U | Estates Services Manager | 21 Aug. 2012 |
| 23 | t (private provider) | V | Sector Director of Healthcare | 5 Sept. 2012 |
| 24 | u (provider) | W | Project Manager (Construction) | 11 Sept. 2012 |
| 25 | v (provider) | X | Private Finance Initiative Contract Manager | 12 Sept. 2012 (phone interview) |
| 26 | w (provider) | Y | Director of Planning | 27 Sept. 2012 (phone interview) |
| 27 | x (provider) | Z | Director of Estates and Facilities | 27 Sept. 2012 (phone interview) |
| 28 | y (provider) | AA | Contracts Manager | 27 Sept. 2012 |
| 28 | y (provider) | BB | Estates General Manager | 27 Sept. 2012 |
| 29 | Z (private provider) | CC | Commercial Director | 2 Oct. 2012 |
| 30 | aa (provider) | DD | Estates Strategic Development Manager | 9 Oct. 2012 |
| 31 | bb (provider) | EE | Deputy Director of Finance | 10 Oct. 2012 |
| 32 | cc (provider) | FF | Director of Estates and Facilities | 17 Oct. 2012 |
| 33 | dd (consultancy) | GG | Partner, Corporate Finance | 18 Oct. 2012 |