Managing change: using organisational change theory to understand organisational responses to Health Policy. A case study of changes in commissioning.

Sara McCafferty

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Declaration

The work presented in this thesis has been composed by the candidate Sara McCafferty. The material has not been previously submitted for a degree of any qualification at this or any university.

The thesis is the candidate's own work and all the work has been completed by the candidate. At the outset of this thesis the candidate was employed as a researcher on a commissioning study funded by the Department of Health, (Bate *et al.*, 2012). This thesis shared some of the data sets and fundamental means of data collection as the research study; namely the semi-structured interviews included in Part A. Although the data was collected for dual purposes, the two studies had different aims and objectives and the analysis for each has been undertaken separately.

Abstract

Background

The NHS in England has been subject to numerous reforms and changes in health policy since its inception in 1948. Such changes often mean that organisational strategies are halted, diverted or otherwise prevented from being completed. To date research in health care settings has considered change in a broad context but there has been limited research which focuses on how organisations respond and adapt to changes in health policy specifically. The objective of this research is to explore how existent change management literature and models can be used to understand how organisations respond to changes in health policy.

Methods

In 2010 the White Paper 'Equity and Excellence: Liberating the NHS' was released. The paper, which proposed ambitious and widespread reform to the NHS, was met with significant resistance and experienced a protracted passage through Parliament. This research utilised the changing policy landscape to conduct a natural experiment, using a commissioning organisation as a case study, to understand responses to these policy changes. The eight factors of receptivity model was used as a medium to explore organisational receptivity to NHS policy changes.

Results

A synthesis of the results is presented in the form of a new model to guide organisations in developing rreceptivity to change. The model identifies four key factors influencing the organisation's ability to respond to policy change: policy, system management, organisational context and change agenda and locale.

Conclusions

Receptivity to policy change in the NHS is influenced by different factors than traditional management induced change or organic organisational change. Implications for policy makers have been drawn from this research which includes the need to develop coherent policy with clearly articulated vision, the requirement to manage national political culture, the importance of tackling system issues, and the need for careful management during transitions to avoid loss of valuable skills and expertise.

Acknowledgments

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List of Acronyms

FESC   Framework for procuring External Support for Commissioning

GP   General Practicioner

GPCC   General Practicioner Commissioning Consortia

NHS   National Health Service

PBC   Practice Based Commissioning

PBR   Payment by results

PCT   Primary Care Trust

SHA   Strategic Health Authority

WCC   World Class Commissioning

Chapter 1 Introduction

1.1 Chapter introduction

This thesis is concerned with how organisations manage changes in health policy. Specifically, the study seeks to understand what factors influence how commissioning organisations manage health policy change. This chapter introduces health policy and outlines the relationships between policy and change, and identifies the opportunity for learning and application of change management literature to policy contexts. The chapter summarises current knowledge about how commissioning organisations respond to policy changes, and presents the rationale for the research pursued in this thesis. The research questions and design are described and the chapter concludes with an overview of the structure of the thesis.

1.2 Policy

Policy as a subject matter has been considered across a range of disciplines and from a range of perspectives such as political science, sociology, anthropology, international relations and business management (Walt, 1998; Beaver and Prince, 2004; Timmins, 2010; Toth, 2010). Political scientists and sociologists have developed a number of explanations of the policy process from rational to incrementalist approaches which will be briefly described below. Each has tended to describe policy from their disciplinary perspective; anthropologists for example have tended to focus on the effect of discourses on policy processes and the language used in policy discussions and statements. Within international relations advocates of neo-realism, institutionalism and cognitive approaches have provided power-based, interest- based, and knowledge- based explanations of policy respectively. Business management literature highlights the complexity of implementing change, and suggests that the implementation of policy is affected by barriers to change, individual reactions to change, skills available for managing change, dimensions of power and influence and system organisation (Sutton, 1999). Policy scholars have noted that, although many writers have offered explanations and interpretations of what determines policy, there is as yet little agreement on its definition (Ham, 2009). Although this can be observed

as developing over time; in 1953 Easton advises that policy constitutes decisions and actions which attribute values. Hill (1997) later describes policy as the product of political influence and a web of decisions, determining and setting limits to what the state does. More recently, Osman (2002) suggests that policy refers to a broad statement, reflecting future goals and aspirations and providing guidelines for achieving those goals.

1.2.1 Public policy

Public policy can be described as a government proposal or decision pertaining to a social issue and the subsequent adoption and implementation of a specific strategy in order to address the problem (Anderson, 1975). In the existing literature a number of interpretations of the process of public policy making have been offered. It is not the intention to replicate these here, as the process of creating policy is not the focus of this thesis, rather a brief summary will indicate the variety of approaches which have been recognised.

The dominant approaches include the rational model, the political system model and the policy cycle. The rational decision making model identifies policy making as a balanced, objective and analytical problem solving process (Lindblom and Woodhouse, 1993). The political system model considers policy making in conjunction with the environment and society, and describes a feedback loop between demands and policy decisions (Easton, 1965). More recently a five stage policy cycle which includes agenda setting, formulation, adoption, implementation and evaluation has been proposed by Anderson (2006).

Other conceptualisations have presented a less structured representation such as the incrementalist model, or muddling through, which suggests that major changes occur through an evolutionary series of small steps, (Lindblom, 1959), and the garbage can model which suggests that both order and disorder prevail, and agendas represent a mix of problems, solutions and politics (Cohen *et al.*, 1972; Kingdon, 1984). Policy has also been considered as arguments, suggesting that reforms are presented as reasoned arguments developed through debate between state and societal actors

(Juma and Clark, 1995) and policy as social experiment (Greenberg *et al.*, 2003) which involves iterative hypotheses being tested as a process of trial and error.

Of these models the 'rational model' appears to be the most widely portrayed. This model assumes that policy makers approach issues in a linear fashion and follow three broad phases of identifying the agenda, making a decision, and implementing the decision. In recent years the British government has given increasing emphasis to the notion of Evidence-based Policy (EBP). Indeed, the election of the Labour government in 1997, has been credited with revitalising interest in the role of evidence in the policy process (Solesbury, 2001; Nutley *et al.*, 2002). Although, it is worthy of note that recent evidence suggests that this is not representative of current practice in UK Government (Hallsworth *et al.*, 2011).

1.2.2 Health policy

Within public policy, health policy has been defined as authoritative statements of intent, usually asserted by governments on behalf of the public, with the aim of improving the health and welfare of the population' (Lee and Mills, 1982, p28). Health policy is concerned with the social, organisational, economic and fiscal context within which it is to be implemented (Walt, 1994). Health policies may be generated in response to new knowledge, offered as a mechanism to address a public issue or problem, or responding to feedback. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people (Wanless, 2004). It is evident that health policy cannot be reduced to health care provision, nor can it be considered in a policy vacuum. Health policy consists of a series of governmental decisions about what type of care is to be provided for the betterment of the health of its population and how this will be done (Paton, 1996). Policy is often subject to reform and review, as it requires updating in light of political, sociological or economic changes. A change in evidence base, for example new findings regarding techniques or operational practice, will stimulate such revisions.

With respect to the NHS, the interdependency of individuals working within established organisations and structures, and interactions between key stakeholders shape health policy through the bargaining and negotiation which occur during policy evolution (Ham, 2009). In developing health policy, ministers and senior managers are required to adopt a range of approaches to policy making and naturally adjust their strategy to the political, time and resource constraints of the given context (Smee, 2005). Like the policy process in general, the health policy process involves a wide and complex range of interests, actors and institutions. It follows that health policy is inextricably linked with power and politics and is thus constructed within certain pre-defined political parameters, which define the boundaries of what is, and is not, possible or acceptable (Bambra *et al.*, 2005). In the UK, health policy is renowned for being highly politicised, and policies are frequently aligned to the ideology of a political party. Thus electoral cycles and changes in government are likely to further perpetuate policy reforms. Further, there is a recognised power differential and continuing struggle, between the state and clinicians for control of the health policy agenda (Salter, 2007). Significant political and power differentials between occupational groups within the NHS have been detailed by Currie and Suhomlinova (2006).

1.2.3 Policy implementation

In general, there appears to be a demarcation between policy making and implementation. Grindle and Thomas (1991) have suggested that the divide between policy making and implementation can be ascribed to the divorce between the political sphere where decision makers tend to formulate policy and the administrative sphere where the implementation of policy is conducted. Policy implementation is the process of enacting the policy in practice and might be summarised as a deliberate set of actions or procedures directed towards achievement of goals and objectives articulated by the policy. However, it is common to observe a gap between what was planned and what actually occurred as a result of a policy (Hunter and Killornan, 2004; Glenngard and Maina, 2007; Ham, 2009; Hallsworth *et al.*, 2011; Buse *et al.*, 2012).

Reviews of policy implementation have identified three major theoretical models: top-down, bottom-up and principal-agent (Matland, 1995; Waterman and Meier, 1998;

Spillane *et al.*, 2002). The top-down approach, regards policy formation as a process which occurs at higher levels in a political process and which is subsequently communicated to subordinate levels charged with the technical and administrative implementation of the policy directives. In contrast, the bottom-up approach, suggests that policy may change during implementation and considers policy implementation as an interactive process between policy makers, implementers and other actors. The principal-agent theory suggests that the amount of discretion afforded to policy implementers varies and is regulated through relationships between principals (policy makers) and agents (implementers) and will be shaped by contracts or agreements depending on the context (Buse *et al.*, 2012).

The implementation of policy whether legislative, guidance, or action based is designed to instigate change. Policies generally seek to generate improvements in effectiveness, efficiency, administrative ease, legality, equity or other desirable outcomes. All improvements require change (Langley *et al.*, 2009). The implementation of policy change has long been recognised as complex and challenging (Crosby, 1996). It has been suggested that the business management literature may inform the implementation of policy change, and indeed the imperative to consider what lessons can be gleaned from existing evidence to improve the NHS was raised by Iles et al (2001). Recent authors continue to raise the implementation of policy as a challenge and suggest that poor policy implementation has contributed to the failure of policy reforms (Carey, 2010; Hercot *et al.*, 2011). Whilst the policy implementation process has been identified as challenging, less consideration has been given to the whether the organisational environment prior to implementing policy, affects success in policy implementation. This thesis seeks to address this gap and in particular seeks to identify if there are organisational features which can facilitate, or conversely pose barriers to, the implementation of policy.

1.3 Justification of research

It has been illustrated above that health policy seeks to bring about changes and improvements in order to raise the health status of citizens. It is a dynamic phenomenon which is continually emerging, and developing in response to population

requirements, evidence base and wider political, economic and social pressures. Policies by their nature instigate change; the organisations responsible for making these changes and improvements are often distinct from those that formulated the policy. Although the implementation of policy is observed as being problematic, few studies have considered organisational attributes which may enable more successful implementation of policy.

The specific context of this research is commissioning; commissioning organisations are responsible for meeting the health needs of the populations they serve, and changes to commissioning policies induce changes to these organisations. As highlighted above commissioning has been subject to a number of policy changes and initiatives. To date little is known about how these changes in commissioning policy impact these organisations, and how receptive commissioning organisations are to these changes.

Within commissioning specifically, changes in policy have also been recorded as challenging. Commissioning is an activity which spans a spectrum of activities and stakeholders has been subject to numerous reforms, and has become laden with uncertainty and unpredictability (Smith and Curry, 2011). Indeed the July 2010 White Paper was branded as the most controversial reform in two decades (Timmins, 2012). Professional groups declared policy changes unclear and potentially undermining fundamental principles of the NHS and lobbied for clarification and changes to proposals (RCGP, 2011). GP stakeholders were found to have divided opinions about policy proposals (Reynolds and McKee, 2012). The reforms were seen as top down reforms, with the Chief Executive of the NHS being quoted as stating staff who do not support the reforms should leave (White, 2010). This context could indicate that commissioning policy may benefit from research to understand how policy can be better implemented; as such this offers a suitable focus for this thesis. A detailed history of the development of commissioning and associated changes in policy is provided in Chapter two.

The research presented in this thesis used an NHS commissioning organisation to identify and understand how this organisation responded to changes in commissioning

policy. The scope for change models to aid organisations management and ability to respond to policy changes is explored. Health policies have significant and long term effects for citizens and as such the impetus for research which could increase understanding of policy implementation is particularly salient (Brownson *et al.*, 2009). The need for research in this area has been asserted by other authors recently. For example, Dixon et al (2010) highlight that the influence of organisational features in policy changes has been somewhat overlooked by research and remains relatively unexamined. Weiner (2008) advocates further health services research to identify determinants for successful implementation of organisational change. A recent multi-country review of the processes of policy change advocates research that might improve policy implementation and which meets the needs of those managing policy change (Hercot *et al.*, 2011).

This research is well positioned to begin to address this gap in the literature. The research question and specific aims and objectives of this thesis are detailed in the next section.

1.4 Research question and objectives

This research attempts to address some of the gaps in the existing literature by generating knowledge and understanding how change management models and literature can be applied or adapted for health policy contexts. The aim of this thesis is to enhance understanding of the issues in managing changes in NHS commissioning policy. There are two separate but closely linked research questions:

1) What factors influence how policy changes in commissioning are managed by health care organisations?

2) How do individuals in healthcare organisations perceive and respond to commissioning policy?

These research questions will be addressed through the following objectives:

1. To identify and critique approaches to management of change and policy change in the business and health services research literatures.

2. To understand organisational context and the process of engaging with and fulfilling policy objectives during a time of policy stability.

3. To examine organisational context during a time of policy change and identify responses to the introduction of new policy initiatives.

4. To identify factors which may facilitate or hinder the management of policy change.

5. To apply and critique Pettigrew et al's eight factors of receptivity model [Appendix 1] in order to understand its relevance and applicablility to the context of health policy change.

1.5 Research design

Philliber et al (1980) describe research design as a plan which provides the "blueprint" for research addressing four issues of: what questions to study, what data are relevant, what data should be collected and how the findings should be analysed and interpreted.

The first of the research objectives involved conducting a literature review to identify approaches to managing change in the business management literature, and identifying where if at all these methods had been used within the context of health services research. The remaining four objectives formed the substantive part of the research for this thesis. In order to address these objectives a qualitative research design was employed, using a case study approach as a framework for collecting data from four sources: organisational documents, direct observation, participant observation and interviews.

The data collection was conducted in two parts, A and B. Part A addressed the second research objective, through a period of observation and a phase of in-depth semi-structured interviews with commissioners at a single Primary Care Trust (PCT), which served as the case study site.

The third, fourth and fifth research objectives are addressed through part B. Part B was conducted in two phases. The first used a period of observation and a wave of in-depth semi-structured interviews with commissioners and clinical colleagues at the PCT site. The second phase of in-depth semi-structured interviews was conducted with general practitioner commissioning consortia (GPCC). These organisations evolved during the research and constituted members previously governed by the PCT. Data analysis methods in part B, drew on a model from the business management literature by Pettigrew et al (1992) to devise a coding framework. This enabled both deductive and inductive coding methods of thematic analysis to be employed, in order to ascertain the relevance and applicability of this model to a health policy context.

1.6 Contextual situation of the thesis research

The purpose of this section is to detail how the opportunity for this thesis came about, such that it was positioned in a timely way to study an unexpected change in health policy. The opportunity for this thesis arose during a time of change in the NHS which occurred when the author was employed as a researcher on a commissioning study funded by the Department of Health (Bate *et al.*, 2012). The conduct and subsequent writing up of this qualitative study was my primary occupation and my source of employment for its duration. Part of this multi-site study, was based at the site which was then adopted as the case study site for this thesis. The empirical data collection for this thesis was conducted during 2009 -2011 and focused on one commissioning region in the North of England. At the outset PCTs in the region were responsible for commissioning health care for their local populations. During the research there were several changes in policy which impacted upon the organisation studied, in particular the introduction of the White Paper 'Equity and Excellence: Liberating the NHS' in July 2010. This paper proposed a number of changes to the NHS including the abolition of PCTs and the transfer of commissioning responsibility to new organisations (GPCC). This changing policy environment presented an opportunistic event to conduct a natural experiment to capture how commissioning organisations responded to policy change. The thesis seeks to identify the key factors which influence how changes in health care policy are managed by commissioning organisations.

Figure 1.1 is a diagrammatic representation of the methods utilised, detailing the research activity as well as providing a brief summary of how the policy context changed over the course of the research. These methods are described in more detail along with the methodology in Chapter four.

Figure 1.1 Research Design

Research Activity	Policy Activity
Part A • PCT interviews • Sep-Dec 2009 • PCT observations • Apr- Jul 2010	• Relatively stable policy context: PCTs have completed year one of WCC programme and are working towards submission of year two self assessment. • New Coalition Government formed (6th May). • PCT submit WCC year two self assessment and are subject to review by external panel.
Part B:1 • PCT interviews • Jul-Oct 2010 • PCT observations • Jul-Oct 2010	• White Paper released (12th Jul), quickly followed by a launch of consultations on four areas of the proposals (19th Jul). • White Paper remains under construction and review, and consultations close to comments (24th Oct). • PCT hold staff wide meeting (23rd Sep) to reveal interim staff structure which would bridge transition from PCT to GPCC whilst satisfying 'Nicholson Challenge'.
Part B:2 • GPCC interviews • Mar- Jun 2011	• Health and social care bill is published and read before House of Commons (19th Jan 2011). GPCC begin to emerge (Jan onwards). Final session of Bill in House of Commons (31st Mar). • Bill 'paused' (4th Apr); series of listening events are launched led by newly launched 'Future Forum' chaired by GP Professor Steve Field. • Future Forum publishes recommendations for amendments to the Bill (13th Jun); Bill resumes progress in House of Commons.

Research and policy progress over time

1.7 Contributions of the thesis to research and policy

The contributions of the research reported in this thesis are fully described in the final chapter (section 9.2). Briefly, in meeting the research objectives identified above this research:

- provides a structured review of approaches to management of change and policy change in the business and health services research literatures

- provides a thick description of PCT commissioning in England, which identifies commissioners' perspectives and experiences of conducting commissioning, and the challenges and facilitators to engaging with and implementing policy.

- offers a new model of factors influencing organisational management of health policy changes

- provides the first application of Pettigrew et al's eight factors of receptivity model to the context of policy change, in the UK and to NHS commissioning.

- offers general lessons for the development of public policy, and for organisations responsible for implementing policy.

1.8 Thesis summary

The remainder of this thesis is organised as follows.

Chapter two introduces the background and context to the thesis and identifies commissioning policy as a focus of the research. It provides a historical overview of the NHS and describes the development and progression of commissioning. Chapter two reported that policy implementation is challenging and little consideration has been given to the effect the organisational environment has on success in policy implementation. This chapter notes that the research utilised the opportunity of the

changing policy landscape as a natural experiment to understand how health policy changes are managed by a commissioning organisation.

The third chapter presents an overview of the change management literature, detailing the classification of change and its theoretical underpinnings. In this chapter the eight factors of receptivity model (Pettigrew *et al.*, 1992) is identified as a suitable tool to understand factors which influence the response to and management of policy changes by NHS commissioning organisations.

Chapter four details the methodology and methods for the research, which adopts a constructivist research paradigm and uses a case study approach with commissioning policy as a focus. The research is unique in its application of the eight factors of receptivity model (Pettigrew *et al.*, 1992) to the study of response to national health policy changes, and to commissioning. Further, the research uses a novel approach to data analysis through the application of both deductive and inductive thematic analysis techniques. The research is conducted in two parts: the first examining how organisations respond to health policy during a time of relative policy stability, the second examining the same during a period of policy change.

Chapter five details the findings from Part A of the research. This chapter provides an introduction to the case study site; describing the organisational context during a relatively stable policy window, and depicts the 'pre-policy change' environment. This chapter provides a thick description of current commissioning context, and the barriers and facilitators to successfully implementing commissioning policy. Perceptions of policy endeavours were explored, and these findings along with concepts of organisational context were used to inform Part B of the research.

Chapters six and seven report results from Part B of the research. This part of the research was conducted during a period of policy change and incorporates the eight factors of receptivity model developed by Pettigrew et al (1992). Given the changes in policy landscape as this research progressed Part B provides an update to the policy context and existent challenges shaping the commissioning landscape. The implications of these policy changes included the transition of commissioning

responsibility to new organisations (GPCC), and the abolition of PCTs following this transition. Data collected during interviews and observations at the PCT site are presented in chapter six and data generated from interviews with the emerging GPCCs are presented in chapter seven.

Chapter eight presents a new model which identifies four factors which influence the management of health policy changes, in the context of this research. The chapter critiques this model with reference to the eight factors of receptivity model developed by Pettigrew et al (1992). Each of the four factors in the new model is explained, and sub-components for each are identified and described.

Chapter nine concludes the thesis; it provides a summary of the thesis and identifies the contributions of the research. These contributions are discussed with respect to the implications of the research findings for future policy making and commissioning organisations. Strengths and limitations of the research are discussed and recommendations for future research conclude this final chapter.

Chapter 2 Background and context

2.1 Chapter introduction

The aim of this thesis is to understand the issues organisations are presented with when managing health policy changes. The research uses commissioning policy as a focus and provides a conceptual basis for the development of a model to inform organisations' ability to respond to future changes. The specific research questions that this thesis seeks to address are: what are the factors which influence how policy changes in commissioning are managed by health care organisations? And how do individuals in healthcare organisations perceive and respond to commissioning policy?

This chapter presents the background to the research and describes the context within which the research was conducted. An introduction and summary of the history of the NHS is provided followed by an explanation of developments in commissioning policy, including those which occurred during the course of the research project. The iterations of commissioning policy reforms to date are described and critiqued, exposing the need to manage commissioning and to account for organisational context when responding to policy changes. This leads to the identification of the research question and an overview of the research design.

2.2 National Health Service

When the National Health Service (NHS) was established in 1948, it was largely financed through taxation and was underpinned by the core principles that: it should be accessible to all in need of health care, service provision should be comprehensive and it should be free at point of access (Webster, 2002). These core principles appear to have endured the history of the NHS and no government has explicitly rejected these core principles (Department of Health, 2000; 2005b; 2010). It has been aptly highlighted by Oliver (2005) that politics is and has always been one of the most important factors in driving the development of the NHS.

There have been numerous health care reforms in the lifetime of the NHS. By way of summary, during the first Thatcher administration a significant reform was undertaken in 1982 when the area health authorities were abolished and the 205 district management teams were reconfigured to form 192 statutory district health authorities in a bid to reduce NHS bureaucracy. During Thatcher's second administration, the consensus style management teams which had existed since 1974, and which were considered to empower doctors and nurses above their previous role, were replaced with hierarchical tiers of management at regional, local and unit levels of the health service. An independent NHS management body was formed and headed by a chief executive, which represented the, later much discussed, 'new public management' movement. Throughout this however central Government maintained accountability for health care provision (Klein, 2001).

An internal market was implemented during the Thatcher-Major administration. It was suggested that purchasers would agree contracts with competing providers, under the premise that this would provide sufficient incentives to increase provider efficiency and responsiveness (Webster, 2002). Under this system district health authorities acted as purchasers in this system and were subsequently joined by GP fund holders, who were general practitioners who volunteered to be a budget holder for primary health care. By 1996 50% of GPs were fund holders (Le Grand and Vizard, 1998), the provider side was made up of 350 NHS trusts, which became semi-independent, non-profit organisations (Webster, 2002). The Patients Charter (Department of Health, 1991) introduced ten patients' rights to care, which were neither legally binding nor resourced, including the guarantee that patients would be admitted for treatment within two years of being placed on a waiting list.

One final effort of the Thatcher- Major administration was the introduction of targets, which sought to reduce mortality across major disease areas(Department of Health, 1992). The subsequent Major administration continued to consolidate the reforms introduced during the 1990s, but furthermore they abolished regional health authorities, established a committee on health variations (Department of Health, 1995) and are credited with laying the foundations for the private finance initiative (PFI) for capital investment (Oliver, 2005).

Labour resumed power in 1997 and remained through the next three administrations. During their first administration, led by Tony Blair, they described a vision in their white paper 'a new NHS' (Department of Health, 1997) which sought to replace the existing internal market with a more integrated organisation and delivery of care. This abolished the quasi-market arrangements, but retained the purchaser-provider split, albeit with a shift in emphasis from competition towards cooperative relationships between the two (Le Grand, 2002). GPs were required to join fundholding Primary Care Groups (PCGs) of which there were 481, and district health authorities were replaced by 99 local health authorities. Two national institutes were formed in 1999. The National Institute for Clinical Excellence (NICE) became established as a special health authority to promote better quality and efficiency and the Commission for Health Improvement (CHI) was established through the Health Act (1999a) to promote consistency within the NHS and to offer guidance to NHS providers on clinical governance (Department of Health, 1999b).

The NHS Plan (Department of Health, 2000) described intentions to increase numbers of frontline staff, beds, and hospital buildings, as well as introducing a focus on performance management, in particular the reduction in waiting times. The second Labour administration, also led by Blair, marked a change in direction with the decision to strengthen the internal market in a bid to modernise the NHS. Primary Care Trusts (PCTs) were subsequently established in 2002 and replaced the 481 PCGs as established in 1998. The PCT's role was to provide primary care and commission, the majority of, secondary care working with local stakeholders to identify local priorities and align resources accordingly (Department of Health, 1999c). The Wanless review (2002) was used to justify considerable real-term increases in NHS spending, which continued for five years after its recommendations were published. Significant changes were made to staff contracts, with GPs negotiating a new contract in 2003 which provided an increase in salary and pensions, permitted opt out of their 24 hour service responsibilities, and introduced supplementary pay for achieving the standards detailed in the Quality and Outcomes Framework (Department of Health, 2004d). Hospital staff, excluding dentists and doctors, also experienced changes through the 'agenda for change' initiative which sought to standardise pay across the NHS, and increase recruitment and retention of staff (Department of Health, 2004a). This drive

for central control, and national regulation such as through NICE and CHI, appeared to be contradictory to their other policies which encouraged greater local autonomy through PCTs and FTs, and Labour were criticised for introducing conflicting policies (Klein, 1998; Le Grand, 2002; Paton, 2006).

Primary Care Trusts (PCTs) became fully operational in 2004 and their number grew to 303. The first 'Foundation Trusts' were formed in the same year and were declared independent from Whitehall; the Government stated its intention for all NHS trusts to receive foundation status (Department of Health, 2005c; Oliver, 2005). Plans to include GP practices in health care commissioning were introduced through the 'practice based commissioning' (PBC) policy (Department of Health, 2004c). The third Labour administration began in 2005 and again was led by Blair, although he was to be succeeded as prime minister by Gordon Brown in 2007.

During this time 'Creating a patient led NHS' (Department of Health, 2005a) argued a precedent for reducing management costs, and subsequently the number of PCTs were reduced to 152 and the number of SHAs to 10 in 2006 (Office of National Statistics, 2011). 'Our health, our care, our say' (Department of Health, 2006b) promoted patient choice, and a shift away from hospital based treatment and towards care in the community. In 2007, the World Class Commissioning programme was introduced to support commissioning organisations, in establishing a longer term and strategic approach to commissioning, and to develop the necessary competences to deliver it (Department of Health, 2007d). This programme was being implemented at the outset of this research and is described more fully in section 2.3.1.

Soon after Lord Darzi led on a major review of the NHS, which culminated in a 10 year vision, 'NHS next stage review' (Department of Health, 2008c) which articulated proposals for significant reconfiguration of hospitals, including the centralisation of specialist services. The NHS Constitution was published and outlined key principles and values on how the NHS should act and make decisions, including a number of pledges related to the rights and responsibilities of patients and staff (Department of Health, 2009b). The UK experienced an economic downturn in 2008-2009 (ONS, 2013). These national economic changes, led the Chief Executive of the NHS to caution

commissioning organisations to be prepared for a range of financial scenarios, such as the freezing of NHS investment (Department of Health, 2009a). This was later followed with the proposals for a Quality, Innovation, Productivity and Prevention (QIPP) initiative, which seeks to deliver up to £20billion in efficiency savings by 2014-15 (Department of Health., 2009). QIPP is a large scale transformational programme, which is designed to improve the quality of patient care, and describes the approaches the NHS is taking at local, regional and national levels in order to reform its operations and redesign services(Gifford *et al.*, 2012). These proposals sought to prepare the NHS for the financial austerity which was anticipated from 2011 onwards, they became known colloquially as the 'Nicholson Challenge' (Department of Health, 2009a). As part of his 2009 annual report NHS Chief Executive, Sir David Nicholson, commended the World Class Commissioning (WCC) initiative for providing strategic and long term planning for local health services, and identified it as a strong lever with which to unlock efficiency gains.

During the UK general election in May 2010 a coalition government was formed and the Rt Hon Andrew Lansley was appointed as Secretary of State for Health. He appeared to recognise the challenge which constant restructuring posed to the NHS, and advised that "in literally the first week at the Department, I announced a moratorium on reconfigurations", highlighting that he was keen to see only change which earned the support of GPs and primary care, was supported by patients and the public, and was linked to better outcomes (Lansley, 2010). Despite this, the World Class Commissioning programme which had been introduced by the previous Labour Government as a development programme designed to run for a minimum of three years was aborted twelve months early. Further 'Equity and Excellence: Liberating the NHS' was published in July 2010 (Department of Health, 2010) and is widely perceived as proposing the most radical changes to the NHS since its inception in 1948 (Ham, 2010; Maruthappu *et al.*, 2010; Timmins, 2010; Health Committee, 2011). This publication will henceforth be referred to as the 'White Paper'; it states four strategic aims of: putting patients and public first; improving health outcomes; improving autonomy, accountability and democratic legitimacy; and cutting bureaucracy and improving efficiency (Department of Health, 2010).

The day after the proposals were released Nicholson wrote to trust Chief Executives nationwide to impress the importance of fulfilling both these policies (The White Paper and the Nicholson Challenge) simultaneously and advised that guidance for the transition would be published soon (Nicholson, 2010a). In particular the Quality, Innovation, Productivity and Prevention (QIPP) programme was hailed as the best vehicle to achieve these savings (Nicholson, 2010a).

The White Paper proposed transferring commissioning responsibility to GPs. A new NHS Commissioning Board was established to oversee commissioning and operated in shadow form as a special authority in April 2011 in order to enable existing SHAs to be abolished by April 2012, however they retained responsibility for overseeing regional transitions up to this point. At a local level GP commissioning consortia (GPCC) became established by April 2012 and spent a year shadowing PCTs and being instructed in the ways of commissioning, before assuming full commissioning responsibility and accountability from April 2013 when the PCTs were abolished (BMA, 2010b).

Initial responses to the White Paper by policy experts revealed that many questions about the proposals remained to be answered in follow up documentation (Dixon, 2010). One commentary on the White Paper noted that those to the right of the political spectrum have welcomed the focus on competitive market, whereas those to the left anticipate the end of the NHS in favour of comprehensive privatisation (Asthana, 2011). Regardless of their political persuasion those who pondered the proposals were observed to have identified many holes in it even within the first week of release (Campbell, 2010). A number of unintended risks have been identified such as large transactional costs, organisational turbulence, financial instability, and the assumption that GP commissioners are willing and able to deliver the aspirations of improved quality and efficiency (Asthana, 2011). Overall the vision, coherence and feasibility of the proposals attracted significant resistance from a number of key stakeholders including the main trade union and professional association for medics, and the professional membership body for family doctors, and the professional membership body for nurses (BMA, 2009; BMA, 2010a; RCGP, 2010; RCN, 2010).

Soon after the publication of the proposals the Government elected to engage in a public consultation on the proposals inviting responses on core aspects of the them. These consultations were based around the following four issues: transparency in outcomes, increasing democratic legitimacy in health, commissioning for patients and regulating health care providers. Although the decision to consult the public was met with suspicion, with some calling for judicial review claiming that the consultation process was apocryphal (Sparrow, 2010). The consultation spanned the duration of part B:1 for this research, and was open from July until October 2010 as depicted in Figure 1.1, overview of research design, in Chapter one.

Over 6000 responses were received, which included responses to the four consultations as well as comments on the White Paper in general. A wide spectrum of respondents contributed to the consultation exercise, including individuals and organisations, charities, NHS organisations, and academics (Department of Health, 2010a). These included many of the key stakeholders who voiced significant resistance towards the reforms, challenging the vision, coherence and feasibility of the proposals (BMA, 2010a; RCGP, 2010; RCN, 2010). Simultaneously within PCTs management cuts, in response to the Nicholson challenge, were being implemented with many staff being offered voluntary redundancy, whilst others were informed that current contracts would not be renewed. Soon after this the Government published their response to the public consultation, reaffirming their strong commitment to the reforms and releasing a legislative framework and guidance for next steps to progress the policy (Department of Health, 2010a). At this time it was evident that some GP practices had begun to collaborate in federations in line with recommendations from the RCGP (2007) which were released before the White Paper proposals. This meant that in some areas GPs were beginning to work in groups, albeit not with the expectation that they would take on responsibility for commissioning.

Although the vision of the original White Paper remained intact the Government did make some revisions in light of responses, including a more phased transition period for reforms to providers, introduction of pathfinder consortia (a term adopted to describe early emerging consortia) to create a clearer more phased approach to the

introduction of GP commissioning and a more rapid introduction of health and wellbeing boards, with a strengthened role.

The proposals were noted to have evolved and developed over time; the bill was subject to numerous amendments and experienced a particularly lengthy passage through parliament. Simultaneous to the progression of the proposals though parliament a series of 'Dear Colleague' letters from David Nicholson were issued to build on the proposals and communicate the updates and iterations of the bill to PCT executives. One such letter (Nicholson, 2010b) re-iterated the importance of QIPP as the vehicle to achieve required efficiency savings, and encouraged leaders to press forward, build momentum and implement reform rather than retreating or hesitating. Interestingly this sanction to progress with implementing the White Paper proposals was issued prior to them attaining status as a bill.

The Health and Social Care Bill was subsequently introduced into Parliament on 19th January 2011. This was in order to progress both 'Equity and Excellence: Liberating the NHS' (initial White Paper proposals)(Department of Health, 2010) and the Governments response to the 2010 consultation 'Liberating the NHS: legislative framework and next steps'(Department of Health, 2010a). Between January and March the bill was subjected to a number of sessions and readings within the House of Commons. During this time a further letter from David Nicholson (2011) was issued. The letter was more extensive than the previous, and advised that the statutory framework for the new commissioning system had been developed. It acknowledged the complexity of the change and impressed the critical need to maintain standards of patient care. The letter described the emergence of consortia, noting that over half the population was accounted for by pathfinder consortia and noted that PCTs would be required to form clusters during handover of commissioning, in order to make space for emerging consortia. It is interesting to note that during this time the policy proposals were being implemented both by PCTs and GPs, at this stage although the proposals had been published as the Health and Social Care Bill, they had not completed their progression through parliament nor attained status as an Act.

Indeed, as of 4th April 2011 the House of Commons elected to 'pause' the bill in order to conduct a listening exercise. A 'Futures forum' was created on 6th April, this was a newly formed group of patient representatives, doctors and nurses, to act as a conduit for wider patient and public opinion and lead a series of listening events. On 13th June 2011 this group reported their recommendations which included slowing the pace of the proposed changes, widening involvement to other health professionals (beyond only GPs) in commissioning decisions, removal of Monitor's duty to promote competition and ensuring the Secretary of State retained accountability for the NHS (NHS Future Forum, 2011).

Further concerns were raised about the loss of key staff and tacit skills, as consortia were unable to employ NHS staff, although it was anticipated that once they progressed to statutory NHS bodies, they would be able to do so (Adetunji, 2011; Caldwell, 2011). The transitional period whilst the policy proposals began to be simultaneously enacted and developed was marked with uncertainty. The bill resumed its passage through the House of Commons on 21st June 2011, and a new House of Commons bill committee was announced. The bill progressed through a total of three readings in the House of Commons before moving to the House of Lords on 8th September. The bill continued to progress through second reading and committee stages in the House of Lords. On 24th November the British Medical Association (BMA) announced that they were moving to oppose the bill, which subsequently completed its final session in the House of Lords on 21st December 2011.

On the 12th January 2012 the Royal College of GPs released results from a national survey showing that 98% of respondents want the Health Bill to be withdrawn. These results were widely reported in trade journals and local media, despite the fact that less than 2% of GPs participated in the survey (Rimmer, 2012). One week later the Royal College of Nurses also called for the Health Bill to be withdrawn (Carter, 2012). The Government responded on 1st February 2012 outlining 137 amendments to the bill. These included restoring the responsibility to provide a comprehensive health service to the Secretary of State, who would also be required to ensure education training and medical research remain core functions of health service provision. Despite these amendments the Royal College of GPs remained unconvinced and

continued to lobby for the bill to be withdrawn argued that the amendments only created greater confusion (Kmietowicz, 2012). The bill began the final session of the report stage on 13th March 2012 before being granted Royal Assent and being enacted on 27th March as the Health and Social Care Act 2012.

The overview of NHS history provided above indicates that the NHS has been subject to repeated national structural reform. Indeed Webster (2002) cautioned that the increasing frequency and pace of changes mean that 'the NHS risks becoming caught up in a vortex of permanent upheaval' (in: Goodwin, 2006, p186).

2.3 Commissioning policy

The specific area of the NHS which is of interest to this thesis is commissioning, and in particular commissioning policy. This section will outline the numerous iterations of PCT commissioning including the introduction of practice based commissioning (PBC) and the national world class commissioning (WCC) programme, as introduced in the previous section. A review of the literature will summarise and critique the policy and theories which have underpinned these commissioning developments. This is followed by a formative description of 'World Class Commissioning', which was the main initiative being implemented at the outset of this research.

The commissioning landscape is complicated. While purchasing and procurement have been a feature of the UK NHS for some time (Department of Health, 2001; Smith *et al.*, 2004; Figueras *et al.*, 2005), commissioning is a relatively new concept. Commissioning terminology is often ambiguously used interchangeably with purchasing and procurement. Whilst purchasing is an integral part of the commissioning process, commissioning is much more comprehensive than procuring a good or service (NHS, 2008; Murray, 2009).   Improving commissioning aims to provide a better service for patients and save money. In an English context, 'commissioning' denotes a more active role than previous notions of purchasing and procurement and has been defined as 'the cycle of assessing the needs of people in an area, designing and then securing appropriate services' (Cabinet Office, 2006, 4). Within health care services this requires

primary care trusts (PCTs) to identify the health needs of their populations and make prioritised decisions to secure care to meet those needs within available resources.

Recent policy developments in England reflect a renewed determination to shift from a provider-led service to one driven by commissioners acting on behalf of patients and the public (Department of Health, 2006a; Department of Health, 2006b; Department of Health, 2007a). Arguably reforms to commissioning began in December 2005, with the introduction of strategies to support patient choice and initiatives to support commissioning as documented in two connected policy updates on 'Health Reform in England' (Department of Health, 2005b; Department of Health, 2006a), the 'Our health, our care, our say' White Paper (Department of Health, 2006b), and, the 'Commissioning framework for health and well-being'(Department of Health, 2007a). There have been mixed thoughts on whether this programme of NHS reform and plans to strengthen commissioning will succeed (Ham, 2006).

The rationale behind these commissioning reforms appears consistent with the overall strategic priorities of the NHS in England. These include: improving clinical quality standards; enhancing choice and responsiveness; raising the standard of population health; reducing health inequalities and maximising efficiency in the organisation and delivery of services (Department of Health, 2004b; Department of Health, 2007c; Department of Health, 2008c; Department of Health, 2008a; Department of Health, 2008b). It is unlikely that one single mechanism can be implemented to ensure the attainment of these objectives and as such current policy incorporates a number of strands.

As noted above practice based commissioning (PBC) was introduced by the government in 2004 with the aim of engaging clinicians in commissioning decisions for their local population (Coleman *et al.*, 2007). Commissioning was given priority status when the Department of Health advised that it should be the core function of PCTs in 2006. PCTs were tasked with a strategic commissioning role which requires them to assess population needs, define priorities, implement contracts to best meet needs and manage providers (Department of Health, 2006a).

PCTs were a focal point of the contemporary commissioning landscape and as allocators of approximately 80% of the NHS budget, were positioned as the key counter-weight to traditionally powerful provider agencies (Talbot-Smith and Pollock, 2006). The expectation was that PCTs would ensure the individualisation of care and satisfy the demands of the educated health care consumer, whilst simultaneously reducing health inequalities and improving overall population health (Smith and Mays, 2005; Wade *et al.*, 2006). They were required to achieve savings and efficiencies, adhere to regulatory and performance frameworks, and stimulate and manage markets, whilst working in partnership with a range of statutory and non-statutory bodies (Department of Health, 2001; Ham, 2006; Talbot-Smith and Pollock, 2006; Wade *et al.*, 2006; Baxter *et al.*, 2007). Practice based commissioners were expected to form another important piece of this jigsaw. As it was anticipated that health care professionals would be incentivised to design and procure services for their patients through PBC (Smith *et al.*, 2005; Department of Health, 2006b). At the level of the individual patient, there was an emphasis on empowerment and freedom to choose, with the potential for future expansion of individual budgets for health care 'consumers' (Glasby and Dickinson, 2008).

The commissioning programme is ambitious and complex in design, and has been swift in both its development and implementation (Smith and Curry, 2011). In order for these arrangements to deliver the expected benefits, a number of challenges must be overcome. Ham (2008), has suggested that reforms such as World Class Commissioning Competencies (Department of Health, 2007d) which focus on the 'demand-side' (i.e. commissioning), are crucial in sustaining commissioning and ensuring countervailing power to the supply-side strengths of entities such as Foundation Hospitals. However, research indicates that, as yet, the actions of commissioners have had little impact on the activities of the acute sector (Smith *et al.*, 2004). Given their centrality to the programme for change, PCTs will need to address this apparent failure. However, it is not clear that the requisite information, skills and levers are yet in place for them to effectively exercise their alleged powers (Smith and Mays, 2005; Allen *et al.*, 2009). As well as this, PCTs have yet to demonstrate the level of public profile and involvement required for them to act authoritatively on behalf of their patient populations (Glasby *et al.*, 2006; Williams *et al.*, 2007). Furthermore, the

necessary incentives for successful implementation of PBC have yet to be determined (Curry and Thorlby, 2007; Kmietowicz, 2007; Greener and Mannion, 2008) and at a conceptual level, there is a need to reconcile the apparently contradictory pursuit of both collaboration and competition (Ham, 2008b), in addition to examining the economic dimensions of scale, transaction cost, and trade-offs between competing priorities (Bevan, 1998; Greener and Mannion, 2006).

Although Nicholson (2010a) hailed QIPP as a mechanism to achieve substantial efficiency savings, leading think tanks raised concerns that in light of a weak economic recovery and prospects for growth being revised downwards, that the conditions of NHS funding would remain austere beyond the lifespan of QIPP (The Health Foundation, 2012).

2.3.1 World Class Commissioning

As noted above World Class Commissioning was introduced in December 2007 to support commissioning organisations to make improvements in their commissioning performance. The programme consisted of 4 elements: vision, competencies, assurance system and a support and development framework (Department of Health, 2007d; 2007e). The vision cast the national direction of better health and wellbeing through the provision of better care and better value which would be delivered locally. The competencies identify 11 organisational competencies which PCT's should develop in order to improve their commissioning ability. Each competency is further divided into three sub-competencies (See Appendix 2). Alongside this a support and development framework was established to better equip commissioners by providing access to the required tools, facilitating knowledge sharing, and providing national guidance on board development (Department of Health, 2007b). An assurance system was introduced to annually assess PCTs performance and progress across each competency on a scale from one to four, level four representing 'World Class' performance. This was designed to assist PCTs in identifying areas of development so they could strategically apply efforts to discrete aspects of competence in order to improve their commissioning performance (Department of Health, 2007e).

2.3.2 Critique of commissioning reforms

Research and evaluation have struggled to keep up with this rapid pace of reform. Indeed, although evidence based policy is being encouraged in the UK health service, it has been noted that research currently has little influence on health services policy or government policy (Black, 2001). Ham (2008; 2008a) conducted a comparative analysis of approaches to commissioning across health care systems. This work identified a number of common concerns and challenges, it also cautioned against simplistic transfer of solutions across settings. These texts augment a growing body of theory and debate which criticises simple solutions to the challenges of health care commissioning (Light, 1998; Chappel *et al.*, 1999; Wade *et al.*, 2006). This highlights the need for further in depth study which appreciates and fully accounts for organisational context when researching commissioning. The rationale for the number of commissioning reforms described above appears to rest, perhaps precariously on two seemingly conflicting notions of competition and collaboration.

It is suggested that competition between health care providers will bring about quality and efficiency gains and greater innovation. Conversely, there is a demonstrated interest in joint commissioning which assumes that patients and practitioners will respond positively to incentives to act as consumers and change agents to the benefit of themselves and the service in general. Resting on the supposition that positive incentives will result in both individual and collective action to improve health and social outcomes (Department of Health, 1997; Paton, 2006).

However, in health care, neither of these ideas has been fully demonstrated as founded. There is very little evidence to indicate the success of joint commissioning or the extent to which co-production of health and social outcomes is fully possible (Bovaird, 2007; Glasby and Dickinson, 2008). This lack of clarity on how best to proceed with commissioning, suggests that subsequent reforms are likely to lie ahead, at least until a robust evidence base is developed. Overall, these discussions suggest that, the directed path of commissioning has meandered somewhat over the years and will likely continue to do so. Scope therefore exists to streamline and develop more

coherent robust commissioning policy, but also to best prepare organisations to readily adapt and respond to the anticipated future reforms.

2.3.3 Managing commissioning change

Health policies by their very nature incite change and are likely to bear some correlation to more traditional, management induced, organisational changes. Much of what has been taught to commissioners to date, is drawn from management literature (Porter, 1980; Bryson, 1995; Moore, 1995; Porter, 1996; Mintzberg *et al.*, 1998; Cummings and Wilson, 2003; Cueille, 2006). What is lacking is a deeper understanding of how this strategic and change management literature can be more readily applied in public sector contexts, in particular to the NHS. Indeed there has been a limited update of organisational change literature by public sector organisations (Fernandez and Rainey, 2006; Piercy *et al.*, 2012). Despite the valuable insights provided by previous research and review, there is a requirement for further research which considers the management approaches whilst adequately accounting for the contextual and contemporary challenges posed to NHS commissioners. This can then be used to provide a conceptual base from which to prescribe future solutions, but also equip commissioners to cope with repeated policy reforms (Smith *et al.*, 2004; Ham, 2008; Ham, 2008a).

The world of healthcare is constantly evolving and changing operating environments often mean that strategies are halted, diverted or otherwise prevented from being completed (Goodwin, 2006). The introduction of policy and their associated changes require organisations to respond, and essentially implement the directives contained within the policy. This means that not only is it imperative that the organisational environment and policy context is understood, but provides a rationale for developing organisations which are well positioned to adapt to the changing flux of a policy driven environment. In terms of the evolution of commissioning, a study which considers the strategic management literature and context will enable much greater understanding of how the commissioning organisations can become better established and developed to withstand policy iterations. Indeed, it has been suggested that whilst some of the challenges that the NHS experiences are unique, many of them may benefit from the

application of concepts drawn from other disciplines, including organisational behaviour and management (Iles and Sutherland, 2001).

2.4 Chapter summary

This chapter has provided the background and context to the thesis, providing a historical overview of NHS developments from its establishment up to the point of beginning the research. Commissioning is introduced as the area of policy interest and a history of related policy developments are described and discussed. This illustrates that the research was conducted within a turbulent policy environment which by its nature is likely to induce organisational change. The next chapter is the literature review, which will introduce the concept of organisational change and present models which have been used to understand change. The application of these models within health care settings are presented and followed by a discussion on how these models could be further used to understand organisational change in response to commissioning policy.

Chapter 3 Literature review

3.1 Chapter introduction

This thesis investigates the effects of health policy on organisations and in particular how organisations respond to and manage health policy changes in commissioning. Health policy is intended to change behaviour, usually with the aspiration to generate improvements in health care outcomes. Numerous organisations are involved in the management and provision of health care, and thus it follows that changes to health care policies will have implications for these organisations. The previous chapter introduced the context of health care commissioning and identified the health policy landscape as a rapidly changing environment. The need for a better understanding of how the change management literature can be more readily applied in public sector context was identified. Specifically this chapter addresses research objective one, that is to identify and critique approaches to change management from the business and health services literatures to understand how they can be applied to the context of health policy change. A critique of the change management literature, which accounts for the contextual and contemporary challenges posed to the NHS, will enable a greater understanding of how the commissioning organisations can manage policy change.

The remainder of this chapter provides an introduction to the organisational change literature. Key terms and concepts in the literature are described and a summary of the main classifications of change is provided, highlighting the breadth and scope of interpretation of the concept of change. This is followed by an exploration of change management models, and in particular those which facilitate understanding change. Selected models are presented and critiqued in relation to their application in healthcare and their suitability to inform this thesis.

3.2 Review of organisational change literature

From as early as 1983 leading change management scholars have described the global business context as 'increasingly uncertain, competitive and fast-moving' (Kanter,

1983). This sense of pervasive and persistent change prevailed into the next decade where it was described as 'normality' (Hammer and Champy, 1993). Contemporary authors continue to describe change as becoming more frequent, of a greater magnitude and much less predictable than ever before (Burnes, 2009). Health care organisations are in no way exempt from this established prevalence of change, if anything their experience is further complicated by changing policies, political agendas and most recently the volatile economic environment (Ham *et al.*, 2012; Timmins, 2013).

Given the ubiquitous nature of change, and the variety and volume of literature available on the subject it is perhaps unsurprising that there are numerous ways in which 'change' is categorised. Strategists have advocated that change, in itself, is not a problem and that it is important that managers do not perceive change as some 'amorphous mass' but appreciate that change comes in many shapes and sizes (Stace and Dunphy, 2001). This section will consider some of the different ways which change has been defined and categorised by key authors from a variety of disciplines. An organized and structured approach was taken to identify relevant literature, which included general management texts, key organisational behaviour texts and review articles. This review highlighted four main perspectives on the classification of change. These are hard or soft; planned or emergent; episodic or continuous, and developmental, transitional or transformational. Each of these is now discussed in turn.

Hard and soft

Paton and McCalman (2000) refer to two types of change 'hard' and 'soft'; this terminology has later been reported as 'difficulties' and 'messes' respectively (Senior and Fleming, 2006). Hard, complex change lends itself to mechanistic change which is reasonably static, has quantifiable objectives with immediate incremental change and short time frames. Examples of hard changes are often found in manufacturing, such as updating factory assembly of items to replace an existing component of a model with a newer, improved component, or reconfiguring factory layout and process to improve technical efficiency (Paton and McCalman, 2000; Senior and Fleming, 2006). In contrast, soft, complex problems tend to reflect non-technical change such as

people focused change. It is difficult to separate soft problems from their context and as a result objectives and timescales are often unclear with subjective goals. Soft problems tend to have a high level of emotional involvement from those affected by the change, and can be related to aspects of culture attitudes, relationships and leadership (Paton and McCalman, 2000). Despite the differences between hard and soft change, Paton and McCalman (2000) highlight that a change may not be purely soft or hard, rather it may contain elements of both, but will usually have more of one element than another. For example, a change to improve organisational efficiency may introduce hard or technical changes to process, which have soft implications such as working in different cross discipline teams which may require new relationships to be established. An organisation can assess types of change by locating it on Paton and McCalman's change spectrum (Figure 3.1).

Figure 3.1 Paton and McCalman's Change Spectrum.
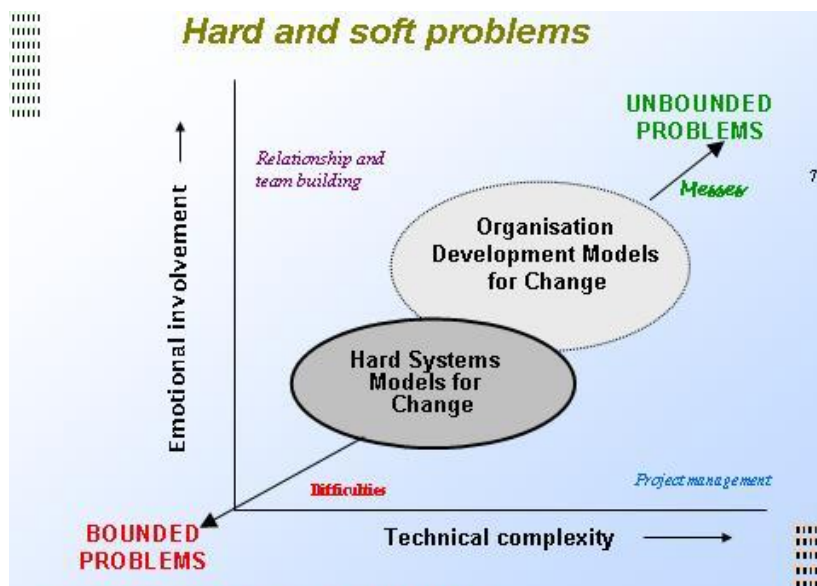
Adapted from Paton & McCalman (2000, p.21):

The Tropics test (Senior and Fleming, 2006) has been used to assess whether a change involves hard or soft complexity and the impact and the magnitude of the change. This assessment can help the problem owner to determine the most appropriate method for the change process (Paton and McCalman, 2000). 'TROPICS' Table 3.1 is used as an algorithm standing for Timescales, Resources, Objectives, Perceptions, Interest, Control and Sources.

Table 3.1 TROPICS algorithm to assess nature of change.

	Hard	Soft
Time scales:	short to medium term	medium to long term
Resources:	clearly defined and reasonable	unclear and variable
Objectives:	objective and quantifiable	subjective and visionary
Perceptions:	shared by those affected	creates conflict of interest
Interest:	limited and well defined	widespread and ill defined
Control:	within the managing group	shared with the group
Source:	originates internally	originates externally

This tool has been applied in practice by organisations such as Philips, IBM, JVC although details of the success of its implementation were not recorded. However, it was noted that even when change is defined as a soft change, hard constraints of time, resources and cost have had negative impacts on change management efforts (Paton and McCalman, 2000).

Planned and emergent change

Planned change is a term which was first coined by Kurt Lewin to distinguish between change which was consciously embarked upon and planned by an organisation in contrast to change which may have come about by accident or impulse (Burnes, 2004). Kurt Lewin (1951) became the pioneer of planned change when he introduced the three-step change model in 1951. This model describes planned change, which is a pre-meditated change which is a product of conscious reasoning and action. The model is often described, as unfreeze, move, and refreeze. An example of such a change in practice is: unlocking of existing methods of operation, the shift to the new process or method 'implementing the change' followed by consolidation of the new process, to embed and stabilise the change (Robbins *et al.*, 2010). Schein (1987), had a particular interest in the human aspects of change, and explored how this model could work with human systems and extrapolated it to detail human resource related elements of each stage. In particular, this conceptualisation considered cultural interactions and observed change in terms of roles, attitudes, behaviours and relationships.

The 'planned change' approach largely dominated the theory and practice of change management until the 'emergent change' approach began to gain prominence in the early 1980s (Mintzberg, 1987; Mintzberg *et al.*, 1998; Weick and Quinn, 1999; Pettigrew, 2000; Bamford and Forrester, 2003; Burnes, 2009). The term emergent change is used to describe change which unfolds in an organic or seemingly spontaneous and unplanned way. A review paper exploring emergent change established that there are two main ways in which change can be emergent rather than planned (Iles and Sutherland, 2001). These were described as either management decisions about seemingly unrelated issues which shape the organisation's future and change direction; or factors (either external or internal) beyond the scope of management decisions which influence the change (Iles and Sutherland, 2001).

The emergent approach espouses that change is a continuous, open-ended cumulative process of adaptation to changing circumstances and conditions. It views change as a process that unfolds through recurrent variations, accommodations and alterations in practice over time rather than a period of dramatic discontinuity or a discrete series of linear events (Dawson, 1994; Bamford and Forrester, 2003; Burnes, 2004; Kickert, 2010). This suggests that even planned changes will likely display some elements of emergent change. A number of authors have raised cautions related to emergent approaches to change, and highlight that this approach is relatively new, lacks coherence, and consists of a disparate group of models (Dawson, 1994; Bamford and Forrester, 2003; Todnem By, 2005). This classification of change was adopted and modified by Orlikowski and Hofman (1997) who extended it to include opportunistic change, along with anticipated change (rather than planned) and emergent change in their improvisational model for change management.

 Episodic or continuous change

Weick and Quinn (1999) are credited with reframing the conceptualisation of change as either planned or emergent, by classifying change as either episodic or continuous (Kickert, 2010). Continuous change, describes changes which are of an evolutionary nature, uninterrupted and cumulative, often these are related to continual improvement of organisations. The continuous change perceptive is micro, dealing with incremental local interactions, it requires   organisations to make regular

modifications, and be self-organising. Change is driven by instability and alert reactions to changes in context, perceived as developmental and on-going as small modifications and daily alterations cumulate over time (Kickert, 2010). Episodic change adopts a macro perspective and identifies change as intermittent and discontinuous with phases of relative stability punctuated by periods of adaptation (Tushman and Romanelli, 1985). Episodic changes are discontinuous, sporadic changes which can be for example the introduction of a new initiative or programme, or a response to market changes (Weick and Quinn, 1999; Pettigrew *et al.*, 2001). Episodic changes tend to be dramatic and driven externally; they reflect Lewinian principles of linear progressive change which requires a period of dis-equilibrium before progressing to a new state (Colville *et al.*, 2013).

Developmental, transitional, transformational

Ackerman (1997) distinguished between types of change by the desired end point of the change in relation to the current position and identified three classifications: developmental, transitional and transformational. Developmental change as the name suggests is linked with organisational development and as such can be either planned or emergent. It is described as change that improves or develops the organisation, either through introduction of a new process, or through refining and improving an existing function. Transitional change describes a change which brings about a shift, transitioning the organisation from the existing state to a new desirable state, this sort of change is usually episodic and planned. This type of change echoes the stages proposed by Lewin (1951) of unfreeze, transition or move to new position and refreeze. One such example could be making a transition from a centralised to a decentralised operational system (Marshak, 1993). Transformational change is similar to transitional change, but with a more radical shift between the new organisational state and the original state. Transformational change requires a transfiguration from one state to a fundamentally different new state (Marshak, 1993; Ackerman, 1997). Change of this magnitude will require a shift in organisational norms and assumptions, which indicate 'soft' changes as classified by Paton and McCalman (2000). Transformational change can include re-structuring, significant changes in processes, strategy and culture (Iles and Sutherland, 2001).

Each of the classifications identified have attracted both acclaim and criticism, tensions have been identified between planned and emergent change, noting that in practice it is nigh impossible to rigidly control and plan change to the extent that all emergent aspects are eliminated (Dunphy and Stace, 1988; Bamford and Forrester, 2003). It appears that any change will likely be subject to emergent aspects and it is therefore more appropriate to consider it as an ongoing process (Colville *et al.*, 2013). Lawler (1986) argues that a visionary end state cannot be reached in a highly programmed way. In an ideal world, organisations would continuously assess the internal, external and temporal environments in which they operate and respond appropriately, such that change emerges somewhat naturally (Senior and Fleming, 2006). Although at a practical level this is less realistic, it has been noted that over the past decade there has been a movement towards leaner, flatter organisation structures and processes which is likely to influence how organisations change, develop and respond (Paton and McCalman, 2000).

There is a suggestion that overly restrictive classification of change may not be helpful, when seeking to fully understand the change process both in practice and in theory. It is noted that, in practice, managers are largely ignorant of traditional change literature and in theoretical study they have been noted to encourage compartmentalisation of perspectives and isolated lines of research (Van de Ven and Poole, 1995; Bamford and Forrester, 2003). Thus it may be more prudent to use these classifications to assist explanation when useful, however succumbing to pressure to only describe change within the bounds of these pre-defined classifications would likely prove limiting and should be avoided (Van de Ven and Poole, 1995). However as these terms, for describing and classifying change, are prolific in the change literature they have been included here as a foundation from which to understand and interpret the models which are explored in subsequent sections.

3.3 Health policy

The changes investigated in this thesis are related to health policy. Health policies by their very nature are intended to bring about change and are likely to bear resemblance to more traditional, management induced, organisational changes.

However, as much of the literature on organisational change has focussed on the private sector, and been derived from such settings, it is not immediately apparent which change classifications tends to best describe health policy changes. Rather, it is likely that each policy ought to be classified on an individual basis. In light of the descriptions provided above, it is expected that policy directives or interventions could be described as planned change, and may address both hard and soft and soft elements of change. It is likely that collectively policy change in the NHS would include some emergent, developmental and transitional aspects.

Golembiewski et al (1982) conducted a review considering if knowledge, theories and models from the private sector can be successfully applied to public sector contexts and found a similar pattern of success for both sectors when implementing a range of interventions. Enabling health care organisations to benefit from the evidence, learning and implications which have been developed from research on organisational change management is thus likely to yield benefits. Of course careful interpretation and translation of the literature will be required, to ensure that generalisable findings are identified. It has been suggested that limiting factors affecting the use of the change literature include an undue focus on differences rather than similarities between private sector and public sector working, the need to manage political conflicting interests, and the vast and complex nature of much of the change literature (Fernandez and Rainey, 2006; Cunningham and Kempling, 2009).

Research has highlighted that the velocity of change for leading industrial organisations has increased due to high customer orientation and expectations and globalisation (Hamlin *et al.*, 2001). Managers and organisations will be judged on their ability to effectively and efficiently manage change. It is evident that this is true for healthcare organisations, and some PCTs have included change management strategies in their operational plans in order to ensure that the many and compelling demands placed upon it are satisfied (NHS Herefordshire, 2010). Although evidence based policy is being encouraged in the UK health service, it has been noted that research currently has little influence on health services policy or governance policy (Black, 2001). Indeed, there is a limited uptake of organisational change literature by public sector organisations (Fernandez and Rainey, 2006; Piercy *et al.*, 2012). The

introduction of policy and its associated changes requires organisations to respond, and essentially implement the directives contained within the policy.

The centralised administration of the NHS has allowed the national government to induce a number of 'top down' changes. The introduction of change through health policy, in particular changing structures is a 'familiar prescription' in NHS system reform (Scott *et al.*, 2003, p117) . Ham (2014), argues that the leadership role of policy makers, politicians and ministers, should be acknowledged and they must use their position to stop constant reorganisations. He welcomes the recognition of the crucial role of leadership in improving NHS performance. Baker, (2011) reflects that successful performance requires sustained leadership and leadership succession that maintains a focus on improvement. It would follow that in order for health care systems to perform well long-serving senior leaders, and transitions that preserve their achievements would be beneficial. However, Roebuck (2011) describes that only a few NHS organisations demonstrate good leadership, and that these are an exception rather than a rule. He suggests this is because organisations do not have the capability to address leadership development, or that it is not an organisational priority. He highlights that within the constraints of the current system there is inadequate provision for leadership support in terms of both internal resources and expertise. It has been suggested by Turnbull James (2011) that leadership in the NHS is particularly complicated and requires carefully negotiated authority across a number of boundaries, such as: between clinicians and professional managers; between different NHS entities; and between directorates.

Previous literature on NHS development has tended to focus on 'management' rather than leadership. (Strong and Robinson, 1990; Pollitt *et al.*, 1991; Harrison, 2003; McDonald and Harrison, 2004; Bamford and Daniel, 2005). The discussion of leadership in the NHS is thus relatively new, with some suggestion that the term is now preferred by policy makers, as it encompasses values which the terms 'management' lack (Martin, 1992). The distinction between the terms management and leadership as depicted in the business literature is briefly described in section 3.4.1. This section notes that effective management often requires both leadership and management skills, and managers often possess both. It is anticipated that an understanding of the

organisational change literature could be key in providing guidance for health care organisations as they seek to implement policy changes. The following section will consider the literature on change management and the models which it offers.

3.4 Change management models

The field of management is multidisciplinary and underpinned by contributions from the disciplines of psychology, sociology and economics (Dobbin and Baum, 2000; Osland, 2000). It follows therefore, that change management involves combinations of technological and people orientated solutions for best fit, and integrated strategies to produce results (Paton and McCalman, 2000). There are numerous change management models in circulation both in practice and in theory which have been developed to aid organisations, managers and change agents in their approach to and implementation of change, from a variety of perspectives and across a spectrum of contexts. Models of organisational change can help reveal why and how change occurs, through facilitating identification of driving forces, triggers and processes of change.

Each model represents a particular ideology to explain and explore different aspects of change (Kezar, 2001). For example models frequently consider specific organisational skills and stages of change, such as the 'Big Three' proposed by Kanter et al (1992) which defines three stages of catalyse, articulate and implement change. Others have more closely reflected Lewin's (1951) model of planned change, in their presentation of stages such as planning, implementation and consolidation (Lewin, 1951; Prahalad and Hamel, 1990; Hammer and Champy, 1993; Drucker, 1994). Others models can be grouped according to their focus on specific elements of change, in particular processes, structures and context (Argyris and Schon, 1978; Deming, 1982; Juran, 1988; Senge, 1990; Feigenbaum, 1991; Johnson and Scholes, 1999). A number of models articulate steps which should be followed to successfully manage change, a notable two are Kotter's (1996) eight step model and Kanter et al's (1992) the 'ten commandments' which are concerned with advising managers on how to implement and execute change. Such models focus on providing guidance for change managers on

key steps which should be followed for an enhanced change experience (Kanter *et al.*, 1992; Kotter, 1996; Senior, 1997; Paton and McCalman, 2000).

It is not the intention of this thesis to conduct a systematic review of these models, as substantive reviews have already been undertaken (Van de Ven and Poole, 1995; Armenakis and Bedeian, 1999; Weick and Quinn, 1999; Iles and Sutherland, 2001; Todnem By, 2005; Fernandez and Rainey, 2006; Mannion *et al.*, 2008). This thesis is focused on understanding how policy changes are managed by commissioning organisations and understanding how organisations respond to policy. As such, in order to identify models which would be most useful to address the focus of the thesis it was decided to specifically review change models which sought to 'understand change'. Kezar (2001) advocates that selection of a change model is an ideological choice rather than an arbitrary one. Thus, in line with the nature of enquiry of this thesis, models which considered the complexity of change, illustrated inter-related elements, and ultimately could act as an aid to explain and better understand the nature of change being explored have been included in this review.

Although not a systematic review, given the extensive and complex nature of literature in this field, an organised and structured approach was taken to identify relevant literature. The core bibliographic databases used were: OVID (MEDLINE) (1946-), EMBASE (1988-), Web of Knowledge (1864-) Scopus (1960-). A structured search strategy was used, formulated using both controlled search terms, including MESH headings where available, and free text terms. Bibliographic searching was supplemented by manual searches of key journals, retrieval of references cited in reviews and primary research texts.

Table 3.2 details the search string that was used in conducting the review; these terms were also used in conducting searches of the internet using the Google and Google Scholar search engines. To ensure that the literature review remained up to date, searches were conducted regularly over the duration of the thesis. Subscription to relevant email discussion lists, and scanning of journal table of content alerts also served to ensure new literature was incorporated. Searches were managed and saved in OvidSP. Approaches from the literature were identified on the basis that they

provided a model or approach with the potential to address the objective of understanding change. Texts were reviewed with regard to their suitability and stored in the bibliographic software package Endnote.

Table 3.2 Search Terms

List one: change terms

Change OR organisational change OR development OR improvement OR transition OR transformation OR innovation OR revision OR adaptation OR diversification OR evolving OR modify OR regenerate OR reform OR advance OR correct OR revision OR revolution OR shift

List two: conceptualisation of change
model OR framework OR steps OR process OR structure OR plan OR symbol OR design OR formation OR construction OR pattern OR schema OR type OR figure OR prototype OR example OR paradigm OR conceptualisation OR representation OR classification OR review

List three: change locale

health OR health care OR policy OR health policy OR NHS OR public sector OR Government

Six models which offer the potential to address the objective of understanding change were identified by this review; an overview of these models is presented in Table 3.3. Each model is briefly described, and key factors within the model are identified along with strengths and weaknesses of the model. Where examples of application of the model have been identified in the literature these are noted. This is followed by a discussion of the application of the model as depicted in the academic literature.

Table 3.3 Models to understand change

Model /Author	Summary	Factors considered	Strengths/ Weaknesses	Application
Cultural Web Johnson and Scholes (1999)	This model uses the notion of culture as a metaphor for the organisation. An analysis of each factor is considered to illuminate unhelpful cultural assumptions and practices, leading to improved organisational alignment to better achieve strategic aims.	Stories, Symbols, Power structures, Organisational structures, Control systems, Rituals and routines	Specific emphasis on the role of organisational culture analysis process itself aims to generate collective deliberation. The model has been criticised for failing to either fully equate culture with the organisation or to identify it as separate from aspects of org life. (Senior, 1997)	The suitability of the model for use in strategic planning of Cyprus education system is discussed by Tsiakkiros and Pashiardis (2002). Handscombe (2003) use this model to reflect on previous culture and project ideologies for future cultures in a UK university.
Leavitt Diamond Leavitt (1965)	Considers change through a 'trigger' analogy assuming that a change which affects any of the individual factors will interact with the others and have resulting impacts on these areas.	People, Task, Structure, Technology	Useful as a guide to diagnose an organisational problems and identify a point of intervention for organisational change(Bobbitt and Behling, 1981). Appears to offer value as an analytical tool rather than practical model as the model is deemed too simple to identify causal factors regarding the four variables. Little advice is provided on how best to manage equilibrium between factors.	Popular in the application of information systems and telecare (Stamoulis et al, 99, Gortzis, 2007, Newman & Zhao, 2008)

McKinsey 7-S Waterman, Peters and Phillips (1982)	Designed as a tool to assess and monitor change, combining four 'hard' and three 'soft' change elements. They propose that elements are interdependent and as such an adjustment to one will have repercussions for others.	Strategy, Structure, Systems, Skills, Staff, Style, Shared values	Takes account of both 'soft' and 'hard' components of change. Credited with raising the profile of organisational culture among managers (Hughes, 1996) . Criticised for providing a 'one sided' perspective of organisational culture, by not adequately accounting for issues of conflict (Martin, 1992 in:Iles and Sutherland, 2001)	Two of the models' developers Peters and Waterman (1982) used this model in their work with 62 companies, otherwise little empirical evidence could be found citing this model.
Weisbord 6 box model Weisbord (1976)	Framework incorporating six broad categories to ensure flexibility to a variety of settings. The model identifies the organisational boundary to make distinction between the internal and external environments.	Purposes , Structure, Rewards, Leadership, Helpful mechanisms, Relationships	Praised for reflecting essential activities and being uncomplicated. Found to be more practical than other models through its inclusion of power and politics. The distinction between the formal and informal aspects of an organisation was perceived as artificial.	Although not used in its original form, the model has been modified or developed to create diagnostic models or questionnaires for use in organisational analysis (Lok and Crawford, 2000; Stegerean *et al.*, 2010).
Content, Context, Process Model Pettigrew & Whipp (1991)	Model developed through empirical work in the private sector. Adopts a contextual approach which considers change as a dynamic and iterative process, based on the proposition that organisational change is a factor of content, process and context suggests that change is understood as a	Coherence, Environmental assessment, Leading change, Linking strategic and operational change, Human resources as assets and liabilities	Emphasises the need to consider previous internal factors in conjunction with external factors thus encouraging consideration of organisational complexity and change environment, which may have impacted the organisation and therefore have implications for its responsiveness to change (McLaren *et al.*, 2002)	Used to investigate the implementation of: Business process re-engineering within the private sector (Peppard and Preece, 1995); and evidence based practice in nursing the USA (Stetler *et al.*, 2007; and 2009). Many of the studies which used this model, used it in conjunction with the later model 'eight factors for receptivity' as detailed below.

	continuous interplay between and across these dimensions.			
Eight factors for receptivity Pettigrew, Ferlie, McKee (1992)	Derived from empirical studies in health care organisations, this model builds on the principles of the content, context and process model to identify factors which create a receptive organisational context for change.	Policy, People leading change, Environmental pressure, Supportive organisational culture, Managerial-clinical relations, Inter-organisation networks, Simplicity and clarity of goals, Change Agenda and Locale	Considers the complexity of change and the importance of interacting factors. Conducted as a significant piece of empirical research. Model provides a diagnostic checklist to aid organisations in their assessment of receptivity. Relevance of various connections between the factors of receptivity in the model remains unclear (Stetler et al., 2009).	This model has been applied retrospectively to analyse change programmes (Buchanan and Boddy, 1992; Pettigrew et al., 1992) and local government outsourcing strategies (Butler, 2003). It has been used to inform and shape research on assessment guidelines of older people in UK NHS hospital (Ross et al., 2004); & nursing best practice guidelines in Canada (Marchionni and Ritchie, 2008); personal medical services within a UK general medical practice (Newton et al., 2003) and in a USA study on evidence based practice in nursing (Stetler et al., 2007; and 2009).

3.4.1 Recurring concepts

The models presented in Table 3.3 have subsequently been used and applied to varying degrees by researchers and consultants alike. Each model has been developed from a particular perspective of how change should best be understood; and each has individual strengths and weaknesses. Within the variety of change management models which exist, there is a degree of overlap between many of the models. The recurrent themes and concepts will be illustrated and discussed below with reference to broader literature which recommends their inclusion in change management programmes. Following this a review of the application of these models within healthcare environments is presented.

Context

The significance of organisational context is highlighted by its inclusion in a high majority of the models. Although widely discussed in the literature, no uniform or common definition emerges. The Oxford Dictionary (2010) defines context as 'the circumstances that form the setting for an event, statement, or idea and in terms of which it can be fully understood'. The vague nature of this definition highlights that a myriad of elements and factors may influence, and contribute to, organisational context. As change management theory has evolved it has shifted towards adopting a more contextual approach which suggests that change should be considered as a dynamic and iterative process (McLaren *et al.*, 2002). Indeed it is widely reported that studying and reporting on elements of context enhances the application of research by managers and other consumers of research (Johns, 2006). This suggests that context is key to understanding and managing change. Mason and Mitroff (1973) identified the two main aspects of organisational context as structures and culture. This notion has been more recently confirmed by Nelson and Quick (2008) who state that the study of organisations requires an understanding of the organisational context and human behaviour. Donabedian (1978) developed a basic contextualist framework which identified a dependent relationship between structure, process and outcomes. In short, contextualism emphasises the need to consider internal factors in conjunction with external factors such as the political and economic environment. This encourages

analysis of factors such as organisational complexity and change environment, which may impact the organisation and therefore have implications for its responsiveness to change (McLaren *et al.*, 2002).

Structure

Historically the study of structure, in change management, has been somewhat limited to physical structures, mechanical proves, facilities and objective measures such as external accreditation (Zairi, 1997; Glickman, 2007). Organisational structure encompasses: processes, capacity, incentives, resources, management and technology. It is argued that an organisation's structure is inextricably linked to the culture (Bate *et al.*, 2000). Indeed, others have explicitly stated that structure cannot be considered in isolation, rather it should be managed in conjunction with other aspects of change such as strategy, skills and staff (Waterman *et al.*, 1980). Recent changes in organisational structures have been seen to shift, particularly since the 1980s, towards leaner, less hierarchical, and more responsive structures (Daft and Lewin, 1993; Morris and Farrell, 2007). It has been suggested that one key contribution to success in these organisational changes has been the effective mobilization of the human resource through flatter more flexible working structures (Peters and Waterman, 1982; Kanter, 1989).

Culture

Culture is an omnipresent phenomenon which has a powerful effect on organisational performance, and has been described as the 'glue' which holds an organisation together (Klein *et al.*, 1995). Indeed, it is the main factor considered in the Johnson and Scholes (1999) model, as detailed in Table 3.3. There are many definitions of culture; it is often used as an overarching term which includes the values, attitudes and beliefs held by individuals and teams, as well as patterns of behaviour, rituals and aspects such as power and politics. One of the earliest and most frequently cited definitions is offered by Schein, an early organisational development theorist. He described culture as the basic pattern of assumptions that an organisation has devised in order to manage its problems of external adaptation and internal integration and which have been effective enough to warrant passing to new members (Schein, 1984). In this thesis the term organisational culture is used to describe the values, behaviours and

ways of working which are associated with, or familiar to, the organisation. This includes explicitly expressed attitudes and customs as well as unwritten or implicit rules and beliefs. This includes relationship behaviours such as, quality of engagement, team working and leadership.

Within the field of health care Glickman (2007) advocates a need for further research to determine the cultural factors which facilitate improved quality and performance. Others have suggested that the emerging role for organisational development is to attend to the dynamics of simultaneous structural and cultural change (Tushman and O'Reilly, 1996; Bate *et al.*, 2000). Organisational cultures can have an effect on the success or failure of change; therefore it is necessary to assess its compatibility with the proposed change (Senior and Fleming, 2006).

Leadership and ownership of change

Leadership, of either the organisation at large or of the particular change initiative, was frequently identified as a variable in the change management models. Leadership itself is a complex topic and one which Yukl (1994) suggests is impossible to define exhaustively due to its complex and multifaceted nature. However it is one which is associated with influence (Maxwell, 1998) personal power (Mintzberg, 2006) and persuasion (Gardner, 1993). Chemmers defines leadership as a process of 'social influence by which an individual enlists the support of others in the accomplishment of a task or mission' (1997, p1). This definition indicates that the role of leadership is social, requires participation from others and serves to fulfil organisational goals. Leadership is also evaluated by the ability to develop organisational vision and develop commitment and shared purposes within the team (Gardner, 1993; Paton and McCalman, 2000). Research literature suggests that organisational commitment can be strengthened by effective leadership and change management (Eisenbach *et al.*, 1999; Paton and McCalman, 2000).

Leadership has been widely written about and the role of leadership is described as broad and wide ranging in scope. Leaders provide strategic direction (Kotter, 1996; Fairholm, 2009), inspire passion (Hesselbein *et al.*, 2002), build loyalty (Newcomb, 2005), facilitate teamwork (Burnes, 2004) and create the organizational climate

(Hrebiniak, 2005). Leaders are responsible for strategy and vision, and clearly communicating organizational goals (Weiss, 2000). They also need to be able to adapt to changing contexts and circumstances (Newcomb, 2005). In addition to roles and responsibilities there has been interest, mostly from the discipline of psychology, in the traits which are associated with successful leadership. These include self-confidence, empathy, ambition, self-control, curiosity (Hogan *et al.*, 1994; Maxwell, 1998; Kakabadse and Kakabadse, 1999), charisma (Bryman, 1992; De Cremer and Knippenberg, 2002) creativity (Kirkpatrick and Locke, 1991) and emotional intelligence (Goleman, 2000). Despite much discussion about traits, Elgie (1995) suggests that traits are limited by and exercised through the institutional structure within which they operate. Leadership within the institutional structure of the NHS specifically is discussed in section 3.3.

The terms leadership and management are often used interchangeably, and it can be argued that leadership and management are similar and that an effective organisation needs both strong leadership and strong management (Yukl, 2008). However, Kotter (1996) and Nahavandi (2000) argue that the main activities and functions of the two are different. Advising that the management role seeks to provide order, stability and consistency to organisations, in contrast to leadership which seeks to produce change and movement. In effect, management is the process of implementing the changes that the leader visualises. It is the process of planning, organising and controlling resources and people in order to produce goods or provide services and in order to successfully turn the vision of the leader into a reality for the organisation (Northouse, 2007). The two are different in that management traditionally focuses on the activities of planning, organising, staffing and controlling, whereas leadership emphasises the general influence process. Burnes (2004) notes that while it is possible to distinguish between the management and leadership processes, leaders and managers themselves do not have to be different types of people. He explains that managers can and do possess both leadership and managerial skills, and use both depending on the situation in order to meet a particular goal.

The term leadership in this thesis draws heavily on the definition by Weiss (2000), who states that leaders are responsible for the strategy and vision, and communication or

organisational goals. However it expands on this to recognise the traits and social dimensions associated with leadership such as charisma, the ability to create organisational climate and facilitate teamwork. Leadership has been extensively studied in its own right, and resulted in a number of theories and leadership models (Lewin, 1935; McGregor, 1960; Fiedler, 1967; Adair, 1973; Hersey and Blanchard, 1977; Covey, 1992; Belbin, 1993). The topic has been systematically reviewed by a number of authors (Grint, 2000; Bolden *et al.*, 2003; Hartley and Hinksman, 2003). Thus it is not the intention to repeat their discussion here, rather to identify that leadership is identified as a central component of managing change.

Interrelatedness

Johnson and Scholes (1999) maintain that organisations must be aware of the interrelatedness of change factors. In particular they highlighted that culture is interrelated with organisational structures, power structures, control systems, rituals and routines, stories and symbols and therefore must address the cultural aspects when managing complex change. Careful analysis of the culture and sub-cultures that prevail amongst employees must be examined as attitudes and beliefs will vary across the organisation (Senior and Fleming, 2006). It appears that newer approaches to managing change have shifted from the view of change as a linear and finite phenomenon (as espoused by e.g. Lewin (1951)), and have increasingly embraced issues influencing change such as power, and politics (Waterman *et al.*, 1980; Pettigrew and Whipp, 1991; 1992). They have begun to draw on disciplines such as sociology, economics and natural sciences to inform their approaches. This has resulted in a plethora of approaches, with various foci from political, institutional to chaos. It has been noted that the management of change should acknowledge that it can never be fully isolated from the uncertainty, surprise and chance (Dawson, 2003). Furthermore it is noted that change can rarely be described as either hard or soft, rather is likely to contain elements of both. As such a change programme which contains both hard and soft elements could be used to facilitate effective implementation and management of the change. A model of change and change management which capitalises on the synchronicities between cultural and structural processes within an organisation is likely to be more useful in practice (Bate *et al.*,

2000). Therefore it is important that researchers retain awareness of the pressures and constraints of systems operating in the 'real world' and appreciate that implementing change initiatives in organisations is extremely problematic (Cheng *et al.*, 2007).

Application in this thesis

For the context of this thesis it is imperative that a model which seeks to understand the complexity of change is identified in order to best capture the rich and intricate nature of health care organisations. It is important that the model can encompass a range of variables in order to offer a holistic consideration of factors impacting organisational change. Although each of the models presented in Table 3.3 were selected because of their potential to contribute to understanding organisational change, they each present different approaches, frameworks and strategies to achieve this. A number of recurrent factors have been identified, highlighting areas of overlap across the models. It could be argued that the factors which are common to a number of models represent core components that are key to understanding organisational change. Thus, selection of a model which encompasses a high number of these common factors would seem prudent. However, as articulated above, it is particularly important to consider the particular change context being investigated in this thesis, and in which the model will be applied; not only the number of common factors the model contains. As introduced in Chapter 1, this thesis will explore policy change within the context of the English NHS, thus the following section will review the application of these models within health care settings.

3.4.2 Application in health care settings

The context of change being investigated in this thesis is a commissioning organisation within the English NHS, and the nature of the change question is seeking to 'understand' changes instigated through health policy. This section reviews the research literature to identify which models are most suitable for application in this thesis.

Of the models identified in Table 3.3 only the models developed by Pettigrew and colleagues (1991; 1992) have been applied in health care settings. These models will be described, followed by a discussion of their application within these settings.

Context, Content and Process Model

Pettigrew and Whipp (1991) developed a model for managing change whilst conducting empirical work in private sector organisations. They proposed that organisational change is a product of the content, process and context of change, explained as the 'what', the 'how' and the 'where'. They contend that change cannot be understood as separate episodic events, without acknowledgement and appreciation of the continuous interplay between and across these dimensions. Using these dimensions Pettigrew and Whipp endeavour to facilitate adequate consideration of the historical, organisational and economic aspects of change (1991). Building on this need to appreciate the context and understand the environment of change, Pettigrew and Whipp (1991) identified key features of managing change, additionally they observed differences in the way higher performing firms manage change compared with their counterparts over time. In developing this model they studied the implementation of change in seven organisations across four sectors of manufacturing, publishing, merchant banking, and life assurance. They used a contextualist approach throughout their research and identified five central factors which need to be effectively managed for competitive success; these are illustrated in Figure 3.2. The model identifies five factors that have a direct impact on the performance and competitive strength of an organisation. These are as follows: environmental assessment; leading change; linking strategic and operational change; human resources as assets and liabilities and coherence in the management of change.

Figure 3.2 Context, Content and Process Model
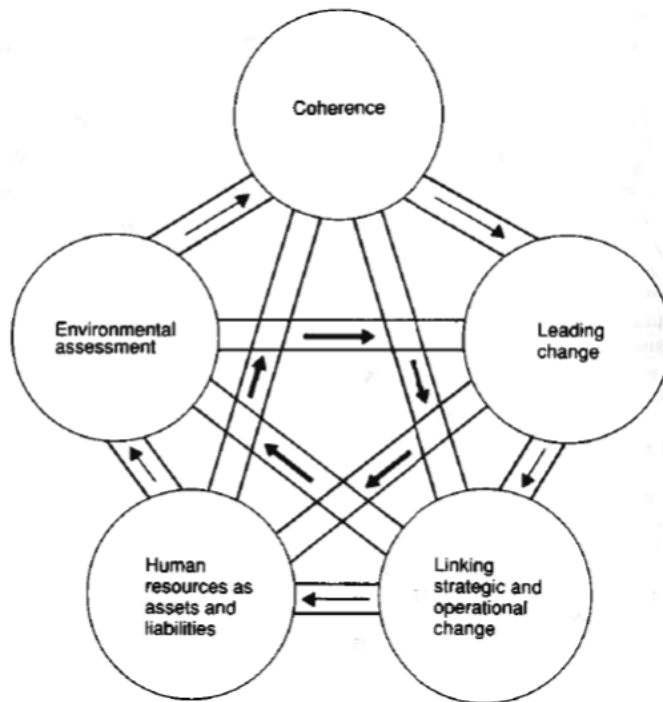
Reference (Pettigrew and Whipp, 1991,p105)

This model has been praised by Iles and Sutherland, (2001) as it stresses the importance of interacting components, aiming to connect the 'what' of change, i.e. content (objective, aims & goals) with the 'how' of change (implementation) and the organisational context (internal & external environment). However, there appears to have been limited application of this model, Stetler et al (2007; 2009) being the notable exception. Stetler et al (2007; 2009) acknowledge the model of managing change for competitive success as one of a number which informed their study. In practice however, rather than using these five central factors, they drew on the overarching dimensions of context, content and process, described as the where, what and how of change (Pettigrew and Whipp, 1991). Their application of the model is described more fully in section 3.4.3. In brief, they describe that these three dimensions of content, context and process informed their theoretical framework and state that interview questions were developed within the framework's essential dimensions. Their coding strategy and analysis of results draws more heavily on the other models which informed their study, in particular the eight factors of receptivity

model (Pettigrew *et al.*, 1992) and they do not offer reflections on the usefulness or influence of the five central factors model in their discussion (Stetler *et al.*, 2009).

Eight Factors of Receptivity

Pettigrew subsequently worked with colleagues Ferlie and McKee (1992) to develop and extend his original work through empirical research with health care organisations, including within an NHS setting. Following these studies they identified eight factors of a receptive context for change. Their model is illustrated in Figure 3.3. Both models have been deemed as major pieces of research and Pettigrew et al, (1991; 1992) are credited as having pioneered the research in this area which has helped form the foundations of the basic literature around strategic change in health care organisations (Iles and Sutherland, 2001).

Figure 3.3 Receptive contexts for change: the eight factors
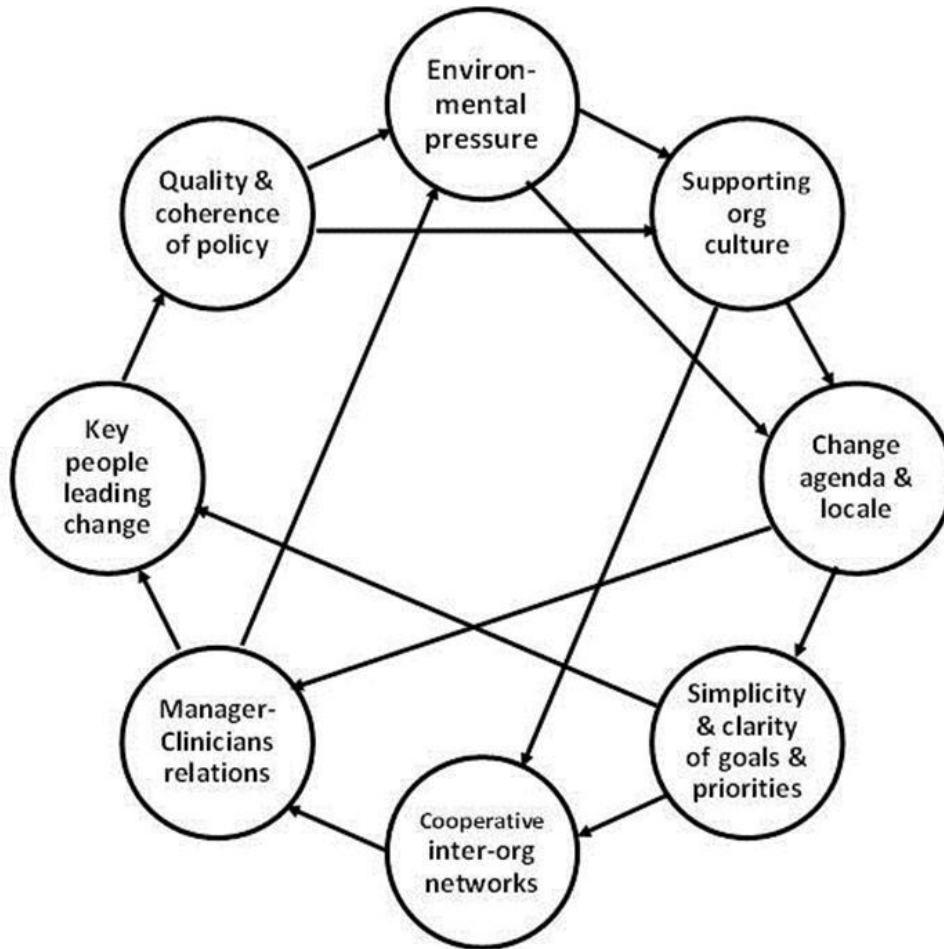
Adapted from: (Pettigrew *et al.*, 1992, p276)

Pettigrew et al (1992) proposed that the factors in Figure 3.3 provide a set of linked conditions which combined can create high energy, or receptivity, for change. The model indicates the importance of interacting components, and the factors are illustrated in a network linked by directional arrows. Although arrows have been ascribed between factors, the authors explain these are intended to illustrate a pattern of association rather than indicate a linear causal relationship. Pettigrew et al (1992) identified the presence of these factors as contributing to a concept they described as receptivity. They found the concept of receptivity to be dynamic and thus highlighted that receptive context can be both developed and reversed. Thus they proposed that the receptivity of an organisation to change would influence the success of change initiatives. They anticipated that an organisation which was highly receptive would be better positioned to manage organisational change. They explain that their view of

change is one that accounts for indeterminate outcomes and implications, and recognises scope for emergence and iteration of change process (Pettigrew *et al.*, 1992).

As highlighted in Table 3.3 this model has been used to explore change within a healthcare setting, both internationally and in the UK (Newton *et al.*, 2003; Ross *et al.*, 2004; Stetler *et al.*, 2007; Marchionni and Ritchie, 2008; and Stetler *et al.*, 2009). The model has been applied to varying degrees and across different change areas within each of these four studies. The application of the model within each of these two settings will be discussed in turn.

3.4.3 International applications

Marchionni and Ritchie, (2008) undertook a quantitative survey as part of a small pilot study in Canada to investigate the impact of organisational context on the adoption of best practice guidelines in nursing. A convenience sample of two hospital units was selected; both had voluntarily applied to participate in the study and had demonstrated support and available resource prior to their selection to implement the guideline. Marchionni and Ritchie (2008) selected aspects of the eight factors of receptivity model rather than using the model holistically. Specifically the model was used to consider just two contextual variables: organisational culture and key people leading change, and found that these are both key elements in influencing the implementation of organisational guidelines. They acknowledged that other factors were likely to influence the implementation of guidelines as well, and recommended more thorough research into the factors present in receptive contexts (Marchionni and Ritchie, 2008). Pettigrew et al (1992) presented their model as a framework of eight highly inter-related factors. They did not recommend selecting elements of the framework and analysing these independently. However Marchionni and Ritchie (2008) opted to select two factors of interest as they were conducting a small pilot study and anticipated that these two would have particular importance in the implementation of best practice guidelines at a local level.

Stetler et al, (2009) used a mixed method case study in two nursing departments in the USA to study the contextual elements and associated strategic approaches required for the institutionalization of integrated evidence-based practice (EBP). Two sites were selected purposively to provide contrasting results, one being nominated as having a high level of institutionalization, the second being selected from a number of volunteer sites which had self-reported low institutionalization. The study used the eight factors of receptivity model (Pettigrew *et al.*, 1992) as the core theoretical framework. In addition, they included the essential dimensions of change (context, content and process) as identified in Pettigrew et al's earlier work (1991). This study applied both the Pettigrew models (1991; 1992) to guide their analysis using both deductive coding, based on the factors identified by Pettigrew, and inductive coding to identify emerging concepts. The study team qualitatively judged each receptivity factor for the sites. They represented these ratings on a diagram, depicting the eight factors and included arrows to represent a negative or positive influence of these ratings on other related factors thus developing a pattern of connection (Stetler *et al.*, 2007; 2009). Factors which they identified as particularly salient included quality and coherence of policy, and availability of key people leading change (Stetler *et al.*, 2009). The patterns between factors and level of influence of each will be discussed, in section 3.5, in conjunction with findings from UK applications of the model.

3.4.4 UK application

Within the NHS, Ross et al, (2004) used the eight factors of receptivity model in their study to evaluate an optional process of change in a single ward in one general hospital. They used a standardised quasi-experimental before and after design to evaluate the implementation of evidence based guidelines. Uptake of the assessment guidelines was on a voluntary basis and sites applied to participate in the study. Ross et al, (2004) used the model in conjunction with other theoretical ideas of change from the literature, including Van de Ven's (1999) model of implementation. They used these theoretical ideas to connect with issues emerging from their analysis of the development and implementation of guidelines for multidisciplinary. Pre- and post-test measures of patient outcomes were collected from 68 patients, and nine in-depth interviews were conducted with a purposive sample of stakeholders to explore their

views on the implementation of the guidelines. The study applied Pettigrew's model (1992) to clarify the links with process and pathways of change, and to inform their analysis. The model was used to facilitate consideration of issues related to changing practice and they mapped issues emerging from their analysis onto the eight factors of the model. This study did not attempt to identify other emergent factors, or reflect on which if any factors were most salient in their study. Some limitations of the model were identified and these are discussed in section 3.5.

Newton et al, (2003) applied eight factors of receptivity model (Pettigrew *et al.*, 1992) retrospectively to data from a pilot evaluation study of the implementation of Personal Medical Services (PMS) in general medical practice. PMS pilot schemes had been introduced in an attempt to foster innovation in primary health care, and participation in the pilot was voluntary. The pilot evaluation constituted of a qualitative study which involved in-depth observations and interviews, including 28 semi structured interviews with clinical staff, group interviews with administrative staff, other informal interviews and documentary analysis. The study authors developed 21 focal questions, derived from Pettigrew et al's (1992) discussion of the eight factors of receptivity, to interrogate the PMS data. The authors attempted to extend the scope of the original framework developed by Pettigrew et al (1992) by subjectively considering the inter-relationships between the factors of receptivity, examining the movement between receptivity and non-receptivity, and considering temporal dimensions to the factors (Newton *et al.*, 2003). The authors evaluated the strength, continuity and direction of links between the factors and found the most significant patterns of association to be amongst policy, leadership, culture and managerial-clinician relationships (Newton *et al.*, 2003).

3.5 Critique of Pettigrew model

Both of the studies outlined above identified the Pettigrew model as useful, either as an analytical model or framework (Newton *et al.*, 2003; Ross *et al.*, 2004), or as a lens for strategizing transformational change (Stetler *et al.*, 2009). Those who partially applied the model acknowledged that all eight factors were likely to have influence in change implementation (Marchionni and Ritchie, 2008).

Two of these four studies went on to reflect on the model in light of their results (Newton *et al.*, 2003; Stetler *et al.*, 2009). Their reflections commented on the salience of factors, and the nature of the relationships between factors, including strength, direction and continuity (Newton *et al.*, 2003; Stetler *et al.*, 2009). The findings from these two studies are compared and contrasted below.

As described in section 3.4.2, Newton et al (2003) retrospectively applied the Pettigrew eight factor model to a study which sought to evaluate a pilot of PMS in one general medical practice. The study by Stetler et al, (2009) selected two contrasting sites which had both voluntarily elected to begin to develop approaches for institutionalising the use of EBP. Although this latter study considered receptivity of both a high performing and a beginner site, the findings below will focus on the high performing site. The beginner site tended to reflect low levels of receptivity across prominent factors (Stetler *et al.*, 2009).

In their results, both studies reflected on the scope of influence and relevance of the individual factors from the Pettigrew eight factor model (1992) for their contexts. Both these studies found the factors of quality and coherence of policy, key people leading change, supportive organisational culture, and managerial clinical relations to have high predominance. These are factors one, two, four and five respectively. In addition Newton et al (2003) identified the most significant pattern of association between these four factors. Stetler et al, (2009) went on to explore constituent elements of each of these factors and identified sub components of leadership such as role modelling, mentorship, and critical enquiry and scholarship as aspects of culture. Stetler et al (2009) also found simplicity of goals and priorities (factor seven) to have high predominance, although this was not emphasised in the study by Newton et al (2003).

Both studies found factors 3 and 8, environmental pressure and change agenda and locale, to have little or no influence on receptivity. It is possible that this may be related to a lack of clarity regarding the definitions of these factors or the sort of constituent elements which may contribute to this factor as highlighted in the limitations below. Stetler et al (2009) described co-operative inter-organisational

networks (factor six), as having a moderate level of influence on organisational receptivity.

In terms of limitations of the model, Ross and colleagues (2004) suggested that attempting to present complex factors of change through a schematic model could be restricting. They identified a potential risk of applying the model as oversimplifying the complexity, dynamism, and chaos of change (Ross *et al.*, 2004). Newton et al (2003) stated that their research identified the nature of the relationships between each of the factors, identifying the strength, continuity and direction of these correlations. This suggests that one weakness in the presentation of the model by Pettigrew et al (1992) is the articulation of the links and inter-relationships between each factor. Stetler et al, (2009) required more substantive and detailed definitions of the factors for application in their study, and drew on wider literature to develop operational definitions for their study. This suggests that a further limitation of the model is the level of explanation or definition provided for each factor. The recommendations for further research made by the authors resonate with these limitations and they advocate further research and refinement of the model. This suggests that development of the model offers the potential to generate useful guidance and recommendations for change management (Newton *et al.*, 2003; Marchionni and Ritchie, 2008). Stetler et al (2009) suggest that that relevance of various connections between the factors of receptivity in the model remains unclear and they advocate further research to investigate their significance and to identify if specific patterns of association are linked to greater potential for success.

3.6 Application in this thesis

Following the review presented in Table 3.3, and the critique of Pettigrew et al's (1992) model above, the eight factors of receptivity model was selected as an approach which could be adopted to explore how PCTs respond to policy change. The model was selected on the basis that it offered a framework to understand aspects of context and process and identify factors which influence the management of change. The model was developed from empirical research in health care organisations and has subsequently been applied by other researches in UK and international healthcare

contexts. Additionally, with the exception of structure, this model includes the common factors identified in section 3.4.1. Although structure is not explicitly identified as an independent factor within the Pettigrew model aspects of structure may be identified and analysed as sub-components of factors four, six and eight (supportive organisational culture; co-operative inter-organisation networks; change agenda and locale). In addition to using the model operationally to guide the research, it would appear from the two studies reviewed above that there is potentially scope to use the research process to develop the model. The model currently depicts each factor equally, although these two studies found some of the factors to be more predominant than others. This would indicate that the relative 'size' or 'strength of influence' of each factor could be further explored. Similarly, it appears further work could explore the pattern between factors, building on early indications to explore, the strength, direction and temporality of relationships between the factors. Substantive definitions of each factor, and descriptions of constituent elements, or example components may be a useful development, in order to address the limitations identified by Stetler et al (2009).

As detailed in Chapter one, the NHS has historically been subject to continual reforms, these have tended to be top down and administered through policy. Developing organisations so that they are well positioned to manage changes, from directed and imposed policy, will likely improve organisational effectiveness and their success in implementing the policy changes. As noted in section 3.4.2 Pettigrew et al anticipated that an organisation which demonstrated high receptivity would be more readily able to respond to and manage organisational change. Although this application to health policy is, as yet, untested it could potentially yield substantial benefits for NHS organisations. Of the four identified studies which applied Pettigrew et al's (1992) eight factor model within a health care setting, two considered implementation of a protocol or guidelines (Ross *et al.*, 2004; Marchionni and Ritchie, 2008), one undertook retrospective evaluation of a PMS pilot (Newton *et al.*, 2003), and one reviewed receptivity to the institutionalisation of EBP (Stetler *et al.*, 2009). In each of these studies the implementation of the guidelines, pilot or EBP was voluntary and the organisation opted into the process. Thus potential exists to explore the transferability

of the Pettigrew et al (1992) eight factor model, to contexts where policy developments instigate mandatory change for organisations.

Iles and Sutherland (2001) recommend developing receptive contexts for policy change in light of their extensive review of the change management literature which identified that a major challenge for health care organisations is developing an environment which is conducive to managing change which is on-going, evolving and cumulative. Notably, the use of top down, centrally imposed frequent reforms is not advocated by the change literature, and thus there are evidently broader questions about how to manage change in the NHS at policy level. Clearly there is scope for improvement at both levels of policy making and policy implementation and exploring organisational receptivity to change is just one part of the process. Nonetheless, given the limitations of the scope of this thesis, the identification of how factors of receptivity influence the management of health policy change was considered both meaningful and achievable. The literature reviewed above would suggest that this concept may be generalizable to the context of imposed policy change, and may facilitate better understanding how receptivity can be improved in these circumstances. The conditions for successful policy change remain unclear and although receptivity is an emerging concept, still under development, it may provide the analytic tools to enable public sector organisations to better cope with managing change (Butler, 2003; Oliver and Pemberton, 2004; Huerta Melchor, 2008). There is anticipation that this will better enable organisations to comply with policy reforms whilst minimising disruption associated with the policy change. This would be of benefit to the organisation and individuals working within them, at least in the interim until the larger forces at play in the political system are addressed.

3.7 Chapter summary

The review of change literature in this chapter has identified limited application of the change management literature to health policy contexts, and highlighted this as a gap in the existing literature. The concept of receptivity is introduced and its potential to improve the management of change is identified. Further consideration of receptivity, with a view to improvement the management of health policy changes is identified as

an area for further research. Although the eight factors of receptivity model (Pettigrew *et al.*, 1992) had not yet been used to do this, it was determined that this is the most suitable model to understand health policy contexts . This model was deemed most relevant because it offered the potential to understand the complexity of changes in health policy, and had previously been used to study health care contexts. Discussion of the studies which have applied this model highlighted a number of limitations and opportunities to develop the model which could be addressed by this thesis; these include the application to mandatory health policy and the use of the model to inform both data collection and analysis methods. Scope to develop the eight factors of receptivity model; in particular with respect to salience of individuals factors and the relationship between these have also been presented. The following chapter details the methodology and methods employed in this research to understand how health care organisations respond to policy changes, using the eight factors identified by Pettigrew et al (1992) as a guide to analyse responses to changes introduced through the 2010 White Paper 'Equity and Excellence: Liberating the NHS (Department of Health).

Chapter 4 Methodology and methods

4.1 Chapter introduction

This thesis is interested in understanding how organisations manage and respond to change, particularly with respect to health policy changes and within the context of commissioning. The context for the study was described in Chapter two, which detailed the iterations of commissioning policy reforms, and highlighted the need to more effectively manage change in commissioning and to adequately account for organisational context. It was noted that, few studies have considered organisational attributes which may enable more successful implementation of policy. Approaches from the change management literature which have been used to understand change were reviewed in Chapter three, further those that have been applied in health care settings were specifically identified. The eight factors of receptivity (Pettigrew *et al.*, 1992) was identified as a model which fulfilled these elements. However, the uptake and application of this model within health care settings is scant, and the model has not been used to understand changes in health policy. It has been recognised that there are a lack of studies considering how organisations can be best positioned in order to respond effectively to changes driven through health policy. As such, it is argued in this chapter that it is important to understand the context and real life complexity, in which policy is received, interpreted and implemented, which can only be undertaken using in-depth qualitative research working within the given context.

This chapter presents the methodology and methods adopted in the research, in order to answer the research question presented in Chapter one (section 1.4). By way of recap, the research question and aims are reproduced here. Following these, the remainder of this chapter provides an in-depth description of the research methodology and the methods which are employed. The research paradigm, within which the research is situated, and the research design are presented followed by the methods of data collection and analysis. The chapter concludes with ethical considerations and the limitations of the research.

4.2 Research question and objectives

Within the field of health care commissioning the questions that this research seeks to answer are:

1) What factors influence how policy changes in commissioning are managed by health care organisations?

2) How do individuals in healthcare organisations perceive and respond to commissioning policy?

These research questions will be addressed through the following objectives:

1. To identify and critique approaches to management of change and policy change in the business and health services research literatures.
2. To understand organisational context and the process of engaging with and fulfilling policy objectives during a time of policy stability.
3. To examine organisational context during a time of policy change and identify responses to the introduction of new policy initiatives.
4. To identify factors which may facilitate or hinder the management of policy change.
5. To apply and critique Pettigrew et al's eight factors of receptivity model [Appendix 1] in order to understand its relevance and applicablility to the context of health policy change.

4.3 Research paradigm

It is important that researchers explain the paradigms within which their work is situated. Not only because it will facilitate design decisions and justifications, but because they have already made many assumptions about the nature of the world. There is interplay between research paradigms and the types of research design and methods which they inform. Making these assumptions explicit will serve to enhance understanding and inform transferability and generalisability of the research (Carter and Little, 2007; Maxwell, 2009).

Methodology is the explanation of the strategic approach to conducting research, thus describing the processes, procedures and overarching system of methods which will be used to address the research questions. The decisions researchers make about how to design and conduct research are influenced by paradigms; that is the particular set of assumptions, values and concepts which underpin how they view reality and make sense of the world. Paradigms are typically considered as a spectrum stretching between two extremes of realist and relativist; from one absolute and objective reality to multiple socially constructed and interpreted realities, respectively. The literature review in Chapter three has identified change as a complex, dynamic and contextual phenomenon. Further, understanding the nature of a healthcare organisation, its internal and external relationships and environmental context has been noted as requiring a broad conceptual research paradigm (Goodwin, 2006). A such, this research adopts a constructivist paradigm, which recognises the active construction of knowledge and respects reality as a dynamic condition, with meanings which are socially constructed and embedded (Hussey and Hussey, 1997). A constructivist paradigm recognises multiple, constructed and equally valid realities. Reality is understood as shaped by the situation context, the individual's perceptions and experiences, the social or organisational environment and the interaction between the researcher and respondent (Henning *et al.*, 2004; Ponterotto, 2005).

Ontology and epistemology are two key components of research paradigms which respectively deal with questions about the nature of reality and how it is perceived, and the nature of knowledge and how it is constructed (Guba and Lincoln, 1994; Benton and Craib, 2001; King and Horrocks, 2010). These will now be discussed in turn with regard to the selected constructivist paradigm. This research adopts relativist ontology. Relativism recognises multiple social constructions. It considers reality as subjective and shaped by contextual factors, such as the social environment, history, perceptions, and interaction between subjects (Ponterotto, 2005). The research epistemology guides the claims which can be made about the data, and informs how meaning can be theorised. Epistemologically the researcher is considered an active participant in the co-construction of knowledge. The researcher engages by participating in dialogue with the respondents and in generating meaning with them (Krauss, 2005). This active interaction between the inquirer and the participants is an

important facilitator in capturing, describing and interpreting the lived experience of the respondents. It is expected that this process will add richness to the findings and their meaning (Krauss, 2005; Ponterotto, 2005). Constructivism seeks to uncover and improve constructions, and thus the researcher is permitted to probe, or question responses rather than blithely accepting them. The researcher's values are expected to mediate interpretation rather than to provide an objective neutral or detached account of events. Similarly, during analysis the researcher can take the given data and unpack it, in order to make meaning from it (Guba and Lincoln, 1994; Ponterotto, 2005).

4.4 Research design

An overview of the research design is provided in the introduction to this thesis, (see Figure 1.1). The research was designed around one case study site, a PCT, in the North of England. A case study approach, using qualitative methods, was adopted in order to collect rich contextual data and capture the complexity of real life events (Patton, 2002). Qualitative research is grounded in a philosophical position which is broadly relativist in that it is concerned with how the social world is interpreted, understood, experienced, produced or constituted. Thus qualitative data collection methods usually require close contact between the researcher and participants, in order to capture emergent and developmental issues as such these processes can generate detailed, rich and extensive data (Moriarty, 2011).

The research design employed in this research incorporated the following methods of data collection: semi-structured interviews, observation and documentary analysis. As noted in the introduction, the changing policy environment provided an opportunity to capture a natural experiment in understanding how organisations respond to policy change. In order to best capitalize on these changes the research design evolved in response to the changing policy landscape. The main evolution during the research was following the transition of the case study commissioning site, from a PCT to GPCC formation. An in-depth description of the methods used is provided in the subsequent section 4.5, but an overview of the research design is provided here.

The research was undertaken in two parts. Part A was conducted during a period of relative stability in terms of commissioning policy context, and addresses research objective one. At this time PCTs were engaged with the implementation of the WCC commissioning policy, which had been introduced approximately 18 months previously, and was scheduled to continue for a further 18 months. Details of the WCC commissioning policy are provided in Chapter two (section 2.3.1). Part A sought to identify how commissioners interpret and relate to WCC, identify features of the organisational context, including relationships with external stakeholders, and extant ways of working, and note any barriers or challenges, preventing the achievement of WCC. This part entailed a series of interviews with key commissioning personnel, followed by a period of observation at the PCT case study site. Interviews (n=11) were conducted between 16th September and 7th December 2009 and observations were undertaken, at the PCT, two days per week from 7th April to 11th July 2010. A detailed breakdown of interview participants is provided as part of the results in Chapter five.

Part B was conducted during a period of commissioning policy change, and addresses research objectives three, four and five. The main policy change during this time included the release of the White Paper 'Equity and Excellence' which proposed the transfer of commissioning responsbility to new GP commissioning consortia (GPCC) and the abolition of PCTs. These proposals are described in detail in the background presented in Chapter two. Part B was thus conducted in two stages: the first , B:1 was conducted with the PCT site and the second, B:2 was conducted with emerging GPCC.

Part B:1 entailed a series of interviews with key commissioning personnel, followed by a period of observation at the PCT case study site. This part of the research sought to understand how commissioners respond to changes in health policy. Questions considered perceptions about the proposed policy, the anticipated implications of the White Paper and the perceived challenges and facilitators to responding to these changes. Interviews (n=12) were conducted between 29th July and 13th October 2010 and observations were undertaken, at the PCT, two days per week from 12th July to 13th October 2010. A detailed breakdown of interview participants is provided as part of the results in Chapter six. The interviews in Part B:1 were informed by the eight

factors of receptivity model (Pettigrew *et al.*, 1992) and this is described in detail in Chapter four (section 4.6) .

Part B:2 entailed a series of interviews with participants from three emerging GPCC, this part sought to capture responses to the policy changes from the perspective of these new organisations. Questions considered perceptions about the proposed policy from the perspective of emerging GPCC, and how policy changes are interpreted and subsequently implemented. Interviews explored the anticipated implications of the White Paper and the perceived challenges and facilitators to responding to these changes. Interviews (n=11) were conducted between 30th March and 15th June 2011. Given the status of GPCC as emerging organisations, it was not practicable to undertake observations with these sites.

Case study research

Case studies take as their subject one or more selected examples of a social entity, such as a community, social group or organisation, which are studied using a variety of data collection techniques. This is considered to allow a more in-depth, holistic study than with any other design (Hakim, 2000). The distinctive requirement for a case study design is attributed to the desire to understand complex social phenomena and through capturing and representing meaningful characteristics of real life events. Case studies have been widely used in organisational studies, for this reason, as the aim is to provide a rich analysis of the social and organisational processes and context (Hartley, 2004). The combination of multiple complementary methods in data collection and analysis, such as in the case study research design employed in this thesis, has been described as methodological triangulation (Denzin, 1978). Using multiple methods within a given single paradigm allows for recognition of multiple realities and served to deepen the understanding of the phenomena understudy. This allows researchers look for convergence among multiple and different sources of information to form themes or categories in a study and in doing so increases internal credibility of the research findings (Creswell and Miller, 2000; Tobin and Begley, 2004).

Hakim (2000), promotes the use of case study research on organisations in the public sector, and for consideration of policy and management issues among others. Case

study research is ideal for exploring contextual conditions related to the phenomenon being investigated and thus has been widely used to understand organisational change. Case studies frequently draw on two or more methods of data collection, such as interviews, surveys and observation and can provide a flexible research design, allowing investigation of the effects of historical pressures, contextual influences and dynamics between and among stakeholder groups (Hakim, 2000; Yin, 2003; Hartley, 2004). The use of multiple methods and sources enables case studies to provide more rounded and complete accounts of social issues and process (Hakim, 2000). Yin (2009) advocates a case study approach as the preferred method when the questions posed explore how or why; when the investigator has limited control over events; and the focus is on a contemporary phenomenon within a real-life context. In this research, the focus is on understanding how organisations respond to change, and how a more receptive context for change can be developed. Further, the researcher is unable to control aspect of the changes as these are being administered through health policy, over which the researcher has no control.   Finally, the literature review has identified organisational change as a contemporary and contextual phenomenon, thus the research seeks to understand change within a real-life context. As the research aims satisfy all three of these criteria, a case study approach was undertaken.

Stake (2003) offers descriptions of three proposed types of case study design, one of which he names 'instrumental case study'. He ascribes this title to cases in which the intrinsic interest is not limited to one particular case, rather the present is examined with the intent to provide insight into a particular issue of inform extant concepts. This partly describes the nature of the case study design of this research. Stake (2003) describes the case study itself as playing a supportive role in facilitating an understanding of another phenomenon. The case is still investigated in an in-depth matter, including detailed description of activities and context, but with the purpose of enabling the researcher to gain understanding about an external interest (Stake, 2003). In this case the external interest is developing an understanding of what factors affect the organisational receptivity to and ultimately management of changes in health policy. However this case study research extends beyond the description offered by Stake, and complements the above by combining it with a thick description. That is the inquiry is interested in the issues, contexts and interpretations embedded within this

case (Geertz, 1973; Guba and Lincoln, 1994; Holloway, 1997). Further the researcher endeavours to adopt the pragmatic advice offered by Carr & Kemmis (1986), who recommend placing your best intellect into the thick of the study context and activities and remaining continually reflective. They suggest that it is inherently more useful to demonstrate commitment to reflexivity, considering impressions, questioning recollections and records, rather than attempt to squeeze meanings into conceptualisations of theorists, actors or audiences.

An introduction to the selected case study site, a PCT in the North of England, is provided in Chapter five. Data was gathered from four sources: organisational documents, direct observation, participant observation, interviews. Relevant and available data were collected in order to understand the organisational setting, how it is organized and operates, as well as to perceive the behaviours, practices, perceptions and assumptions of people within the organisation. Where opportunity arose, insight into how the organisation interacted with other commissioning partners, for example GPs and the Strategic Health Authority, was gained through attendance at extra-organisational events. Details of the site selection process and a summary of environmental context of the PCT follow in section 4.5.4.

4.5 Research methods

The case study design in this research incorporated qualitative methods including interviews and observations. Qualitative methods were employed because the offered the flexibility necessary to research a complex phenomenon such as change, and because they provide a method of obtaining rich, in-depth data for understanding dynamic and multifaceted environments and contexts, such as health care organisations. Whilst there is scope for different variants to focus on different elements, such as norms, interpretations, relationships, discourses, processes or constructions for example, all qualitative research will consider some of these as meaningful elements in a complex social world (Mason, 2002). An important characteristic of qualitative approaches is that they seek to provide a holistic view of the field of study (Patton, 1987). Qualitative research is thus ideal for examining and understanding phenomena such as 'organisational change' as it allows researchers to

explore a variety of elements and dimensions of organisations, through methodologies which consider multidimensionality and complexity (Cassell and Symon, 1994). It facilitates consideration of context and helps identify links between concepts and behaviours, this lends it well to a role in both generating and refining theory (Glaser and Strauss, 1967; Miles and Huberman, 1994; Corbin and Strauss, 1998; Pope and Mays, 2000; Mason, 2002). Much has been written in the methodological literature about the diversity of qualitative approaches, the individual nuances between different schools of thought and the disciplines and academic traditions from which they stem. It is not the intention to replicate that discussion here rather a summary of the selected approach will be presented along with justification for the chosen method detailing why it is most suitable for this research. A summary of the data collection methods used is presented in Table 4.1, and each of these are described fully in the following sections. The remainder of the chapter will detail methods of analysis and ethical issues and limitations of the research.

Table 4.1 Summary of data collection methods

Data Collection Method	Type of data obtained	Phase and location of data collection
Semi-structured interviews	In-depth reflexive accounts from key strategic and commissioning personnel	Part A; PCT Part B:1; PCT Part B:2; GPCC
Participant observation	In-depth field notes, and rich experience of participating and observing the 'strategic commissioning team'	Part A; PCT
Direct observation	Field notes from key commissioning meetings including: team meetings, board meetings, decision panel meetings, inter-organisational meetings, WCC preparations and board training and development	Part A; PCT Part B:1; PCT
Documents	Key organisational documents including; strategic and operational plans, progress reports, WCC submission, executive bulletins. Documents from	Part A; PCT Part B:1; PCT Part B:2; GPCC

	national and local press and articles from trade journals.	

4.5.1 Qualitative interviews

Interviews are often considered one of the most commonly used methods of data collection for understanding complex phenomena (Ghauri and Grønhaug, 2010). They are well suited to enable the interviewer to develop rapport with the subject, to clarify questions and to make several attempts to obtain key facts. They encourage subjects to express their views at length, the ordering of questions can be adjusted to suit the interviewee, and obsolete questions can be omitted by the interviewer (Crombie and Davies, 1996). The course of the interview is thus guided by the interviewer and their skills when asking questions and probing further with supplementary questions (Ghauri and Grønhaug, 2010).

Given that the research objectives are concerned with eliciting organisational responses, thoughts, perceptions and experiences of policy and its implementation, semi- structured interviews were adopted as the principal research method within the case study. Semi- structured interviewing offers a tool to generate rich insight into an individual's position or behaviour and as such is a highly appropriate method to address exploratory objectives, such as those outlined above. The term 'semi-structured' is widely used and encompasses a spectrum of interview styles and depths (Yin, 2003; Bryman, 2004; Jankowicz, 2005). The interviews in this research are guided by a schedule of open ended questions; however adherence to this is not rigorously prescribed. Follow up questions in response to participants' conversation can readily yield rich data, and this approach is used to provide more conversational style of interview, which still generates in-depth responses. Semi-structured interviews demand greater skills from the interviewer than structured interviews, as they can elicit a greater range of response, which may include attitudes and other value laden data which need to be handled with sensitivity (Ghauri and Grønhaug, 2010). To gather the highest quality of information the interviewer has a comprehensive understanding of both the research area and specifics of the research question, and actively seeks the information that is required to address these (Ghauri and Grønhaug, 2010). Good contact was established through demonstrated interest in the responses, attentive

listening, understanding and respect for what the participant says, as advocated by Kvale (2007). Care was taken by the researcher to minimise bias during the construction of the interview, such as the sequencing of questions and any unintended omission of questions. The questions were posed dynamically in such a way that they would promote positive interaction between the participant and the interviewer, maintained the flow of conversation between the two and stimulated the participant to share their experiences and points of view (Kvale, 2007). Interview schedules were designed to explore the management of commissioning policy change and as such were informed by some of the challenges identified in the background and context section (2.3.3). They also explored broad concepts identified in the change management literature, in particular those which were common to multiple models as identified in section 3.4.1.

The interview schedules were developed in collaboration with academic supervisors with expertise in the fields of health care commissioning, policy and change management. The interview schedule in Part A was deliberately broad to allow interviewees to focus on what they considered most relevant to the topic, providing the broadest set of perspectives. Follow up questions or probes, were used to elicit more detail, elaborate on themes and clarify concepts. The interview schedules in Part B were developed and refined in light of findings in Part A and were more closely aligned to the Pettigrew et al (1992) model. Specifically, interviews in Part B included probes to explore each of the eight factors identified in the Pettigrew model. In line with recommended practice for qualitative interviews all interviews included an opportunity for participants to comment on any topic covered in the interview, or any new topic which they felt was relevant (Patton, 2002; Rubin and Rubin, 2005; Kvale, 2007; Turner, 2010) . Copies of the interview schedule for all phases of interviews are included as Appendices 3-5. Details of interview participants are reported with the results in Chapters five, six and seven.

4.5.2 Observation (direct and participant)

Observation settings are not simplistic containers of naturally occurring data ready to be mined, neither can the presence of a participant observer be overlooked, rather

they simultaneously become part of and transform the dynamics of the setting which they explore (Mason, 2002). Observations are influenced by the way a researcher conceptualizes the setting. Indeed, it is well documented that it is not possible for a researcher to generate a full and neutral account of a setting through observations, thus it is appropriate and imperative for the researcher to identify how they will be selective in their observations and what perspective they will adopt in doing so (Mauthner and Doucet, 2003; Flick, 2009). As such it is important to consider how far the selected physical setting encapsulates the phenomena under investigation. That is to ask questions regarding motivations, culture, norms and interactions which may originate or occur out with the organisation and as such cannot be readily understood by an observer on the inside (Mason, 2002; Flick, 2009).

As stated in section 4.3, the ontological perspective of this research considers interactions, behaviours and structure and routine as central to addressing the research question. There will be interaction between the researcher and the research participants, in order to minimise any undue influence created through this it is important to consider researcher conduct in the field. Cassell and Symon (1994) recommend that researchers adopt a positive and non-threatening disposition. Others have suggested that researchers demonstrate interest in participants' views, avoid arrogance, emphasize common factors between themselves and participants and do favours to help participants whenever possible (Taylor and Bogdan, 1984). To this end the researcher made efforts to dress in a similar way to participants, was respectful and attentive of participants at all times. The researcher demonstrated interests in participants' out of work interests and participated in tea and coffee making rituals with participants. When opportunity arose to offer assistance or undertake small errands such as preparing papers for meetings, these were pursued. Observational methods provide an opportunity to capture such social phenomena and their context as they occur in their natural setting (Mason, 2002). As described in section 4.4 observational methods were employed in both Part A and Part B:1 on a two day a week basis for a period of three months within each data collection period. Observations were recorded throughout these periods in a researcher diary, which is a recognised aid used by qualitative researchers. Notes were made in line with recommendations by Symon (2004) and the research diary was used to record key

quotes, personal reflections, impressions and ideas. It also served as a log of research activity, details about the meetings attended and key personnel with whom the researcher interacted.

Direct observation

For the period of observations, the researcher was based within a small team which consisted of two directorate level staff, two senior managers, three managers, four clinicians, one WCC lead and a member of administrative staff, for ease this will be termed the 'strategic commissioning team' henceforth.

Direct observations were made throughout the fieldwork, in particular these were confined to meetings of executive teams, such as executive board meetings, practice based commissioning (PBC) meetings and professional executive committee (PEC) meetings. Attendance at these meetings is described as direct observation as no participation was expected or invited from the researcher. At the beginning of meetings the researcher was introduced and noted to be observing the meeting, rather than participating, at no stage during these meetings would the researcher participate or communicate with staff with regard to shaping the meeting proceedings, providing input or otherwise.

Participant observation

The researcher was permitted to participate in meetings of the strategic commissioning team or meetings led by members of this team. This included team briefings, meetings of the commissioning decisions panel (CDP), board leadership and development training. Similarly the researcher was allocated a desk within this team, and assisted the WCC lead in identifying the competency requirements and managing collected organisational data for submission. Other desk based interaction, conversations or comments regarding current organisational issues have also been classified as participant observation, as they have been shaped by participation and interaction from the researcher.

During the observation phase two days per week were spent at the case study site, three days were spent at the University. This is in line with recommendations by

Hartley (2004) to provide distance from the organisation to ensure the researcher is not overloaded with impressions, or get too close to the data. These days also provided opportunity for reflection and writing up notes of observations, as well as other research activities.

4.5.3 Documents

Documents are constructed in particular contexts, by particular authors, designed for a particular audience and with particular purposes and consequences.(Mason, 2002) As such, documents vary in their level of detail and comprehensiveness. Further they may or may not be readily identifiable and available, that is they may exist but may be difficult to gain access to, or to be identified using systematic retrieval processes. The inclusion of documents in qualitative data collection, specifically within health care settings, has been advocated as beneficial and valuable for triangulation of data (Miller and Alvarado, 2005).

Documents were gathered over the course of the research, but particularly during the observational work. Papers which were collected included administrative documents proposals, progress reports, meeting minutes, and the output of formal evaluations. A strategic sample of articles from local and national press and trade journals were also collected during this time. The process of reading, understanding and selecting documents in this manner has been described as adding a dimension of data generation or construction to the process of data collection (Mason, 2002). During Part A, documents tended to be related to WCC and the fulfilment of competencies and sub-competencies, in Part B they tended to be related to the White Paper proposals and responses to this. Endeavours were made to ensure that sampling of articles was not biased, in particular that trade articles were drawn from both medical and management disciplines, in line with Yin's (2009) recommendations to collect, present and analyze data fairly.

4.5.4 Sampling

Case study selection

As described above this research was conducted in one case study organisation, in the North of England. The restriction of the site selection to the North of England, was because the researcher is based in the North of England, and travelling beyond this region would have had significant implications in terms of time and cost which would not have been practicable. After consideration of this geographical restriction, this site was selected on the following criteria: PCT commissioning competency score (total), population size and ONS classification of local and health authority areas. These criteria were applied in the order reported. A decision was made to select a mid-scoring PCT, with a mid- sized population, and with an ONS classification which was reflective of the majority of PCTs in the region. The case study site is described in the presentation of findings, in Chapter five (Figure 5.1).

Selection of participants

Interview participants were selected using a mixture of purposive sampling and snowball sampling. This allowed the researcher to both identify the most appropriate participants at hand on the basis of their job title, and also allowed identification of further suitable participants from recommendations by other participants. Forty-two people were approached to take part in this research, to provide a range of views and perspectives at various organisational levels. Where participants did not respond to initial contact, follow up was made a maximum of three further times. Where participants declined to participate, their explanation was recorded and they were asked to recommend another suitable person to participate in their place. In total, 34 people participated in the formal research interviews (20 males and 14 females). Details of interview participants for each part of the research are presented along with the findings in Chapters four, five and six.

Conduct of interviews

Before commencing the interview participants were asked to sign a consent form giving permission for the interview to be recorded and transcribed, and confirming

that they had read the information sheet as detailed in Appendix 8. Participants were also provided with the opportunity to ask questions about the study, or seek clarification on any issue arising from the information sheet. The interviews were all conducted by a single interviewer, the researcher, who was both interested and knowledgeable in the subject area, as advocated by Britten (2000) and Kvale (2007). All interviews were undertaken face to face and conducted at the participants' place of work. All interviews were audio recorded, to avoid the interference of note taking with the interview process (Pope and Mays, 2000). An interview schedule (Appendix 3-5) was used to guide the researcher and contained probes to facilitate supplementary questioning if required. Interviews took approximately 45 minutes to conduct and ranged from 33 to 65 minutes.

4.6 Methods of analysis

4.6.1 Transcribing of interview data

Transcriptions provide a written text which can be quoted, sorted, copied, inspected and interrogated; most qualitative research employs language as data and one of the first steps in handling the data is to transcribe it to written text (Miles and Huberman, 1994; Lapadat, 2000). As is common practice for qualitative data analysis the audio recorded data were transcribed verbatim (Rapley, 2007). One file from each phase of interviews was transcribed by the researcher to gain familiarity with the data. The remaining interviews were outsourced and transcribed by qualified transcribers. A transcription guide was developed for each phase, detailing common acronyms and key words, and an outline of the research topics to prepare the transcribers for the data and facilitate more accurate transcription. The level of transcription detail required was also outlined on this transcription guide and for all phases verbatim transcription with notation was used. in line with recommendations by Rapley (2007) notation was used to identify overlaps in speech, interruptions, pauses, laughter, coughs, sighs and other auditory placeholders. Where the transcribers were unable to identify speech, this was marked, with an estimation of the number of words missing and the corresponding time on the audio file. The transcribed files were checked to ensure the quality of the transcription, by making corrections where required and

completing omissions where possible, this process is advocated by Bryman and Bell (2007) to reduce mistakes in transcription. In addition good quality recording equipment was used, and tested prior to each interview.

4.6.2 Analysis of transcriptions

Interviews are often complex to analyse and interpret, indeed the individual background and experiences of the researcher can influence their interpretation and objectivity (Ghauri and Grønhaug, 2010). The analysis of data begins during transcription as the researcher transcribes initial audio files, and during the process of checking subsequent transcriptions. Through reading, listening and checking the transcriptions the researcher becomes immersed in the data and through this process becomes aware of key ideas and themes (Ritchie and Spencer, 1994). The subsequent sections discuss how coding and thematic analysis have been used to analyse the data gathered in this research.

Coding

Coding is a method of sorting and organising qualitative data such as transcripts. Once familiar with the data, the researcher can use this method to group portions of text together to represent areas of interest or patterns in the data. Coding can be undertaken in a variety of ways, with paper copies of the transcripts, highlighting text which is similar with the same colour, or cutting up the paper and gathering similar sections together, or digitally using specially designed software (Gibbs, 2002). In this case coding was facilitated using computer assisted qualitative data analysis software (CAQDAS), specifically NVivo 8. NVivo is a qualitative software package which stores codes, links codes to sections of text and facilitates electronic memos to be created and linked to codes and documents. Codes are essentially a sophisticated method of highlighting data which are similar in some way and attributing them a title or 'code' which describes the concept or attribute which the data have in common. Sections of text can be coded to more than one code simultaneously, if for example the section of text refers to two or more concepts identified in the coding structure.

Other analytical approaches such as content analysis, often prescribe specific guidelines for the 'unit' of text which can be coded for computation, such as sentences, words, minutes of speech. Each choice of recording unit has individual advantages and limitations. For example sentences may contain data which is relevant to more than one category, whereas single words have insufficient context to code meaningfully (Rourke *et al.*, 2001; Beattie and Thomson, 2007). Within thematic analysis the recording unit is not pre-defined. A range of unit types may be coded during the same analysis, such as short phrases, sentences or short paragraphs. It is common for longer portions of text to be coded in the initial stages of coding, the coding process is cyclical and one which evolves during the course of analysis. Larger portions of text may then later be refined and divided into sub-codes (Gibbs, 2002). The process of coding in itself forms part of the analysis and assists the researcher in ordering the data through allocation to categories (Richards, 1999). The methods of analysis used should be systematic, comprehensive, grounded, dynamic and accessible. In keeping with these principles the same coding procedures should be applied to all the data. Analysis should remain close to and representative of the raw data, or what was actually said. The process should be dynamic, in that it is flexible enough to change and develop to best represent the data, and others should be able to follow the process (Miles and Huberman, 1994).

The coding process used in this research was undertaken in line with recommended practice and a description of the activities undertaken is detailed below in Table 4.2.The coding structure developed for use in this thesis is described subsequently in section 4.6.3.

Table 4.2 Description of coding related activity

Coding related activity	Description
Conceptualise research	At this stage the concept of study was defined, and relevant theories and existing literature were critically reviewed. From this, specific research questions were articulated, and the research paradigm and theoretical perspective were selected.

Collect Data	An appropriate research design and methods to obtain data were selected. In this instance direct interaction with key stakeholders and use of audio recorded semi structured interviews.
Transcription	One file from each phase of interviews was transcribed by the researcher to gain familiarity with the data. The remaining interviews were outsourced and transcribed by qualified transcribers.
Prepare the transcript	Transcripts were read in conjunction with the audio recording of the interview, to check validity and verify content. The researcher ensured that the data was thoroughly anonymised, and removed any data which may enable participants to be identified.
Familiarisation of transcript	Each transcript was read at least twice to allow the researcher to become thoroughly familiar with the content of the interviews, and the scope of views expressed.
Import transcripts into NVivo	Transcripts were imported in turn into NVivo. Documents now appear as 'sources' in NVivo pane.
Populate NVivo with a priori codes	Tree nodes were created to represent each factor of Pettigrew et al's (1992) model. Using the coding framework which has been deductively generated from this model, the tree nodes were populated with second level 'child' nodes to represent the sub components of each factor.
Initial coding	Each source was read line by line. The researcher carefully thought about the data, ensuring sensitivity to the context. Where text represented an interesting idea or concept, the relevant portion of text was selected and allocated to the appropriate node. If no appropriate node existed, a new suitable node for the data was created. At this stage selected portions of text can be large and broad, or small and narrow. Coding broad sections at early stages of analysis is useful, as surrounding sentences can provide useful

	context, which will help avoid misinterpretation in subsequent analysis.
	The researcher took care to record the criteria on which coding decisions were made, to aid allocation of future text to appropriate nodes. Each node was specific and self-contained, to ensure that there was no overlap between nodes.
Make memos	During the process of coding, memos were made to capture analytical thoughts. Memos are designed to capture flashes of insight instantly, these can be as long as required and can be edited later. Memos can be used as reminders to check for further supporting data, if a memo is related to a 'hunch' not yet supported by the evidence from coded data. Similarly memos can be used to record an expectation that another related concept may emerge, and a note to consider this in subsequent iterations of analysis. Documents can also be linked to memos, for instance strategy documents attached to supplement statements related to vision or when documents have been referred to in interviews.
Revisit each node	Once all sources were coded, each node was re-visited in turn to carefully consider and interrogate the content to ensure it was a good fit, and suitably representative of the node. This stage is flexible, and allows the researcher to extend, modify and discard nodes as required. Once categories had been identified and established the researcher looked for patterns and relationships between them to explore potential associations. Any irregularities, paradoxes or contrasts were recorded at this point.
Compare and contrast	The research adopted a contrasting perspective during this stage and questioned the data to explore other potential interpretations (e.g. 'what if?'). This process can help stimulate the researcher to recognise ideas and concepts within the data. This was undertaken to address the risk of failing to notice some

	significant ideas because they were familiar to the researcher. Such constant comparative techniques were used to compare data with data, category with category and concept with concept.
Check data which has been coded to more than one node	It is possible that some data may have represented more than one concept or idea, at initial coding. This data were revisited, returning to the original transcript to refresh the context of the text as required. The allocation of text was then reconsidered, in light of iterative developments to nodes and codes where this data should be coded to.
Review highlighted sources to interrogate nodes	Each source was read in turn, along with details of how it had been coded. In NVivo this could be achieved by selecting 'show all highlighted codes' from the main menu. The researcher read each source line by line, to verify that current coding was correct, and questioned interpretations to explore if the data could be interpreted in any other way. Reading the full texts in context again helped identify additional concepts or meanings which were not initially identified.
Review categorization and organisation of nodes	Having read each source in turn, the current categorization of nodes was revisited. Nodes can be moved within the tree framework. The patterns of how nodes were linked were reviewed and if some nodes could be better represented in new positions they were moved accordingly.
Merge or divide nodes	Nodes were collated or merged where categories were small and related, or divided into sub-nodes where categories contained more detail. NB: This activity took place at various stages of analysis and in conjunction with the steps outlined above.

Thematic analysis

Thematic analysis, using a constant comparative approach is a common analytic methodology in qualitative research, however it is one which is not often well defined or demarcated (Braun and Clarke, 2006). Thematic analysis offers a method for identifying, reporting and analysing patterns in data, which can provide rich and detailed accounts of complex data (Boyatzis, 1998). Social scientists have endorsed thematic analysis as a comprehensive method for qualitative analysis, noting that it provides core skills that will be transferable and useful for other nuances of qualitative analysis (Taylor and Bogdan, 1984; Grbich, 1999; Holloway and Todres, 2003). Braun and Clarke (2006) demonstrate how it can be applied within a constructivist paradigm, among others and praise its theoretically flexible approach to qualitative analysis.

This section provides an overview of the definitions, processes and advantages of thematic analysis. Qualitative approaches are diverse, complex and nuanced (Holloway and Todres, 2003), and thematic analysis has been identified as a foundational method for qualitative analysis (Braun and Clarke, 2006). "Thematic analysis is a process for encoding qualitative information. The encoding requires an explicit 'code'" (Boyatzis, 1998, p4). The process of thematic analysis enables the researcher to progress from basic descriptive analysis, identification of patterns and organisation of findings, to interpretation. Thematic analysis is a method for identifying, analysing and reporting patterns or themes in data. It facilitates the organisation and description of data in rich detail (Boyatzis, 1998).

Historically thematic analysis has been considered as a process to use across different methods and analytic traditions rather than a specific approach (Boyatzis, 1998). However, it is now commonly considered a method in its own right (Braun and Clarke, 2006). Thematic analysis is essentially independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches. It is compatible with both the realist and constructionist paradigms. One of the key benefits of thematic analysis is its flexibility. Through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data.

Once all the text has been coded, themes are abstracted from the coded text segments. A theme is a pattern found in the information that, at the minimum, describes and organises possible observations or, at the maximum, interprets aspects of the phenomenon. A theme should capture something important about the data, and represent a concept or meaning within the data set. A theme may be identified at the manifest level that is, directly observable in the information or the latent level. In latent content analysis the researcher explores underlying aspects of the phenomenon which represent a higher level of abstraction. The themes may be initially generated inductively from the raw information or generated deductively from theory and prior research. Contrary to more objective analytic techniques such as 'content analysis', a theme does not rely on numerical quantification of text characteristics. Researcher judgement is necessary to determine what a theme is. A high frequency of a particular data item does not necessarily mean it will constitute a theme. Furthermore, how major or 'key' a theme is does not necessarily depend on quantifiable measures, but rather on whether it captures something important in relation to the overall research question (Boyatzis, 1998; Braun and Clarke, 2006).

As detailed in section 1.1 the aim of Part A of this research is to provide descriptive information about the case study site and its commissioning context. In Part B, however the data analysis extends beyond descriptive analysis to interpret the data. This allowed the researcher to consider the broader meanings and significance of the case study findings. This was achieved through immersion in the data, coding the data, writing memos and corroborating with field notes before progressing to generating themes, this is in line with recommendations by Patton (2002).

This research used a hybrid approach to analysis which combines both inductive and deductive coding methods . Inductive coding methods were used to generate

contextual background and description. Inductive analysis is an approach which allows the researcher to freely generate codes, concepts and themes through reading and interpretation of raw data (Miles and Huberman, 1994; Corbin and Strauss, 1998; Pope and Mays, 2000). The hybrid approach used *a priori* codes from existing theory (Fereday and Muir-Cochrane, 2006). It is argued that where theory already exists about the phenomenon being studied, potential exists to use explanations and models developed thorough previous research as a basis or framework for analysis of new data (Fade, 2004). In this way, existing frameworks may offer predictions about themes or topics of interest, or the relationships between variables and as such may help develop an initial coding framework for analysis. The combination of deductive and inductive reasoning methods in this manner is associated with traditional relativist methods. That is to say this method facilitates interplay between the data, researcher experience and broader concepts (Coffey and Atkinson, 1996). The application of previous research or existing theory relies on a more structured process than would be conventionally used in thematic analysis, and can be used to validate or conceptually extend an existing theoretical framework or theory (Hickey and Kipping, 1996; Mayring, 2000; Hsieh and Shannon, 2005).

In this case a hybrid process, including a deductively generated template 'coding framework' of *a priori* codes, was used alongside an inductive approach to analysis. This approach is similar to the template analysis as outlined by King (2004b), in that it encourages a flexible and pragmatic use of coding. Template analysis can be used in conjunction with a number of theoretical perspectives, including constructivism. In template analysis the initial template is generated from a small subset of the data to be analysed. This initial coding template is subsequently applied to the remaining. The researcher systematically works though the transcripts to identify sections of relevant text and allocates this to a code in the initial template. If no suitable code is available, a new code is generated and in this way the initial template is developed until codes for all relevant data have been created. In a similar fashion codes, which are represented in the initial template may become redundant or may fit better as a sub-category and should be removed, or repositioned respectively. In this manner the initial template for this study was developed and continued to be refined over the course of the analysis using inductive processes (King, 2004b).

This research differs from template analysis outlined by King (2004a) as described above in that the *a priori* coding framework was developed from extant literature, rather than a subset of the interview data. In this case the theoretical framework on receptive factors for change developed by Pettigrew et al (1992) provided a hierarchical framework in the form of written codes to facilitate the organisation of relevant text during the coding process. Fereday and Muir-Cochrane (2006) have demonstrated use of a hybrid approach, which used extant theory to inform and develop the coding framework. However, they applied their template retrospectively to the data, having already analysed it solely using an inductive thematic analysis.

4.6.3 Deductive coding framework – generation and application

The *a priori* coding framework was developed from a model of receptive change contexts developed by Pettigrew and colleagues (1992), following empirical studies across eight NHS organisations. The model defines eight factors which are deemed to create a receptive organisation to change; this is illustrated in Appendix 1. To develop the coding framework, each factor in the model was allocated an integer code which corresponds to the factor number allocated by Pettigrew et al (1992). Sub-codes were then derived from the discussion and reflections of the factor which are, provided by Pettigrew et al, in their original presentation of the model, to devise a complete coding framework (1992). Sub-codes were each allocated to each factor, or focal concept, and not created as a free list of unstructured codes. Structure was provided by creating a placeholder code for each factor. A placeholder code is created as a higher level theme, which allows a selection of other codes to be grouped and allocated beneath the placeholder (Gibbs, 2002). The sub-codes were derived using a process of open coding, which is described by Strauss and Corbin (1998) as a method of examining the text to identify salient categories of information. This framework has endeavoured to abide by the principles and ideas presented by Pettigrew et al, (1992). Potter and Levine-Donnerstein (1999) advocate that a coding framework is valid if it is faithful to the theory in its orientation of codes to the focal concepts.

By way of illustration: 'quality and coherence of policy' is factor one and as such was allocated code one (1). In Pettigrew et al's, explanation of the factor they note that

"ensuring that a strategic framework considered questions of coherence between goals, was feasible…" (1992, p277). Firstly, the code 'policy coherence' (1.1) was generated from this statement. To facilitate allocation of raw data to this code, this was further sub-divided into coherent (1.1.1) for the allocation of data which supports the coherence of the policy and fragmented (1.1.2) for the allocation of data which states that the policy was not coherent. An extended excerpt from Pettigrew et al's (1992) discussion of their findings and reflections on factor one is presented in Table 4.3, along with a demonstration of the development of codes and sub-codes. This process was applied to the full discussion and reflections provided by Pettigrew et al (1992) until a deductive coding framework for this factor was developed. This process was repeated for each factor; a complete list of codes and sub-codes generated using this method is included in Appendix 6. Placeholder codes as discussed above are those allocated with an integer code, sub-codes are allocated a position beneath the applicable placeholder.

Table 4.3 Illustration of codes derived from Pettigrew model

Excerpt from Pettigrew explanation of factor (Pettigrew et al., 1992, p277)	Codes derived	Numerical Code
Factor 1 The Quality and Coherence of Policy	Policy quality Policy coherence	1.4 1.1
"The ordering of such data within clear conceptual thinking helped frame strategic issues, especially where they were initially characterized by complexity and uncertainty, and gave direction. Strong testing of initial thoughts was also important in ensuring that a strategic framework considered questions of coherence between goals, was feasible (a strategy should not create unsolvable problems) and complemented the service strategy with parallel functional strategies (such as finance, human resources, communications)."	Policy quality - articulate - vague Policy vision - broad - narrow Policy coherence - fully coherent - fragmented Policy feasibility - implementable - limited feasibility Policy fit - in line with/ - divergent from existing strategy	1.4 1.4.1 1.4.2 1.2 1.2.1 1.2.2 1.1 1.1.1 1.1.2 1.6 1.6.1 1.6.2 1.5 1.5.1 1.5.2

Using a structured approach like this alongside inductive analysis makes explicit the reality that researchers are contaminated with theory and are not working from some naïve perspective, as is the assumption of many naturalistic designs (Hsieh and

Shannon, 2005). However, the primary benefit of including an open and inductive approach to analysis alongside a structured coding framework is to minimise any restriction from the imposed methodology by allowing research findings to emerge from the data (Fereday and Muir-Cochrane, 2006; Thomas, 2006). This suggestion is further supported by Fade (2004) who notes that existing models can be used by researchers to analyse new data, with the caveat that they should be continuously re-evaluated against emerging data and revised accordingly. Thus, new data and emerging findings would be used to evolve, refine or dispute existing models and theory. This contributes to research objective five which aims to understand the relevance and applicability of Pettigrew et al's (1992) eight factor of receptivity model in the context of health policy change.

Application of the coding framework

The coding framework was thus developed *a priori* to analysis of the transcripts, the framework served as a data management tool as it facilitated the organisation of similar or related segments of text. In this research both inductive and deductive approaches were applied in conjunction, although inductive analysis was given primacy. The first step in the analytical process was to read each transcript through several times to gain an overall sense of the data. In this manner relevant sections of text which were selected for coding were allocated to a code. If this code was already represented by the coding framework then the section of text would be coded to there, if no appropriate code existed in the framework then a new code would be generated. Protecting the integrity of the data and its meaning, took precedent over any desire to 'fit' the data to the existing framework. Additional codes which were identified through this inductive method were listed alongside the codes provided in the initial coding framework. Coding the information, in this way, organises the data so that themes can be identified and developed from it, such that the phenomenon can be described and interpreted by the researcher. Once all the data has been interpreted and allocated to codes in this way the data can be revisited and the codes further refined, by collating or merging codes where categories are similar, or by dividing into sub-codes where categories contain more detail (Gibbs, 2002; Bryman, 2004). The application of the coding framework is described below.

The transcript was then read line by line and each sentence or concept of note was allocated to a code, as presented by the coding framework. In any instance where the researcher felt that the statement was of interest but was not adequately captured by the codes provided in the framework a new code was created. As each transcript was read and coded, codes were revisited, redefined and grouped together as appropriate. Table 4.4 provides extracts from a set of transcripts to demonstrate the application of the coding framework. This illustrates use of the coding framework by demonstrating how relevant text has been selected and allocated to codes included in the framework. In addition, it demonstrates where new codes have been generated to describe concepts emerging from the text.

Table 4.4 Example of hybrid coding

Interview and line number	Quote	Code *
ID 16, 93 ID16, 95	If you are not paying for the time and the resource for clinicians you are not going to get anywhere so if collaborating with clinicians as being pathetically and poorly resourced all over the country really although it has varied I think from PCT to PCT...	1.5.3 achievable financial framework *variation in practice*
ID16, 101 ID16, 103	another barrier is, despite what the PCT thinks, how they operate is usually top down [ok] decisions are made you know by execs and stuff or by higher up often from the SHA	2.1.1 local leadership *top down* *decision making* 4.1.1 formal hierarchies 6.3 organisational power
ID19, 320 ID19, 322 ID19, 324	you'll hear people say "this is the 3rd reorganisation I've been through" or "this is the 6th one I've been through" or whatever and so many people in the organisation, not everybody but many people in the organisation, have been through these a number of times and for that reason they're probably not sanguine about but they're sort of realistic about the fact that, you know the next wave of change is here it's going to happen.	8.1 pace of change 8.2.2 NHS political culture 3.3 energy drain 4.2 openness
*Italics indicate additional codes inductively derived from the text, over iterations of the analysis it is expected that these codes will change, and perhaps merge with existing codes.		

In depth inductive coding

Thematic analysis is an on-going and iterative method, thus once all the data has been interpreted and allocated to codes, all data will continue to be further interrogated, in order to progress beyond the manifest meaning of the text, to critically interpret the data and generate meaning (Kvale, 2007). In light of the preceding analysis the codes may be further refined, by collating or merging codes where categories are similar, or by dividing into sub-codes where categories contain more detail (Gibbs, 2002; Bryman,

2004). Developing themes in this manner and featuring the words and experiences of participants is an important output of qualitative data analysis which adds richness to the findings (Krauss, 2005). As per the first wave of coding, detailed in section 4.6.2 this process was facilitated using NVivo 8. NVivo proved a very time efficient tool in that it facilitated management of the transcripts and allowed passages of text to be coded electronically, collated, retrieved and re-arranged effectively.

Documentary analysis

Documents collected during the case study were not subject to formal scrutiny of the texts themselves or in-depth documentary analysis rather their primary purpose in this project was to corroborate and augment evidence from the interviews and observations. Documents were useful in providing specific information to supplement generalities which were referenced in interviews, on occasion participants made reference to document titles, memos, and policy papers which could then be retrieved to provide further detail and background.

Presentation of results

After generating and analysing a substantial amount of data, reporting the findings from thematic analysis in a concise and meaningful way can be challenging. The most common way of organising such findings is to describe and discuss each of the main themes in turn, using direct quotations from the data, to validate claims for the reader. Not every sub-code will necessarily be mentioned, and it is unlikely that descriptive codes will be included, rather those which most effectively illustrate and explain the theme as a whole, and in doing so address the research question (King and Horrocks, 2010). This is the approach that was adopted in the presentation of the findings which follow in Chapters five, six and seven.

4.7 Ethics

Part A and B:1 of this research were assessed by the National Research Ethics Service and Local Research Council, and received a favourable opinion. The application was made as part of an ethics submission related to the WCC project (REF 10/H0908/190). The regional NHS Research and Development department also approved the research

and provided a letter of access allowing physical access to the organisation. Part B:2 was conducted out with the PCT with GPs who as independent practitioners were not subject to NHS ethics permissions, at this time the consortia were beginning to emerge and had not become statutory NHS organisations.

In line with the guidelines for conducting ethical conduct of the research, participant information sheets were provided to inform participants about the research methods and design. Doing this helped facilitate informed consent and encouraged participants to consider this before deciding whether or not to take part. To ensure that participants did not feel coerced into participating in the study, it was explicitly stated that participants who elected not to participate, or to withdraw would not be penalised in any way. Consent forms were provided to obtain written consent. Examples of these forms and participant information sheets are provided in Appendices 7-8. This information was verbally reiterated at the time of interview, and participants were advised that they did not have to discuss anything that they did not want to, and that they were free to stop the interview at any time, either for a break, or to terminate the interview. All data were anonymised and stored securely in accordance with the Data Protection Act. Paper data were stored in a locked filing cabinet and digital data were stored password protected computer.

Observation was conducted overtly, and as the research site did not provide open public access. Permission to observe the field had to be obtained. Feldman et al (2003) describe closed fields as controlled by a gatekeeper, thus organisational permission for access to and observation of the field was sought from the Chief Executive, on behalf of the PCT. An e-mail was distributed to all staff that would be affected, indicating that this permission had been provided and allowing participants to opt out. Participants who did not want to be included in the study were invited to contact the researcher in person, via e-mail or telephone. It was made clear that no penalty would be incurred in this case, and that although the researcher may continue to be present at meetings no data pertaining to those persons would be collected. Opportunities to opt out verbally were also offered at the start of each meeting, to ensure on going consent.

In all cases informed written or oral consent was obtained from participants prior to their involvement in the research. No participants opted out of the organisational research. Consent forms were signed by both the research and the participant. All data were anonymised and stored securely. Every effort has been made to ensure that no individuals are identifiable in the dissemination of these data. Other administrative access was provided by the PCT in order to best facilitate the study, including a smart card for daily access, a computer login and password, as well as use of a desk, computer and telephone.

4.8 Critique of research design and methods

This study is subject to a number of limitations, these are made explicit here in order to assist future researchers to judge the extent to which they are able to generalise findings to other policy areas or contexts (Leedy and Ormrod, 2005; Creswell, 2007). This section will critique the selected methodology to demonstrate rigour and in order to provide support for later claims about the research findings and their relevance. Limitations of the research will be discussed with respect to: the use of case study design, the use of qualitative methods, sample size and study duration.

Case study approaches, and qualitative research more generally have been subject to criticism over the credibility, relevance and validity of their findings (Mays and Pope, 1995; Pope and Mays, 2000; Simons, 2009). Qualitative methods are increasingly being used in health services research yet remain at risk of being dismissed as anecdotal, overly subjective, lacking generalisability or deemed "unscientific" relative to quantitative methods (Guba and Lincoln, 1994). Most research approaches will have strengths and weaknesses and rather than trade approaches off against each other as better or worse, a more pragmatic approach would advocate careful consideration of method based on the nature and context of enquiry and select the most relevant and appropriate method for the topic to be studied (Simons, 2009).

Criticisms of case study approaches tend to raise issues of subjectivity, generalisation, and scope to generate theory. Whilst these are genuine complexities, they can also (subjectivity for example) contribute to the strengths of qualitative case study

research. Arguably much of this criticism is based on misconceptions about the nature of qualitative research and the paradigm which it is situated in. Simons(2009) and Flyvbjerg (2006) present very well-reasoned responses to these criticisms providing a balanced critique, which challenges misconceptions about case study approaches. Simons (2009) advocates a shift in perspective in when considering case studies, rather than challenging generalisability for example she recommends exploring how findings may be transferrable to other contexts, or beneficial for others and terms this usability. The use of an in-depth qualitative research approach, by its nature potentially restricts the ability to immediately generalise the findings to other organisations or settings. However, the generation and discussion of rich, detailed interpretation of the phenomena studied is key to addressing the research question of 'understanding' organisational response.

Limitations occur for all methods; this research used interviews and observation as the main in-depth methods; both of these qualitative approaches are subject to their own limitations. The limitations of these methods and the steps taken to mitigate these are described in turn below.

Interviews rely on verbal responses, that is to say the researcher will not be able to witness the reports and claims made by respondents. Perceptions of the researcher and interaction between the participant and researcher can influence the nature of participants' responses (Brewer, 2000; Bryman, 2008). In order to diminish any effect this may have on the findings, the researcher used a semi-structured interview format and endeavoured to maintain a conversational style throughout. The interviews were all conducted by the same researcher, and as noted in section 4.5.1 care was taken by the researcher to minimise any bias during interview. Similarly, it is impossible to observe everything; observations are limited by a number of characteristics including practical restraints such as the amount and schedule of time, during which observations can be made (Rubin and Babbie, 2012).

Verbatim transcriptions, serve a research purpose, however it is recognised that transcripts are not a comprehensive record of the activity and interaction during the recording. Transcription freezes speech from its fluid, situational, and contextual state

in conversation to a static permanent and more readily analysable form (Lapadat, 2000). Poland (2001) notes problems with sentence structure, the use of quotation marks, omissions and mistaking words or phrases for others. These may all cause the transcribers to struggle to identify the intended meaning and deliberate how the spoken conversation is best punctuated to provide the intended meaning. Potential threats to validity of description and interpretation have been highlighted by Robson (2002).

A number of strategies were employed to mitigate these risks. Firstly with respect to accurate description, interviews were audio recorded, and transcribed verbatim, supplemented by the researcher's interview notes. The use of multiple sources of data, documents, observations and interviews also serves to reduce this threat. Secondly, with regard to interpretation, the inclusion of inductive methods alongside the coding framework means that the extent to which the framework is opposed is minimised. Adoption of a pragmatic and flexible approach to coding, and the use of memos ensured interpretations were captured at various stages of analysis. The use of rigorous, systematic techniques, including coding and memos and the explicit account of these, serves to strengthen the methodological rigour of this research. Triangulation of analysis was pursed to ensure trustworthiness of data interpretation, this was achieved by having two colleagues, independently analyse a selection of transcript sections; this led to agreement and confirmation of the coding framework content.

4.9 Chapter summary

This chapter has presented a detailed account of the methodology, and methods adopted in this research to explore how commissioning organisations respond to changes in health policy. A qualitative case study design has been adopted in this research, which incorporated methods of in-depth interviews and observations, supplemented by documentary analysis. This chapter has outlined each of these methods, the rationale for their selection and their associated limitations. The data generated through this research were analysed using thematic analysis to identify themes and common concepts which emerged. The eight factors of receptivity model (Pettigrew *et al.*, 1992)was identified by the literature review as most useful to inform

this study, and so a hybrid approach to thematic analysis was adopted to facilitate inclusion of codes based on this model. The final sections of the chapter deal with ethical considerations and limitations of the research. The next chapter is the first of three results chapters and presents the findings from Part A.

Chapter 5 Part A Results

5.1 Introduction

Part A entails the first phase of interviews and a subsequent period of observation within the commissioning organisation. Part A is concerned with gathering baseline data about the health care organisation in a relatively stable policy environment. In this instance the main commissioning policy being enacted was World Class Commissioning (WCC) which had been introduced approximately 18 months in advance of this research. Part A thereby aims to understand the organisation in a 'pre-policy change' environment. Specifically this part of the research explores how commissioners interpreted and related to the WCC policy, and considers features of the organisational context, including relationships with external stakeholders. Barriers and challenges which prevented the organisation achieving their commissioning goals and developing 'commisisoning competencies' are indentified in this part of the research. The findings from this part of the research describe the organisation's engagement with the WCC policy and contextual factors related to the organisation, which inform Part B of the research.

As outlined in Chapter two (section 2.3.1) the WCC programme was introduced to strategically develop PCTs and to establish the necessary competences to deliver commissioning. The programme consists of four elements: vision, competencies, assurance system and a support and development framework (Department of Health, 2007d; 2007e). An assurance system to annually assess PCTs' performance was established. This process measured PCT performance across three main areas, competencies, outcomes and governance. First, eleven organisational competencies, each with three sub components were identified (see Appendix 2) and PCT performance against these was rated on a scale from one to four according to defined criteria, with level four representing 'World Class' performance. Second, the PCTs were assessed against ten key health outcomes and quality indicators; two of these were mandated whilst the remaining eight were selected by the PCT from an approved list issued as part of the WCC programme. Two of these indicators assessed national

strategic priorities, and eight were allocated to local strategic priorities. These indicators were assessed according to nationally or locally collected outcome data respectively. The third and final strand of the assurance process measured governance, which was assessed across three strands of strategy, finance and board and was measured using a subject traffic light scale. At the time of data collection the PCT were in year two of the three year WCC programme and were preparing a submission for the end of year two assurance process. This involved organisational 'self-assessment' across the competencies and sub-competencies and the preparation of an extensive report detailing how the criteria for these competencies had been met.

5.2 Participants

The case study site was selected on the basis that it was a mid-scoring PCT, as defined by the assurance system described above. The PCT had a mid- sized population, and an ONS classification which reflected the majority of the region. The case study site is described below, in Figure 5.1.

Figure 5.1 Description of case study site

Case study site

This PCT cluster serves a population of approximately 800,000 in the north of England. The population is spread across both urban and rural areas. The PCT is supported by over 100 GP practices, over 150 community pharmacies and three large secondary care providers.

Two of the secondary care providers are well established Foundation Trusts which are perceived to hold a strong and powerful position within the health economy.

The level of deprivation, including homelessness and child poverty within this population is significantly worse than the English average. The population experience higher instances of circulatory diseases, respiratory diseases, cancer and mental health issues than the national English average. Smoking, alcohol abuse - particularly binge drinking and teenage pregnancy are also higher than in other areas in England.

Historically, relationships with the SHA in this site were based around stringent control and performance management. Subsequently, the PCT appear to adopt a similar approach during initiatives such as PBC.

In Chapter four the research methods for the entire thesis were detailed, describing the methods employed in both Part A and B. Within Part A, a case study design was used to gather data from four sources: organisational documents, direct observation, participant observation, and interviews to provide a rounded and in-depth account of organisational context. Data collection during Part A involved gathering baseline information about the organisation, and the roles of commissioners. It explores current commissioning processes, and how existing policy is implemented and achieved. Challenges and barriers in performing organisational roles, and in fulfilling policy objectives are explored along with participants' perceptions of commissioning, policy, and health care reform.

The interviews for this part (n=11) were conducted between 16th September and 7th December 2009. These were followed by a period of observation at the PCT, which was undertaken two days per week from 7th April to 11th July 2010. Interviews were conducted with PCT commissioners, representatives from PBC and the Strategic Health Authority (SHA) at this case study site to explore participants' perceptions of the introduction and impact of WCC within the commissioning context. A breakdown, by role, of individual participants interviewed is provided in Table 5.1 below.

Table 5.1 Part A Interview Participants

Phase	Role	Gender	ID
P1	PCT Executive	M	1
P1	PCT Director	M	2
P1	PCT Director	F	3
P1	PCT Director	F	4
P1	PCT Director	M	5
P1	PCT Executive	F	6
P1	Non-Executive	M	7
P1	PBC representative	M	8
P1	PCT Director	M	9
P1	PCT Director	M	10
P1	SHA representative	F	11

Thematic analysis and constant comparison were used to analyse the transcribed data from the interviews. Thematic analysis was guided by an *a priori* coding scheme based on the Pettigrew et al (1992) eight factors of receptivity model. This is explained fully in the methods chapter (section 4.6.3). Interpretation was iterative and involved revisiting the data, refining codes, merging similar categories and dividing into sub-codes where categories contained more detail. This process enabled a rich or 'thick description' of the research context to be produced. This resulted in 23 codes which were then collated into 14 sub themes and from this four broad themes were generated. These broad themes of: policy; organisational context; change agenda and locale; and engagement are presented in Figure 5.2. which also illustrates the sub-themes. This figure is followed by an in-depth discussion of the findings.

Figure 5.2 Map of Themes (Part A)
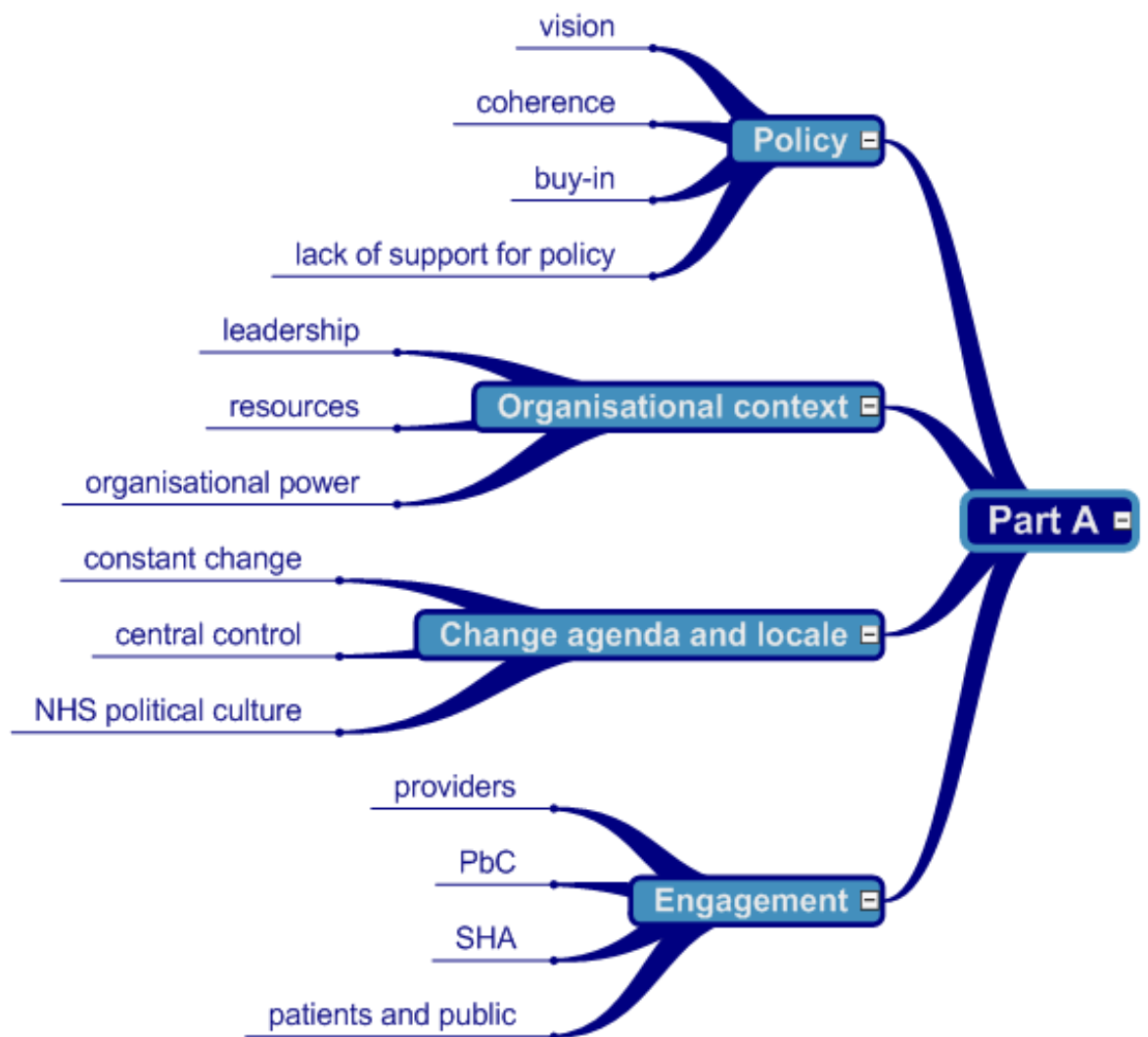
The intention of this section is to provide a rich description of the case study site in a period of relative policy stability, focusing on the existing policy initiative at the time which was World Class Commissioning (WCC). The findings presented here are described in terms of four broad themes, as illustrated in Figure 5.2. The first theme describes participants' perceptions of the WCC policy; this theme identifies the extent to which participants expressed support of the policy vision, and their perceptions of the policy coherence. This theme also details the level of commitment generated by the policy in terms of participants' buy in, and lack of support for aspects of the policy.

The second theme describes aspects of the organisational context which were reported by participants. These pertained mainly to three topics of hierarchy,

resources and lack of organisational power. The third theme captures the change agenda and locale, and included issues of constant change, central control and the NHS political culture. Finally, the fourth theme describes engagement and relationships, in particular between the PCT and; providers, practice based commissioners, the SHA and the wider community. These four themes are discussed in turn using quotations from observation field notes and interview transcripts to evidence the description and support the claims made of the data.

5.3 Policy

This section describes participants' perceptions of the WCC policy; it presents their thoughts and reflections on the policy and explores aspects such as their individual support of the policy and expectations about changes which the policy may instigate. The findings in this section are presented in four sections which will discuss: policy vision, policy coherence, buy-in and lack of support for WCC.

5.3.1 Policy vision

Policy vision reflects what the aims and goals of the WCC policy were perceived to be. Policy vision should inform participants about the future direction for their organisation, articulate organisational aspirations or an 'end point' describing what the policy seeks to achieve. Vision is often considered to detail the 'what' (aims) rather than the 'how' (mechanisms) and thus, consideration of the mechanisms underpinning WCC will be discussed in the subsequent section which deals with policy coherence. This section aims to capture how individual reflections on and perceptions of the policy vision, and early expectations of what the policy may deliver. Participants advised that the policy vision was well embraced initially and the identification of discrete competencies was considered useful, but not revolutionary; these perceptions are described further below.

The introduction of the competencies, as part of the WCC programme, was seen as a positive progression in both national commissioning policy and the development of local commissioning within PCTs. The majority of participants agreed that they were a

useful initiative and responded favourably in their initial comments, largely agreeing with the underpinning rationale:

"You know they were quite well embraced initially." (ID3)

"So we think World Class Commissioning is a sensible and cohesive set of policies […]as a whole load of programmes of improvement […]they do hang together and they do make sense largely" (ID1)

Participants suggested that the explicit description of requirements for commissioning was a useful exercise. They indicated that this provided a welcome focus for commissioning; one which provided a useful platform from which PCTs could assess and consider which competencies are lacking and require development. The competencies were credited with orientating the organisation towards commissioning and thereby clarifying the PCT role, with some suggestion that this focus had been lacking in the past.

"Well on the whole I think they're good really -to identify those competencies and to be specific about whether or not those competencies exist […] I don't think there's anything that obviously stands out to me that's missing." (ID 8)

"It gives a certain focus to what we're doing, because you know, we have certain targets now." (ID7)

Although participants agreed with the general principles of WCC and the competencies, their responses were not overtly enthusiastic, suggesting that they were somewhat underwhelmed with the policy. This is communicated by the use of conditional statements in their responses, which was illustrated in the use of terms such as 'fairly comprehensive' 'adequate' and 'not unreasonable'. This may suggest that as a whole the WCC programme was a natural progression, in line with expectations for commissioning development. Although some participants raised concerns with discrete aspects of the programmes, such as the competency focussed on stimulating the market, no one suggested that the programme in general was unreasonable.

5.3.2 Policy coherence

Although there is no uniform definition of policy coherence, the term is considered to mean both the absence of inconsistencies between different policies and the successful interaction of policies with a view to achieving overriding objectives (Ashoff, 2005). Here, it is used to describe the perceived quality of the policy in terms of appropriateness for PCTs and the alignment of the policy with other commissioning initiatives and other policy objectives in the health care system. Participants highlighted that the policy contained a lack of guidance for implementation, identified challenges with the generic approach of the policy, and reported incongruences in assurance processes and the cohesion with other health policies, these are described below.

Participants noted that there was limited instruction or guidance beneath the competencies, suggesting that whilst they dictate the standard to be achieved, there was insufficient detail on how to achieve the standard. This meant the detail on how to move from a baseline position to improving commissioning performance, and scores, had to be developed by the organisations themselves.

> *"It doesn't really tell you how, it just tells you the 'whats', you know, that you do these things and then they have those results. It doesn't tell you the how. When you start to work out the 'hows' behind these...I think those are very powerful as well." (ID1)*

With regard to how appropriate the policy was deemed for PCTs, participants described the policy as having a blanket approach partly by nature of being a nationally implemented policy endeavour. Participants noted that the competencies were prescribed at a certain generic level; they anticipated gaps at the level of implementation due to local variances and noted that these would need to be addressed and managed. Further, it was reported that the competencies were less relevant for practice based commissioners and were deemed to have been written with a greater focus on PCT commissioners.

"I think overall, it probably covers the full spectrum and I think it's down to the local areas as to where the gaps might be that need filling in more than somewhere else," (ID7)

Concerns were raised about the fit of WCC alongside existing health policy and governance requirements. Respondents highlighted that there were several commissioning policies that they had to implement or operate within, the goals of which were rarely explicitly aligned with one another. Specifically, they noted multiple reporting commitments both regionally to the Strategic Health Authority, and nationally to the Care Quality Commission and the Audit Commission. This resulted in duplication of similar information and multiple lines of accountability for the same outcomes. There were concerns that WCC would add to this burden of assessment and it was evident that this was a source of frustration as well as an indication of inefficiency.

"We've got CQC*, we're part of the CAA** so they're comprehensive area assessments, so health gets dragged into that as well and then also part of the local area agreement and kind of the performance of those agreements[…] so we're being held to account in multiple fora for the same things." (ID3). [* CQC Care Quality Commission, **CAA Comprehensive Area Assessment by the Audit Commission]

Participants anticipated challenges in implementing WCC within the overall landscape of policy initiatives which the organisation were expected to deliver; even if this policy was considered achievable as a stand-alone initiative. They expressed disapproval towards government approaches to policy making in general, and advised that within commissioning there were numerous policies which were not mutually coherent at the level of implementation.

"One of the problems you've got is that central Government is policy making, it's done very much in silos, so; and even within some Government departments it's done in silos, even within the Department of Health err, we can get several policy initiatives; one on its own might make sense, but when you try and join up the four or five you've just been given, they don't always join up." (ID5).

In summary, although participants supported the general aim of the WCC programme, they would have valued further guidance about how to implement the policy, in particular with regard to developing the competencies, there were also concerns about the limits of blanket policies, and the cohesion and fit of the programme with other policy initiatives at the level of implementation. These issues will likely be useful to inform and improve future policy development.

5.3.3 Buy-in

The commitment generated by the WCC policy, pertained to the benefits that participants anticipated from the policy and experienced during implementation of the policy.

Anticipated benefits

Participants supported elements of the policy in anticipation of benefits that it would deliver to both organisational processes and engagement. Firstly, with respect to process, participants expected the policy to improve and provide structures for the development of commissioning at an organisational level. They reported that the WCC programme offered scope to focus on process, and to improve the development of commissioning practices at the PCT with the stated implication that an improvement in process would generate improvements in outcomes. They acknowledged the need for process and identified that whilst WCC reflected current commissioning thinking in PCTs, the policy enabled this to be translated as a potentially useful formal and structured commissioning process. There was an expectation, or at least a level of optimism, that following this process and achieving the competencies would ultimately result in better health outcomes and improvements in population health, this is described in the second quote below.

> *"There needs to be a process and PCTs need to be held to account."(ID5).*

> *"In terms of how we want to develop health care services and improve health care services and to improve the health of the population. So…so my desire would be in the next few years to be able to look back and see how the use of these processes has led to that outcome." (ID1).*

Secondly, the policy was identified as aptly encouraging engagement from key stakeholders. The opportunity to involve other key personnel in the policy implementation, such as clinicians and the public, as well as other regional partners was acknowledged. The broad scope of the competencies in encompassing and engaging relevant personnel from a range of commissioning areas, including planning through to contracting was also commended.

> *"It brings in clinicians, the public, you know, partners, so it sort of goes through all the different areas, it addresses procurement contracting, you know, so it does seem to be all embracing." (ID11)*

The reference to the full range of commissioning cycle activities within the programme, and the inclusion of opportunities to engage key stakeholders also led participants to anticipate that the programme may offer a comprehensive approach to developing commissioning.

Experienced benefits

Benefits which participants attributed to the implementation of WCC included: organisational reflection, a renewed focus on health outcomes, and some inter-organisational collaboration. As detailed at the outset of this chapter the assurance process for WCC entailed health outcomes, competencies and governance measures. The assurance process required that PCTs demonstrate their achievement across each of these areas by evidencing their performance across national and local key indicators. Key indicators included outcomes such as life expectancy, under 18 conception rate, prevalence of breastfeeding, number of smoking quitters, and rates of hospital admissions for alcohol related harm. PCTs reported that this process of self-assessment encouraged self-reflection and evaluation and thereby served as a stimulus for the organisation to reflect on and evaluate their existing commissioning process. This facilitated the identification of strengths and weaknesses as teams evaluated their capacity to satisfy the conditions of each competency. These reflections are illustrated in the quotes below:

"We looked at these and how we fitted into it… we've gone through each of these in some detail and identified where we think our strengths and weaknesses are in each of them."(ID7).

"They're good really, to identify those competencies and be specific about whether or not those competencies exist" (ID8).

Another welcome feature of WCC was the shift in focus from performance targets to population health and outcome measures. The competencies were considered by respondents to have lifted commissioners' attention away from the minutiae of targets to the broader purpose of commissioning, that of improving the health of the local population:

"I think the focus on health improvement outcomes was quite helpful from a public health point of view…it gave us that focus which was good…" (ID3).

One aspiration detailed in the vision for the competencies was that they would stimulate improvements in commissioning performance. Participants readily indicated their eagerness to improve and awareness that progression would require initiative and continued effort. To this end the competencies were credited with instigating a degree of collaboration and knowledge translation, as a number of chief executives formed a regional group to consider the competencies and review their current organisational performance.

"for example the chief executives got together and did some work on world class commissioning competencies so they worked through all the competencies together and they got groups, one for each competency so that's – and worked through what they would need to do to improve within each competency." (ID1)

"Clearly training and development; we've got a training and development programme in place, we've clarified roles and responsibilities, we've clarified the business planning process, we've clarified the arrangements for, money and incentives..." (ID5)

The competencies were also credited with stimulating further training and development for commissioning staff. Participants reported that a programme had been put in place, which facilitated clarification of organisational roles and

responsibilities and was expected to lead to improvements in organisational planning and competence.

5.3.4 Lack of support for WCC

The level of buy-in from participants was impacted by a number concerns with WCC and anticipated weaknesses with the policy. These related to the perceived feasibility of WCC and the administrative burden associated with it.

Feasibility

When reflecting on the policy, participants raised a number of concerns related to the feasibility of the policy. These included aspects of the policy strategy, the ability of the policy to achieve its aims, and the ability of participants to implement the policy within the given timeframe.

Participants queried the policy strategy of separating commissioning into eleven competencies, and emphasised the importance of considering the competencies within the entire WCC programme. The rationale for these comments was based on the consideration that the competencies were interlinked and even overlapping thus there was little support for compartmentalising these into separate elements. To illustrate the perceived risk of underperforming on, or side-lining one of the competencies one participant likened it to the analogy of removing a 'cornerstone' from a building.

> *"To be honest I think it's quite dangerous to start separating some of these [competencies] out because you need to do them all and, you know, if you've got one of them that isn't being done properly then, it's like the cornerstones of a building, you know, if you start taking a cornerstone out the whole building gets inherently unsafe" (ID1).*

In hindsight some of this anticipated risk, was likely related to the organisational ways of working, rather than an inherent risk of the competencies initiative. It may indicate a narrow tick box approach to satisfying performance measures, at the expense of being able to adopt a holistic approach. A focussed 'ticking the box' approach to

achieving the competencies is discussed in greater detail in the next section which identifies challenges in the administration of WCC.

Some participants expressed scepticism that the implementation of the competencies would actually deliver the changes and improvements in commissioning practice that were intended in the development of WCC. In particular, some respondents questioned the hypothesis that there would be a causal relationship between the adherence to, and implementation of, the competencies and improvements in local population health. As such, respondents highlighted that it was possible to follow due process and provide the requisite evidence to demonstrate fulfilment of the competencies, yet not necessarily improve commissioning. Alignment with organisational strategy and goals, namely the overarching goal of improving population health, appeared to be the basis against which participants assessed the 'value' of the assurance. Regardless of issues of process, respondents advocated that the usefulness of an initiative ought to be interrogated before implementation.

Further, participants were particularly dubious that competency seven was an effective mechanism to address commissioning issues, and noted that this was topic of wider debate in the health services arena. The extent to which the market could and should be used was particularly controversial, this appeared to because of the uncertainty of how effectively and successfully it could be used. Indeed, this is reflected in the history of commissioning developments (Chapter two,) which details that the UK policy pendulum has oscillated between initiatives which rely on market mechanisms and those that are controlled from the centre, settling on neither.

> *"You could go and find evidence of lots of things in an organisation and it might still not be making the difference that it ought to be making" (ID1).*

The inclusion of competency seven, 'stimulate the market' also appeared to be a source of contention as there was debate about whether market could effectively be used to address commissioning issues:

> *"I suppose the controversial things are stimulating the market and I know that that's the sort of big debate really as to whether or not the market is the best way to solve health provision problems." (ID8)*

Further to concerns regarding the content and potential effectiveness of the competencies, participants anticipated that the proposed time frames were unachievable. WCC was introduced as a three year initiative and participants suggested that it would take much longer than this to generate the requisite improvements in commissioning and outcomes. It was suggested that there was a naivety in this policy making, which considered that the social re-engineering required to change the health behaviours of local populations could be implemented within such a time frame.

"I understand where they're coming from, but again it's not something that you can deliver in three years." (ID5)

In summary, the introduction of the WCC was welcomed initially and perceived as providing a focus and raising the profile of commissioning. The formalisation of existing commissioning processes and provision of increased structure was commended and noted as necessary. There was some suggestion in responses that the subsequent implementation of the policy will raise issues in terms of both processes and structure as well as context and these are discussed further in the remainder of the analysis.

Administration of WCC

Participants advised that the nature of the assurance process, and the organisation's strict adherence to the implementation of the competencies, led to an undue focus on the assessment rather than commissioning development. Despite welcoming the use of the competencies in providing a structure and process for commissioning, (section 5.3.3), respondents expressed concern that the organisation was consumed by the 'process'. They indicated that this would cause the organisation to lose sight of the wider objectives of WCC and broader aims of commissioning. In particular the assurance process itself was found to be awkward to complete. Furthermore, participants advised that it was difficult to escape the 'tick box' nature of the assessment due to the detailed and specific criteria to be evidenced alongside each sub-competency and strict word count restrictions on the application. In particular it appeared that there were a high number of requirements to satisfy, as such the demonstration and evidencing of achievement became a lengthy exercise in itself.

"As a process that's a different kettle of fish altogether because it has become a competitive ticky [sic] box thing, and on that basis it's just a nightmare because actually it's another assessment process rather than a developmental process." (ID3).

The process was described as cumbersome, and time intensive, requiring extensive amounts of documentation. It was recognised as taking considerable effort to effectively communicate evidence that the competencies had been achieved, particularly within the scope of the prescribed documents which were allowed to be submitted as evidence. This process of gathering evidence and uploading submission data was noted as a substantial administrative burden to the organisation. The extent of the assurance assessment and review procedures appeared to add to the perception that the Department of Health was scrutinising PCTs.

"We've had a secretary actually doing this [assurance submission] full time for days on end" [Field notes, 29.04.10]

Participants suggested that the process was top heavy, and subject to central control by the Department of Health. The perception of scrutiny was considered unhelpful and the generic nature of the programme in its prescription of the same requirements on all PCTs was not deemed fit for purpose. There was suggestion that a blanket approach which generically prescribes the same requirements on all organisations was not fit for purpose. A more refined procedure which would target poorly performing PCTs was recommended.

"The process is too top heavy and it's detracting from what it's actually trying to achieve, then there's something wrong with that. So I think it wants a lighter touch process and where the effort needs to go, is where PCT's are demonstrably failing, that's where I'd start to put the greater effort, but don't treat all 152 the same..."(ID5)

It was evident throughout participants' reflections on the assurance process that it was received as an assessment process, rather than as the intended developmental process. Rather than solely related to the assurance process, these comments may reflect the PCT approaches to satisfying policy or organisational ways of working, perhaps reflecting a 'what gets measured gets done' approach.

5.4 Organisational context

This section outlines issues of organisational context that came to light through the interviews. Organisational context will be discussed within three themes of: leadership, resources and organisational power.

5.4.1 Leadership

The notion of leadership was closely related to or aligned with the formal hierarchy of the organisational structures. This suggests that participants were inclined to consider leadership as a position rather than leadership qualities or skills. Executives advised that a WCC and system management group had been formed at a regional level, this was a sub group of a regional, cross PCT, management board and included representation from the SHA and executives from each PCT.

> *"You've got chief executive level, which is the management board. We've got world class commissioning system management leads, which is a sub group and that's director level and then there's another level which is I guess assistant director level where it's more the operational side of world class commissioning so there's like the three tiers." (ID11)*

Those in executive roles within the organisation were quick to assert that the organisation held a distinct set of values which were actively communicated to staff. These values included role and behavioural expectations, and also emphasised valuing and protecting individuals. The use of 'us' and 'them' ('they're important to us'; 'how we expect them'), in the excerpt below may suggest a separation between a central management core and the rest of the workforce.

> *"We've put a lot of effort in recent months into having a very clear set of values, for example, talking to people around what they are, why they're important to us, how we expect them to behave and work with others. That we'll never attack people, we'll attack issues but never people and you know." (ID1)*

It is perhaps noteworthy that this statement lacks reference to any bottom up engagement, rather seems to embrace a centrally held and pushed out message. This

was further evidenced when describing the organisational development strategy, ID1 went on to state:

"I think you'll find a hugely variable view across the organisation as you get into talk to other people. Particularly once you get beyond the management team into the Associate Directors and then below them […] below that we haven't really penetrated that far yet. So we've got a knowledge which is sort of spreading from the middle of the organisation." (ID1)

The Chief Executive was credited with effective communication across the organisation, evidenced by the explanation that a process was in place to ensure effective internal and external communication, to ensure that critical issues reach the attention of all staff. In addition, innovative methods of communication were adopted and observed within the case study site, such as short video briefings. When this was first introduced staff feedback was sought, and as responses were favourable the method was adopted as a more regular method of communication in addition to more traditional media.

"We have an excellent internal and external system of communications, we have a weekly Chief Exec's bulletin which goes out to all staff; any critical issues are also flagged up by inserts into payslips" (ID7)

Leadership has been identified as closely associated with position and role within the formal organisational hierarchy. The distinction between leaders and operational staff was implicit in comments which described one way communication and the use of terms like 'them' and 'us'. Communication from leadership down was considered to be effective, although reflections on communications upwards to leadership where not provided. Within the management literature, leadership is often defined by qualities or traits rather than job title or role, as noted in the literature review (section 3.4.1). It is interesting to note that participants did not engage in discussion about tenets of leadership, such as vision, charisma, creativity or passion. This may indicate that the leaders in the organisation lacked such qualities. Equally it may indicate that those who did possess such qualities were constrained in their ability to display them. Indeed, the stifling nature of some top down organisations on leadership is noted in section 3.3 of the literature review. These hypotheses could be explored in future

interviews, as it is perhaps premature to draw informed conclusions from the data at this point, given that no questions were asked specifically about leadership in these interviews.

5.4.2 Resources

A lack of resources was identified by participants as a barrier or obstacle to effective commissioning. The term 'resource' was often used generically as a catch all to describe money, time, and human capacity (staff). Resources in general were noted to be closely interlinked and it was evident that a reduction in time, money or human capacity had repercussions for the others. Participants advised that neither PCT nor PBC commissioning were sufficiently well resourced and they expressed concern that the organisation lacked sufficient human capacity (staff), time and money to enable the effective development of commissioning. These three issues will now be discussed in turn.

Staff

Participants repeatedly reported a lack of investment, in terms of staffing and human capacity, for commissioning. Lack of management capacity was seen, not only to reduce the organisation's ability to commission effectively, but also to place them at comparative disadvantage relative to other organisations in the commissioning landscape. It was also noted that the acute trusts that the PCTs were dealing with had significantly more management capacity which gave them a relative advantage over the PCT when it came to investment opportunities. This is illustrated by the statement below, which also recommends an increased investment in resource to improve the rate of commissioning development.

> *"The organisation is not adequately resourced to do what it's been asked to do. Currently management costs are about 1% of turnover and if you look at most major complex organisations, the management costs will be significantly more than that […] if the Department of Health and Central Government wants to move quicker in making commissioning work, it's going to take more resource than we've currently got." (ID5).*

Aside from inadequate capacity, staff reported a lack of experience and expertise in commissioning skills. It was apparent that the commissioning process requires a wide range of skills and competencies. These included new skills, which were not considered to traditionally reside in PCTs, such as market management, respondents acknowledged that progress was being made in developing these skills, but this was a time consuming process. Participants suggested that this lack of capability was not specific to their organisation and noted that it was an issue that was recognised nationally:

"We haven't had a lot of experience or expertise or necessarily confidence in commissioning but I think we're sort of getting there slowly but it is quite a slow process." (ID8)

"The issue is, there is a huge shortage of people with appropriate procurement skills, not just with NHS expertise, but just generally, I mean it's an issue nationally." (ID7)

The agenda for WCC required human capacity, and in particular management resource, yet PCTs found that they lacked both the human capacity and the capability in terms of appropriate levels of skills to successfully implement commissioning.

Time

A lack of time to complete the tasks associated with commissioning, and in particular achieving the competencies, was expressed by representatives from both PBC and the PCT. Clinical commissioners advised that there were challenges with finding time to undertake commissioning activity, as this was new work which was additional to their existing commitments. It appears that although clinicians agreed to undertake PBC and to contribute to WCC, they expected some provision in terms of allocation of time to support these new activities. PCT commissioners reported similar struggles, and considered much of the work associated with WCC as an extra or additional task to the current workload. This was expressed through terms such as 'run ragged' which convey a feeling of weariness or exhaustion with trying to fulfil all the organisational requirements in PCTS. The concept of work related to the WCC policy as being over and above the '9-5' day job suggests that limited provision has been made to support staff in implementing the policy. A reliance on the good will, or the expectation that

staff will take on additional workload, may reflect the existence of a public sector ethos but is unlikely to be sustainable in the long term.

> *"Well it means that a lot of things just had to happen and you know, it was extra for me to do it and it was hard to get the time to do it." (ID8)*

> *"I think people are run ragged really with the day job and a ticknocratic [sic] approach to this sort of thing is not helpful, you know," (ID2)*

As noted earlier in this section, the assurance process appeared to be the most time consuming aspect of the policy which was criticized for taking up '*an enormous amount of senior manager time*,' (ID3). In general, it was evident that time was a precious commodity, and the introduction of the competencies was correlated with an increased number of requirements to satisfy.

Money

Participants voiced two main frustrations with money; firstly a lack of control of available money, and secondly that there was not enough money to fully resource the commissioning agenda. Commissioners advised that additional funding would be required to implement the changes envisioned in WCC. The proposed transformation commissioning on a national scale was expected to require an injection of additional resource beyond that which was currently available. At an organisational level the lack of available money was associated with the financial restrictions of the management cuts as proposed by the 'Nicholson Challenge' (Department of Health, 2009a) which sought to reduce the NHS management spend by £20 billion. Staff anticipated that this financial reduction would not only reduce management spend but would result in health projects being cut too. They expressed dissatisfaction with the Government's presentation of these cuts, suggesting that the savings had been framed to avoid recognitions that services would be cut. Finally participants highlighted that the financial position of the NHS in general, combined with an inability to release resources from acute care meant that there was no money available for developing commissioning and thus participants considered the scope for fully developing commissioning to be restricted.

"I don't think the government's been very honest up until now about how much the cuts will have to be but I think in the last few weeks they've become a bit more open haven't they about the fact that health projects are gonna [sic] have to be cut" (ID8)

"the financial position that you might have hoped for to be able to deliver on this has changed out of all recognition, [...] there's no development funding to do new things either with new money or with money coming out of the acute side, [...] we don't have the cash to do what we want to, to develop things and make a difference." (ID3)

Clearly there is significant interplay between staff, time and money as resources and an investment in one will impact the others. This section has described participants' perceptions that the organisation had insufficient capacity in terms of staff, time and money to full develop commissioning. The following section will present details of the organisational context in order to provide a rich description of the case study environment.

5.4.3 Organisational power

Participants advised that within the NHS system at large, the PCT was not sufficiently powerful, relative to the other organisations, to exert the control necessary to manage commissioning. Further commissioners reported not having the necessary autonomy to commission effectively; the issue of control, in particular with regard to money, was discussed along with issues of power and independence. A lack of control of the available money was also seen to restrict commissioners' ability to improve commissioning outcomes. In particular it was suggested that there was not sufficient local flexibility with budgets for commissioners to allocate money to the objectives which they set out in their strategic plans. Participants advised that the PCT had limited influence over where funds were allocated as money was instantly allocated to issues dictated by the Government. This was particularly challenging when Government directives were considered to be 'London-centric', and consequently not always relevant or a priority issue for the North of England. Challenges were also identified in shifting spend from secondary to primary care, and from acute care towards prevention and public health interventions. Frustrations were voiced with the need to shift more care out of secondary care, this was described as an on-going issue

which had presented challenges for a number of years. It appeared that it was difficult to extract money from secondary care, and participants were sceptical that even if there was a shift in care provision that money would not be released from secondary care. Additionally the transition of money to support preventative and health improvement services was reported as being difficult, as the majority of money is spent on treatment of ill health.

> *"There wasn't the money to spend on the things we'd identified as outcomes that were important, or that were key things in the strategic plan because […] government policy is 'though shalt do', then that's the first call on the money. The local discretion stuff [um] by and large was not funded in the way that we would have hoped." (ID3)*

Control over resources was also considered to be reduced by other restrictions within the commissioning system. For instance the role of organisations such as the National Institute for Health and Clinical Excellence (NICE), which conducts economic evaluation and assesses cost effectiveness of new interventions, was seen to interfere with the autonomy of commissioners to make decisions. PCTs are required to provide technologies and drugs which have been recommended by NICE and participants reflected that '*the impact of NICE has been to increase costs*' (ID3). This was considered to be in tension with the purpose of its role which was perceived to be helping PCTs improve cost effectiveness of commissioning. It was suggested that treatment policies were one of the limited tools available to commissioners to control spend, and that a focus on the clinical threshold for treatment could offer a more effective way to contain costs. The payment by results policy (PBR) was also identified as preventing PCTs from addressing some of the core issues fundamental to the WCC agenda such as the need to deliver fewer services in acute settings. PBR was described as 'payment by activity' and was perceived to incentivise increased activity within the acute sector. Although PCTs were unable to control, or limit this activity, as commissioners they were still liable to pay for it due to the nature of commissioning contracts which had been established on a tariff basis.

"Things that have stopped us being able to save the money are firstly we don't have control over the capacity because that's an FT's* business. If they want to open beds they can open beds [...] and we pay for them at the tariff." **(ID1)** *** Foundation Trust**

The implementation of WCC has been described as being complicated by a burdensome and assessment focussed implementation, a lack of cohesion was identified between policies, and commissioners' abilities to control resources was noted to be hindered by imposed directives, regulatory bodies and unintended incentives.

5.5 Change agenda and locale

Participants raised concerns related to the change locale and the manner in which changes were introduced and developed. This section details participants accounts of an environment of constant change, the perceptions of central control and the challenges managing the NHS political culture.

5.5.1 Constant change

Participants described operating in a commissioning environment which was constantly changing, and in which new and existing policies were not always well aligned and coordinated. When discussing policy, in addition to commenting on the actual policy document, aims and direction, participants frequently remarked on the constancy and rate of change in the policy environment. Participants anticipated a change in government with the next election and wearily expected that this would be an impetus for structural reform.

> *"Everybody that I've ever met and I've been working within the NHS as a non-executive now for over 15 years, seems to accept and expect that the NHS will always be in constant change"* **(ID7)**

> *"I reckon we will see a change of Government with the next election and I'd be surprised if there's not some sort of major structural change again"* **[Field notes 15.04.2010]**

Continual change was seen to impact negatively on PCTs' ability to maintain and sustain focus and momentum in commissioning. Change was often short term and was

seen to generate inconsistent, disruptive patterns of working. Participants described the introduction of new initiatives which were put in the spotlight as '*flavour of the month*' (ID5) and pushed to the top of the agenda for a number of months. This was considered an unhelpful distraction from pursuit of more focused organisational objectives and to the achievement of longer term strategies.

Co-ordination

A further challenge of implementing WCC related to the lack of cohesion and fit with other policy initiatives. Participants suggested that if the timeframes of the other policy initiatives had been better co-ordinated in relation to each other they may have reduced the management burden. For example, in the first quotation below the participant had originally been optimistic that work related to the joint strategic needs assessment could be completed in parallel with that of WCC and submitted to satisfy both sets of requirements. Unfortunately however, a clash in time frames meant that this wouldn't be possible.

> *"but our time frame for doing that wasn't, didn't match the time frame for this, therefore at the point where we needed to say where we were at we couldn't tick that box to say yes" (ID3)*

> *"Locally it's um bedevilled by the fact that the roll out of PBC coincided with the amalgamation of [area name], management structure of the PCTs" (ID8)*

At a regional level, the implementation of practice based commissioning (PBC), which is an element of PCT commissioning and necessary for the fulfilment of WCC, coincided with the amalgamation of management structures between a number of separate PCT sites. This was considered to have negative consequences on the success of PBC, as the PCT was distracted with management revisions and reducing expenditure. This suggests that more diligent consideration of the policy landscape in planning policy may improve implementation by reducing duplication in efforts and thus the administrative burden of satisfying policy.

5.5.2 Central control

It was clear that NHS management was centrally driven and directed from Department of Health. Translation of strategies and initiatives from 'the centre' to the PCT level was identified as a challenge. Participants suggested that the local implementation of WCC and other policies was limited by a lack of local flexibility and freedom to adapt to the requirements of specific local context. This process was considered to be heavily prescribed by the Department of Health and participants expressed a feeling of being inspected and scrutinised, advising '*they need a lighter touch from the centre*' (ID5). Further, central control was identified as detrimental by imposing London based solutions nationwide. This is articulated in the quotation below which describes that although the introduction of 'Darzi Centres' may have been relevant for London boroughs were not appropriate for the North of England. Indeed the blanket implementation of this initiative was considered wasteful as regions in the North have some of the highest ratios of GPs per head of population. The lack of local ability to reject the implementation was considered to be a failing of the national process of policy implementation.

> *"These new (Darzi) practices and that was a classic example of a London problem- a solution to a London problem being posed...imposed on the whole country so we're told we have to have another GP Practice in (area name).We haven't been able to get out of that, we've tried and not been able to get that across the lines of contract. (Same area name) has got the...the highest ratio of GPs, per head of the population of anywhere in the country. Why the hell would we want to put more in? But you haven't got a choice… so there's parts of them that just don't make much sense at all […] you've got to give them all local control on that and if you remove some of the contract allowances we talked about we might end up with very different Primary Care services to meet our needs." (ID1)*

Although central control was evident, participants perceived that central support for implementing WCC was lacking. As part of the national support and development strand of WCC the Department of Health had developed a framework for securing external support for commissioning (FESC). However, a number of participants were not aware this support existed; of those who were aware of it none had actually used it. It transpired that FESC was a cumbersome framework to engage with and that it

was more straightforward to arrange external support independently. This suggests that an implication of high levels of central control may be a lack of engagement, or co-production, with those implementing policies, this may be a helpful consideration for future policy makers.

5.5.3 NHS political culture

It was clear from both observations and interviews that the NHS is situated in a unique political culture, and the case study site was evidently influenced by this political context. In particular the political culture was marked by a feeling of scrutiny and performance management and participants suggested that nothing could be done in the NHS without being turned into performance management. This is reflected in concerns with the implementation of WCC, and the administration of a rigid performance management style assessment process. Participants suggested that the parliamentary politics interfered with strategic direction within the NHS, and advised that previous policy innovations such as the emphasis on a primary care led service had been promulgated '*because the leading politicians needed something to announce*' (ID1).

Further, the political environment was criticised as being unsupportive in the area of disinvestment, and MPs were accused of providing mixed messages. For example PCTs found disinvestment decisions increasingly difficult as MPs both promoted a reduction in spending on acute care, and then supported communities as they campaigned to keep local hospitals open.

> *"In terms of consistency, MPs who they're part of a party that says, we've got to, reduce the spend on acute care, and start to put more money into prevention and local services -who then man the barricades when there's part of the local hospital going to close. They're giving out a mixed message, giving out the wrong message to the public. […] MPs and particularly the Government of the day have got to behave far more responsibly." (ID5)*

These actions were considered contradictory, and in order to commission most effectively, a shift towards prevention and public health spending was deemed required supplemented by a reduction in acute care provision, which may necessitate

the closure of local wards and hospitals. PCT staff appeared to resent the lack of support from the Government when making and implementing such closures.

5.6 Engagement and relationships

The WCC programme, and guidance such as the Operating Framework (Department of Health, 2007c), required PCTs to work with local authorities, community partners, other agencies and the public to undertake commissioning. The main relationships identified by participants based at the PCT case study site were those with: providers, practice based commissioners, the SHA and the public each of which will be discussed in turn.

5.6.1 Providers

Relationships between the PCT and providers, were one of the most prominent mentioned, and often the first that participants referred to. Providers include any organisation that is commissioned by the PCT, for example hospitals, trusts, private sector centres. Interestingly, few of the participants spoke positively about the relationship and readily identified challenges in working together; these related to power and willingness to work together. Of these the key factor interfering with the success of relationships with providers was power. Foundation Trusts were described as strong and established, and having substantial knowledge and expertise. Their powerful status was identified as a source of tension in the working relationship with PCTs, and Foundation Trusts were described as having '*rolled over the PCTs in any negotiations*' (ID7). Participants reported that PCTs were powerless to influence or control activity levels within Foundation Trusts, whilst simultaneously being contractually bound to bear the financial cost of activity conducted by the Foundation Trusts. This echoes the challenges related to a lack of autonomy and control over the allocation of funds, (section 5.4.2). Although personnel were pragmatic about the situation and attributed blame for these misaligned incentives to the system rather than the Foundation Trust in question, this was seen to create a system in which commissioners were powerless in relation to providers.

"I think so long as we have hospitals who can treat whatever comes through the door and charge us for it as commissioners we are not in a position to have a strong – we're not in a position to be strong commissioners because actually the power is all on the provider's side."(ID3)

Participants perceived that Foundation Trusts were unwilling to work with PCTs towards developing stronger relationships. The quotation below uses the analogy of tango dancing to illustrate that in the relationship between the two organisations either can destroy the partnership if they choose, and does not require any co-operation from the other to do so.

It takes two to tango...so the relationship stuff is really important...if you've got two people in a relationship and you decide to destroy it you can destroy it. You don't need the consent of the other person to destroy it you can just ruin it. So for the relationships to be really strong and effective it needs two to tango and ...that's a problem for us with one of our big providers because they don't wish to tango so there are some challenges in terms of how we move from the relationships we have to what we need. (ID1)

Although a dancing relationship may suggest an equality of roles, the perception that a Foundation Trust was able to destroy the relationship highlights the vulnerability of the PCT. It also demonstrates a perceived lack of value in the commissioner- provider relationship, and may indicate a lack of pervasive incentives for Foundation Trusts to invest in developing the partnership.

5.6.2 Practice based commissioners

The relationships between PCTs and practice based commissioners regionally were considered to be variable, and there were was suspicion about the potential effectiveness of practice based commissioning. There was some suggestion that this would distract GPs from their core local population based focus.

The variation, and range in extent of engagement was largely attributed, to the level of enthusiasm and commitment of the practice based commissioner in that area. It was recognised that some GPs had enthusiastically embraced the concept of PBC and were keen on progressing it, whilst others were more likely to wait and follow this lead. The

strength of relationships and management support from the PCT were considered key in facilitating practice based commissioners in advancing this.

"across the region there's a bit of a spread you know, there's some real people who are practice based commissioners who are really keen on taking it forward and [...]there's struggles in other parts of the patch [...] relationships are a key issue you know, that need to be addressed." (ID11)

Although PBC had been introduced prior to WCC competencies those involved in PBC expressed concern that PCT managers were not fully supportive of the PBC initiative, suggesting that the underlying cause for this may be due to uncertainty about the effectiveness of PBC in delivering commissioning benefits. There was uncertainty surrounding the potential of PBC to transform commissioning, and it was noted it hadn't really been tried or tested, and there was no guarantee that the initiative would work, suggesting that scepticism was warranted. The perceived hesitancy about PBC, as a mechanism to improve commissioning, may have impacted the working relationship between PCT commissioners and GPs involved in PBC, as participants on both sides may be less likely to invest in the relationship if they see limited value in the partnership.

"PCT managers must have their doubts about whether practice based commissioning is worth the money or whether it's going to deliver any real benefits." (ID8)

It was also suggested that GPs and commissioners have a different focus, and perhaps are required to do so. When discussing cost and value for money it was suggested that because GPs were focussed on the local populations they treat, and on acute care provision that they would be less likely to consider illness prevention and upstream public health interventions. It was expected that this would create tension in the working relationship, as practice based commissioners may be less open to making the strategic economic changes, and disinvestment decisions that PCTs are required to manage when commissioning.

"You're not expecting GPs who work in primary care who are primarily practitioners, to start to get involved in that kind of scale of change. They're going to be much more focussed on the populations they work with and treat." (ID5)

The extent of engagement between practice based commissioning stakeholders and PCTs appeared to still be in the early stages of development, despite PBC having been introduced in advance of WCC. This section describes a variation across the region of the strength of these relationships and highlights some of the concerns about the usefulness and potential effectiveness of PBC.

5.6.3 Strategic Health Authority (SHA)

As detailed in the background provided in Chapter two, the role of the SHA is to provide strategic regional oversight for commissioning, ensure national directives are implemented and develop plans for improving health services in their local area. The relationship between the SHA and case study PCT site was described as 'light touch' or 'hands off'. Although other comments suggest that these terms may indicate that relationships are not well established and are currently relatively superficial in depth. Despite reporting attempts to work together and co-production of documents, there was an ambiguity surrounding the working relationship, in that the SHA were unsure how they were perceived by the PCT. In the quote below, there is a recurrent reference to the phrase 'on the surface', which may indicate a degree of token role playing, rather than an open and honest working relationship which would indicate a truly collaborative and high quality relationship.

"on the surface we appear to have good relationships, but if you go to [PCT name] and interview them they might say, there's a lack of clarity from the SHA, [...] I mean we've tried to work together, relationships are relatively, or appear to be on the surface, relatively good [...]I'm sure there's frustrations, there's always frustrations in processes, [...] I think they got fed up to tell you the truth, but all we were trying to do was help." (ID11)

The excerpt above appears to be tainted by the intimation of failure, or resignation, through terms such as 'we've tried' and 'all we were trying to do' and was offered in response to a question about internal barriers to achieving successful commissioning.

5.6.4 Public and patients

PCT engagement with patients and the public was endorsed by the Department of Health, which advocated that it strengthens accountability and helps develop relationships with their local communities. The expectation was that this engagement would improve both the quality of patient care and health outcomes. Participants were quick to exhort that efforts were being made to engage with patients and the public. Examples were provided which detailed an organised series of engagement sessions with local communities and use of existing community groups, such as parish councils in order to ensure that there was regular communication with the public.

> *"We've done a lot of work to establish relationships with a lot of different public groups. A lot of parish councils for the rural areas and patient groups and others for service reviews." (ID1)*

> *"We've got a programme of regular engagement sessions with local communities [...]where we can go and engage with, what we think, are some of the key issues, but also we can listen to them about what they think some of the key issues are in relation to health." (ID5)*

The case study PCT site had a directorate specifically focused on public engagement and communications, although this did not appear to be a widespread practice among other PCTs in the region. The quotations above indicate that significant efforts were directed towards attaining engagement with the public. What was less evident however was why this engagement was being undertaken, aside from the WCC directives to engage with patients and the public. In particular what the PCT intended to do with the results from their engagement, in particular if the engagement was intended to inform changes in practice or influence future processes.

5.7 Chapter summary

This chapter has introduced the PCT as the case study site and provided a summary of the data collection and analysis methods employed in conducting Part A of this thesis. The key findings are summarised here with respect to: the WCC policy; the organisational context; the change agenda and locale; and stakeholder engagement.

In general participants did not find the WCC programme to be remarkable. Participants reported that some aspects of the programme such as the identification of discrete competencies required for commissioning were useful. Initially WCC was well embraced by the PCT and it was credited with encouraging organisational reflection on performance and stimulating engagement among Chief Executives regionally. Participants described the policy as focused on the 'what' rather than the 'how'. That is, although WCC identified standards and competencies for commissioning, participants perceived a lack of guidance and support on how to develop these. The WCC assurance process attracted the most criticism, and participants described it as cumbersome to complete and resource intensive. The PCT perceived and approached the assurance process as a 'tick box' performance assessment. They considered WCC to be an additional requirement to an already full workload and identified a lack of resource as a constraint to implementing WCC. Participants perceived the PCT to be relatively powerless within the broader NHS system of stakeholders. Further they perceived the PCT to lack management capacity, particularly when compared to management capacity of Foundation Trusts. Participants identified a need to more fully develop skills and expertise in commissioning and procurement within the PCT.

The commissioning context was notably marked by the national political culture, in particular with respect to political stimulus for change and a constant rate of change. Politically driven changes were perceived as interfering with and hampering the development of commissioning and the NHS in general. A constant pace of change was described as energy draining and an unhelpful distraction. The quality of relationships between the PCT and key stakeholders such as the Strategic Health Authority, practice based commissioners, Foundations Trusts and the public was variable. There appeared to be a lack of unity in common purpose between these stakeholders, and issues such as power differentials, control and historical disputes tainted engagement between them and the PCT.

This chapter provides a snapshot of the case study site in a 'pre-policy change' environment; that is, midway through a relatively stable phase of policy and policy

implementation. This in-depth description introduces and provides context for the case study site and thus sets the scene for Part B of the thesis.

Chapter 6 Part B:1 Results

6.1 Introduction

This chapter reports results from Part B:1 of the research, which entailed a period of observation within the commissioning organisation and the second phase of interviews. Part B:1 was conducted during a period of policy change and is concerned with understanding how the PCT responds to manages changes in health policy. The Health Policy change alluded to here is that of the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010). The introduction of this policy is discussed in depth in Chapter two. The data upon which these results are based were collected during a time of turbulent change in the English NHS. Full details of these changes are provided in Chapter one (section 1.5). By way of recap and in order to situate this part within the policy context, it should be noted that the consultation period which the Government instigated was on-going for the duration of this part of the research. Simultaneous to dealing with the changes in White Paper proposals the PCT was implementing management reductions in order to satisfy the savings required by the 'Nicholson Challenge'. Consequently, a number of staff had been offered redundancy, soon after this the period of observation at the PCT ended.

6.2 Participants

The PCT continued to serve as the case study site for this section of the research, and as with Part A data were gathered from four sources: organisational documents, direction observation (or non-participant observation), participant observation and interviews. This phase of data collection sought to explore individual perceptions and experiences of changes in health policy, and to understand how the PCT manages changes in health policy. The eight factors of receptivity model developed by Pettigrew et al (1992) influenced the design of data collection and analysis methods, specifically interview questions included probes related to the eight factors of receptivity and the thematic analysis was guided by an *a priori* coding scheme based on the Pettigrew (1992) model. This is explained fully in the methods chapter (section 4.6.3). Although the PCT is largely a management based organisation a number of clinicians and GPs

were engaged with the organisation, through PBC or another medical management role. In the presentation of these findings a GP respondent, thus refers to a participant with clinical training who also holds a role at the PCT. Interviews were conducted between 18th August -13th October 2010, and a breakdown by role of interview participants is provided in Table 6.1 below.

Table 6.1 Part B:1 Interview Participants

Phase	Site	Role	Gender	ID
B:1	PCT	Director	M	12
B:1	PCT	Manager	F	13
B:1	PCT	GP	M	14
B:1	PCT	Manager	F	15
B:1	PCT	Manager	M	16
B:1	PCT	Manager	M	17
B:1	PCT	Assistant Director	M	18
B:1	PCT	GP	M	19
B:1	PCT	Manager	F	20
B:1	PCT	Manager	F	21
B:1	PCT	GP	M	22
B:1	PCT	GP	M	23

Through an iterative process of analysis codes were refined by collating or merging codes where categories were similar and by dividing into sub-codes where appropriate. This resulted in 17 codes which were then collated into 10 sub themes and from this four broad themes were generated. These broad themes of policy constitution, political context, local climate and organisational context are presented in Figure 6.1 which also illustrates the sub-themes and codes within each. This figure is followed by an in-depth discussion of the findings.

Figure 6.1 Map of Themes (Part B:1)
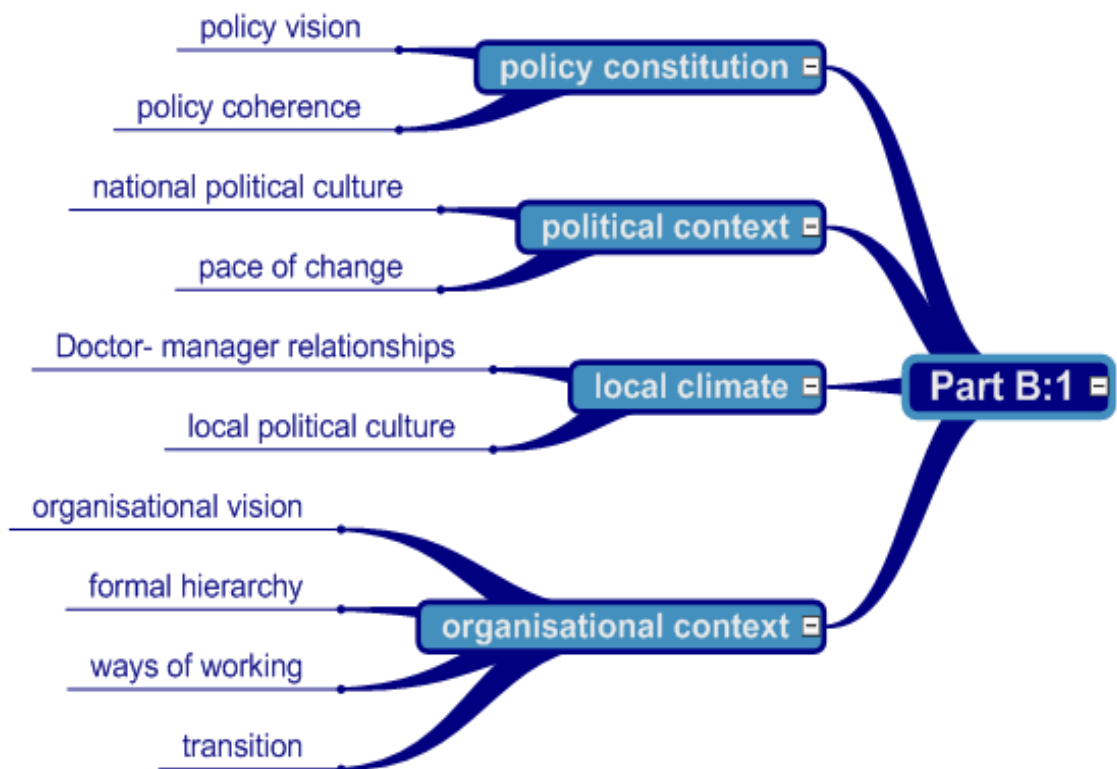
The findings presented here are described in terms of four broad themes of policy constitution, political context, local climate and organisational context. The first theme describes the constitution of the White Paper proposals and participants' perceptions about the vision and coherence of these proposals. The second theme describes features of the national political culture which were perceived to contribute to the context of policy making and to have influenced the content of the proposals. Features relating to the local climate, in particular relationships between doctors and managers are reported along with aspect of local political culture in the third theme. The fourth and final theme describes aspects of the organisational context, such as vision, ways of working and formal hierarchy and aspects related to the changing organisational context during the transitional period stimulated by the policy proposals. The remainder of this chapter describes each of these four themes in turn.

6.3 Policy constitution

Policy is concerned with the social organisational, economic and fiscal context within which it is to be implemented. In the introductory chapter, it was acknowledged that there is frequently a separation between those involved policy making and those responsible for implementing the policy directives. As noted in the background (Chapter two), there was notable to and fro between these two groups during the formulation of and revisions to the White Paper. The proposals were noted to be particularly unusual in the longevity of their progression through parliament and the number of changes, some stimulated by consultations with specifically established forums, which they were subjected to. This section describes policy, from the perspective of those responsible for implementing the policy, as described in Table 6.1. Although the main policy discussed here refers to the White Paper, where participants refer to other on-going policies and initiatives this is explained in the text. Two main areas relating to policy were discussed in participant interviews; policy vision and coherence of policy and these will be described in turn in the following sections.

6.3.1 Policy vision

Policy vision is used here to capture what the aims and goals of the White Paper proposals were perceived to be. As identified in Chapter five, vision tends to deal with the 'what' (aims) of policy rather than the 'how' (mechanisms) and thus, consideration of the mechanisms to deliver the proposals will be discussed in the subsequent section which deals with policy coherence. Participants' reflection on the White Paper vision will be described in three sections of policy fit, feasibility and the extent to which they supported the vision.

Policy fit

A number of participants commented on the fit of the policy with the current health care economy, these tended to consider two issues of 'divergence from existing strategy' and 'timing'.

The divergence from the previous trajectory of commissioning was noted with respect to two main issues related to: an increasing number of commissioning organisations;

and a major structural reorganisation. First, contentions were raised with regard to the formation of new consortia particularly in relation to the number. Participants perceived the shift to GP led consortia (GPCC) would result in a higher number of smaller commissioning organisations. Participants advised that PCTs had previously been actively encouraged to amalgamate into cluster structures in order to improve their commissioning ability and pool their risk. The proposals to form new GP consortia were expected to result in much smaller size commissioning bodies and this was seen to reverse the direction in which local level commissioning had been progressing.

> *"five years ago we were told that all the PCTs […]couldn't manage commissioning or risk on its own and […]had to become an amalgamated management structure because otherwise we couldn't deliver commissioning because we were too small, so the logic of then commissioning smaller groups of GP consortiums I'm afraid is a bit lost on me … I don't understand how those two things match … I don't think they actually do …" (ID19)*

Second the policy proposals were seen to represent a mass structural re-organisation of the NHS which was considered detrimental to the development of commissioning. This was largely opposed on the basis that historically these were costly, increased inefficiencies and compromised patient experience. Given the current period of financial austerity and the NHS ambition to generate cost efficiencies, these consequences were considered contrary to the current aims of the PCT and the NHS at large and thus the participants failed to support the proposal vision.

> *"We know that a major re-organisation will reduce, will result in more inefficiency and worse patient experience, we know that every time there's a re-organisation that's what happens […] I can't quite work out what is going on here." (ID20)*

The timing of the proposals was described as challenging as they coincided with the premature abolition of WCC and with organisational management cuts. Further the proposals directed the abolition of PCTs alongside the development of GPCC and the timing of the transition was considered ambitious as participants anticipated that there would be a gap between PCTs being dissolved and GPCC being fully operational.

Participants described the premature withdrawal of WCC as unhelpful, and this subsequently appeared to influence participants' judgement of the timing of the White Paper. They reported just beginning to develop and make progress as commissioning organisations and stated that they were not '*ready for another dramatic shake up yet* (ID21)'. The policy proposals to dissolve PCTs and to hand over responsibility to new and emerging GP consortia were considered to be inopportune. The timing of the White Paper announcement coincided with the announcement of the organisational restructuring, which was being conducted to reduce management spending in line with the 'Nicholson Challenge' (Nicholson, 2009). At the time of the release of the policy proposals, the organisation was due to release the new interim structure, detailing which jobs would remain for the transition period, and thus participants were still adjusting to internal organisational restructuring as well as absorbing the implications of the White Paper proposals.

> *"the timing is all wrong at the moment because we don't know who the commissioners are never mind we don't know how the GPs are going to commission it, […] they're all changing in this new interim structure […] so while all that is going on it's really difficult to then try and implement a system" (ID 16)*

GP organisations also raised concerns about these changes, highlighting the number of changes they were being exposed to simultaneously, including developing new structures, and working under new contracts. GPs raised concerns about the substantial loss of staff from the PCT and anticipated the loss of support and tacit knowledge as a result of redundancies, management cuts and restructuring. It was suggested that attempting numerous changes simultaneously would be detrimental.

> *"we're going to have a major change, three quarters of the people we work with they're not going to be there any more […] and you'll have a new contract […]all of this bombarding you [...] it's very, very challenging. […] you can't fight on too many fronts – you don't achieve anything. […] you don't start ten wars if you're going to win one" (ID22)*

Participants anticipated that there would be a timing gap between GPCC being ready to take on full commissioning responsibility and the ramp down of PCTs in managing

commissioning. It was expected that GP consortia would take at least six months to a year to develop and be in a position to take on commissioning responsibilities.

> *"there's going to be a gap because the … most of the changes here happen in December and GP commissioning isn't going to be up and running I wouldn't have thought at least six months … a year" (ID19)*

This gap was identified as a risk to NHS commissioning, and was identified as an area of fragmentation in the White Paper proposals.

Policy feasibility

When discussing the policy proposals, a number of concerns were raised about their feasibility. However, it was clear that the policy itself was taking time to be understood and absorbed by staff and as articulated by one participant who noted that it was '*just dawning on staff that this huge change is real* (ID23)'. This may indicate that over time and as the implications of the proposals begin to be realised, further issues of feasibility may be identified. At this stage, issues pertained to funding, capacity and training in commissioning skills.

In terms of funding, the explicit financial provision to 'buy out' clinician time so that they could become involved in commissioning was highlighted as a priority. Failure to do this was predicted to result in chaos. GPs indicated that taking a day out from clinical work has an '*absolutely seismic effect* (ID14)' on the practice and thus the implications of becoming involved in commissioning activities were greater than for clinicians working in hospitals.

The consequences of a lack of funding were directly associated with insufficient human capacity to fulfil the policy requirements. Participants anticipated that the depletion of staff from the PCT during management efficiency savings exercise, voluntary redundancies and those who sought employment elsewhere once aware that the White Paper proposals sought to abolish PCTs, would create significant challenges to delivering commissioning.

"It does feel a bit superficial because no extra resources followed it […] that's going to get worse under the new structure. So it is a difficult one." (ID20)

The PCT were required to fulfil existing commissioning requirements, although extra activity needed to be undertaken in order to prepare and deliver a handover to GPCC. This was described as '*in addition to our day jobs* (ID16)'. For this reason participants noted that the proposals had not achieved buy-in, further they criticised the fact that existing PCT activity was not redressed in order to create capacity for transition activity. It was also expressed that GPCC also had limited capacity to engage for similar reasons and this created a struggle for both parties to engage in handover activities such as training and knowledge translation. In addition to this it was noted that the Strategic Health Authority would not be there to support the transition. Participants were concerned that the Government would be keen to instigate further monitoring and would request extra data to ensure they could quickly identify areas which require remedial action. Concerns about available capacity were also linked to skills and knowledge. Many of the departing personnel had worked in commissioning for many years and their departure marked a significant loss of tacit knowledge accumulated over their period of service.

"Well I think it's the loss of the staff and the risk of the programme not delivering. […] we know we keep hearing about someone who's leaving […] people at grade band six and seven and actually they're the people who've probably been with the service maybe ten years and then they're very, you know, information. We can't manage; we can't recruit anybody now so we've been using agency staff to fill vacancies." (ID21)

A lack of training for GPs to prepare them for the transition into commissioning consortia was also noted to be an obstacle. Participants recounted that training had previously been available to clinicians who had opted to participate in commissioning as practice based commissioners or involvement in the professional executive committee, and contrasted this with the lack of support and training which was available in relation to the White Paper proposals. One participant acknowledged that the proposals make reference to an amount of funding had been allocated for this training, but noted '*we haven't seen it*' (ID23), indicating that this was not yet visible or attainable for implementation. Participants justified these concerns by reflecting on

previous experience and noted that during WCC, clinician involvement in commissioning had not been adequately funded and was described as being conducted *'almost as a hobby'* (ID14) with clinicians expected to find time to be involved in commissioning over and above their existing workload.

Commitment building

The White Paper did not appear to generate buy in from commissioners and other key stakeholders. A number of participants voiced strong objections to the proposals with statements such as '*I wouldn't have done it this way anyway'* (ID19) and '*in five years' time this will be seen as a total nightmare*' (ID13). The perceived failure of the policies to generate commitment from participants can be described with relation to three main issues: the proposals were considered incomplete and required development, the role of managers did not appear to be valued, and the perceived shift towards NHS privatisation.

The incomplete nature of the policy proposals was reported as affecting commissioning decision making and planning, which participants indicated would impact on care provision. Difficulties in making decisions were described and participants advised that they were unable to make some decisions, related to commissioning and service provision, because they did not know who would have authority for those decisions in the future. Recommendations were made to develop the proposals, particularly with regard to the interim transitional period, to minimise disruption to patient care, capacity constraints, and loss of staff and expertise. Participants illustrated the uncertainty surrounding the transition with the phrases such as '*hopefully there is a new form for us*' (ID21), and raised concerns for the future of commissioning if the existing expertise contained in PCTs is lost.

> *"They just need to think very carefully, especially in this interim period while we're going to be losing people and then, and all our most potentially expertise is going to be waning and the capacity is going to be waning as we shift into our new form, hopefully there is a new form for us otherwise things could be very difficult for the consortia if they can't take some of these people with them. I think the SHA needs to think carefully about the ask that they're going to put on PCTs." (ID21)*

It was widely acknowledged among participants that white paper proposals did not value the role of management. The transfer of commissioning to GPs and the removal of the SHA and PCT was expected to make a radical impact which would cast the Government in a favourable light for removing bureaucracy from the NHS. Although participants advised that it would not be possible for the NHS to function. Two layers of management were removed and it was anticipated that these would gradually be reinstated after the restructuring stipulated in the proposals. A number of the press releases and statements by ministerial staff surrounding the White paper did not reflect management and PCTs as valued institutions. This was experienced as particularly destructive and demoralising to the PCT, and the impact on morale contributed to the ability of the proposals to generate commitment and buy-in from participants. Participants reported that people were '*becoming more and more demoralised*' (ID20). It was suggested that this drain of morale was so significant, that in conjunction with uncertainty and the pace of changes that there would be high numbers of applications for voluntary redundancy. This expectation was justified through references to wider media reporting, including newspapers and trade journals which reported estimated percentages of senior management that intended to leave the NHS in light of these proposals.

Reflections on the methods of policy implementation indicated a lack of staff consultation and perceived ownership of NHS decisions, which indicates a top down approach. Consequentially, participants advised that the majority of personnel were resigned to the idea that the proposals had arrived and would be implemented.

> *"People are basically just saying it's here and it's going to happen I'm just going to have to see how it pans out basically but you know I'm sure you have seen the HSJ* and all those you know the various media feeds that are coming through and people are doing polls for people in the NHS and all this sort of stuff, I saw one in the HSJ* the other day 48% of senior management and directors are saying "yeah I'm going to be leaving the NHS". (ID12) * Health Service Journal*

Participants were concerned that the proposals represented a shift toward privatisation of the NHS; this appeared to contribute to the lack of support for the proposals. Despite participants recounting an almost continual rate of change, and

constant reorganisations, the White Paper was perceived as the most drastic. The proposals were noted to invoke an emotional response, with participants sharing their upset and distress at the indication that the NHS would be dismantled and this was the beginnings of the fragmentation of a public service which many had served for numerous years. Participants were aware of the austere economic climate at the time and recognised the need to improve public sector spending. However a few adopted a more, self-confessed, cynical interpretation and suggested that as part of the shift towards privatisation there was a drive to cut spending on public sector pensions and salaries.

"I'm steeped in the NHS and I have been through many reorganisations in the past, I feel that this is the biggest fundamental change that will ever hit the NHS and I'm very very upset at what they're proposing, quite simply because I feel that it's the beginning of dismantling the NHS as we know it." (ID13)

The policy vision was considered fraught by the majority of participants; although there was support for increasing clinician involvement and influence in commissioning, the changes proposed by the White Paper were not considered the most appropriate way to achieve this. In particular participants criticised the timing of the proposals, and voiced concerns regarding the strategic fit of the proposals with existing commissioning policy strategy. Participants questioned the feasibility of the proposals, suggesting that the proposed time frames were overly ambitious and highlighted a lack of skills and capacity to make the transition of GP commissioning consortia. Many participants indicated a distrust towards the Government with their concerns that the proposals had been introduced to progress an unspoken political agenda and marked the beginning of shift to privatise the NHS.

6.3.2 Policy coherence

Policy coherence refers to the articulation of how to achieve the policy vision. It is used to describe the perceived quality of the policy document, both in terms of the explanation of the terms of the policy, as well as the appropriateness of the proposals for the health economy. In discussing policy coherence participants tended to refer to three areas of complication with the policy these are contradictions, articulation and fragmentation.

Contradictions

The proposals were criticised for containing a number of contradictions, these included the involvement of clinicians, (who are also providers) in the commissioning and hence purchasing of services; the freedom new GP commissioners would hold and the increased cost of GP involvement in commissioning.

The concept of involving clinicians in commissioning was seen to be in contradiction to the historical separation of purchasing and the provision of services. This is commonly referred to as the purchaser provider split and was introduced during reforms to the NHS in 1990. Participants reflected on the difficulties which were previously experienced when providers and commissioners had to work together to commission services, advising that the system fell apart because of conflict and alienation. This shift was seen to be in contradiction to the historical purchasing and provision divide, and attracted criticism as it was seen to be a conflict of interests to involve GPs in both the provision of and commissioning of primary care. This shift from provider to commissioner was likened to a 'poacher turned gamekeeper'.

> *"I don't think the people who wrote those policies actually understand what commissioning is and how much it involves and it does sound as though what I'd heard was Andrew Lansley's brother he's very keen on fund holding so he's – you know that was a disaster – that didn't produce good commissioning. That provided, you know, even in terms of cost-effectiveness it wasn't successful, but even in terms of patient experience it was unsuccessful as well." (ID20)*

Additionally, the White Paper was perceived as presenting conflicting messages in the freedom it afforded GP consortia for local commissioning which the PCT did not hold. This appeared to cause upset among PCT participants for two reasons. Firstly, related to the tensions between the PCT and the SHA, as articulated in Chapter five (section 5.6.3). These related to the recognition that the PCT operated under the control of the SHA, who were perceived as regularly intervening in PCT administration. Secondly, they appeared to reflect concerns that the PCT would be branded as having failed in commissioning, and GPs may be hailed as being successful, however this would not be a fair comparison if GPs were permitted more autonomy and flexibility to administer commissioning. However, other participants pragmatically suggested that the

described freedoms were notional and contradicted within the proposals. The quotation below suggests that GPs would be subject to similar restrictions that the PCT face. Specifically the introduction of a commissioning board for the GP consortia which participants expected would fulfil regulatory role similar to that provided to the PCT by the SHA.

> *"the White Paper, it gives conflicting messages out about - they [GP consortia] will have freedoms to determine and make decisions locally when we [PCT] know we don't have those same freedoms […] in the White Paper it's saying that they will give the GPs the freedoms to commission but actually that they will be held to account by the Commissioning Board though we'll have to see" (ID21)*

In addition it was noted that the increased involvement of GPs in commissioning incurred a financial cost: '*if the GPs are managing it, it's going to be more expensive*' (ID20). Participants noted that GPs are more highly paid than existing PCT managers and advised that the transfer of these management activities to GPs would increase costs; this was seen to be in contradiction to the current endeavours of reducing the management budget by twenty per cent. Participants were concerned that this would be counterbalanced by a reduction in the number of commissioning staff. This was also considered to be in contradiction to the widespread opinion that commissioning was currently under resourced, as illustrated by the findings from the earlier Part A (section 5.4.3).

Articulation

The White Paper proposals were considered to be ambiguous and participants had many questions. They expressed requests for a greater level of detail about future commissioning arrangements reflecting that '*nobody knows what GP commissioning is really going to look like*' (ID12). When considering the articulation of the policy, participants discussed two main issues; the link between vision and articulation, and the implications of poorly articulated proposals.

A lack of buy-in from participants was identified in section 6.3.1 because the policy vision was considered vague and incomplete. Similarly, the articulation of the

proposals was criticised for the lack of detail underpinning the policy vision. As the key purpose of policy is to communicate the vision and changes to be implemented, the ambiguity and lack of clarity of the vision subsequently hampered the ability of this to be expressed articulately within the proposals. Some participants suggested that the ambiguity in the articulation of the White Paper proposals was due to uncertainty about the direction of travel; suggesting that this was still subject to negotiation or *'all to be played for at this point in time'* (ID12). Participants perceived that the proposals had not been carefully thought through and described them as *'half-baked'* [Field notes, 12.08.10]. There was a general consensus among participants that the detail to underpin the White Paper would not become available until after the consultation exercise which was being conducted during the period in which this research was conducted.

The implications of a lack of a well-defined and articulate policy were two fold, first that unclear proposals led to a range of interpretations, and second that a lack of direction stunted organisational momentum. The lack of coherence in the policy was evident through variation in participants' understanding and interpretation of the White Paper and its implications for PCTs and GPCC. For instance, some participants expected that PCTs would cease to exist in the future, '*I think everyone has resigned to the fact that primary care trusts won't exist*' (ID16). Whilst others speculated that they would still exist, albeit in an alternative format, to provide commissioning services to GPCC: '*they will need people like us to do what we do now*'(ID20). This disparity in views continued to be noted during the observational work, in particular during an SHA wide event 'designing a system for the future', where GPs and other delegates discussed how to avoid losing the knowledge, skills and expertise resident in the PCT before their demise in 2013. This certainly indicated that they expected the PCT to be abolished and for GPs to take on commissioning responsibility [Field notes, 17.09.10].

Second, a lack of information was considered to have reduced organisational progress and momentum. The ambiguity of the proposals created difficulties at the frontline level, when attempting to make informed decisions about how to develop GP consortia. In particular, the lack of clarity in the proposals about the 'shape' and organisation of new structures was offered as rationale to put on hold any immediate

developments and used to caution against early adoption of the consortia proposals. Participants expressed fears that any organisations developed would have to be dismantled and used these as justification for their hesitancy to engage in the development of GP consortia.

It was evident that the QIPP (Quality, Innovation, Productivity and Prevention) agenda would continue throughout the transition, as indicated by letters for the Chief Executive of the NHS, and its inclusion in the White Paper proposals (Department of Health, 2010; Nicholson, 2010a). As detailed in the background (Chapter, two) QIPP was a project introduced by the Department of Health which focussed on improving quality whilst making efficiencies. So although not a core function of the organisation, the focus appeared to shift to delivering QIPP as one of few initiatives which would prevail until 2015. This may indicate participant preferences to find some stability, in the midst of change, by identifying something which is to remain and focussing attention on that, but also indicates the degree of uncertainty which surrounded many other commissioning activities.

Fragmentation

The White Paper was deemed to be fractured or fragmented in its proposals, which were not considered to fully account for the complexities of the NHS as a system. The practical implications of the scarcity of detail within the White Paper, was highlighted with terms such as *'trying to anticipate'* (ID23) which suggests that participants were grappling to fill in the gaps in the policy. Two main areas of fragmentation appeared to dominate the discussion, namely that of a gap in skills and a failure to address structural constraints.

It was recognised by both clinical and managerial participants that there was a skills gap which would need to be addressed prior to the transfer of any commissioning responsibility:

> *"I think it is important to say that it's a different skill set and it's not a skill set that GPs are taught as part of their education and also ... but equally there's no good career structure or training scheme or leadership hierarchy that GPs can take to lead into commissioning." (ID19)*

Concerns were raised noting that GPs had no formal training on commissioning, as such skills were not included traditionally in medical training and indeed that these skills are inherently different to those required for medicine. Additionally a gap in tacit knowledge was noted, as GPs have limited experience of commissioning and as such will not be as informed about commissioning services or have experience of the numerous skills which make up the commissioning cycle. There were concerns that the need for management input for commissioning was overlooked in the White Paper.

Implementation gap

It was recognised that the White Paper had failed to acknowledge the structural flaws with the commissioning system; these relate to a power imbalance in the commissioning structures, and the constraints of national legislation on statutory organisations. First, power imbalances were identified with respect to the position of Foundation Trusts, and in particular the need for a mechanism to stem demand for health care. These reflect concerns identified during Part A of the research (section 5.6.1). Participants advised that Foundation Trusts held a much more powerful position within the system; they highlighted the perverse incentives of 'payment by results' and reported that PCTs felt powerless to control the flow of patients through Foundation Trusts.

> *"they need to look at the sort of fundamentals of the system that created with FTs, you know, payment by results, 'cause it's not payment by results at all, no […]'cause it's one thing GPs won't even be able to manage the demand but it's another thing FTs then exploiting the number, whatever number of patients they get just to keep their order of accrual." (ID 18)*

Second, incumbent commissioners as NHS staff were potentially protected under a UK employment policy called 'Transfer of Undertakings (Protection of Employment)' (TUPE). This legislation ensures that when a person's employment is transferred from one company to another that they are able to transfer their contract of employment, continuity of service and all statutory employment protection rights. This means the notion of dissolving PCTs and transferring commissioning to new organisations could be problematic, as some commissioners' roles may be protected by TUPE.

"it's one of these things that's really uncertain […] whether TUPE will apply and that depends on how; I mean you'll have a set of people who have generic commissioning skills and then you'll have an organisation that needs commissioners and it does seem unlikely that under employment law as it currently stands you shouldn't be TUPE'd in, but who knows." (ID20)

Issues of coherence were seen to stem from the ambiguous and vague nature of the policy vision as described in session 6.2.2. The coherence of the proposals were generally criticised by participants, and concerns were raised with perceived contradictions within the policy, issues with the articulation of the policy and fragmentation of the proposals.

6.4 Political context

Both the scale and frequency of re-organisation was identified as a challenging feature of the political culture, '*changes are coming round about every three years now for a major re-organisation*' (ID20). The constancy of change was identified as a substantive feature of NHS context. Indeed findings from Part A presented in section 5.5.2 suggested that participants anticipated a major restructuring of the NHS following the general election. The political context will now be discussed firstly with reference to the national political culture surrounding the NHS, and secondly the pace of change.

6.4.1 National political culture

Having a significant system re-organisation on such a frequent basis was criticised as creating organisational instability and disruption. The NHS was reported as experiencing significant structural change on a three to four year basis. This historical pattern was so consistent that it appeared to have become an ingrained expectation and participants accepted it as '*part of working in the public sector basically'* (ID12). Participants criticised the political nature of reorganisation and cautioned that insufficient progress was being made by the health system because of political decision making, election schedules and changes of leadership. The lack of continuity in terms of direction was noted as preventing the system from fulfilling its potential.

"we always have five year plans, government are very good at making five year commitments but they never achieve the five year end stage [...]because with each change in the leadership of the health service come new policies and new direction. Now you know, a big organisation cannot – it's like the tanker, it cannot go in any direction if it's constantly shifting." (ID22)

The political culture was considered detached and brusque in terms of consideration of the practical implications of policy decisions on individuals and their livelihoods. Organisational wide restructuring, meant that Chief Executives had to announce new structures to employees, this process was understandably described as tense, as individuals came to the realisation that their job did not exist in future structures. It was not unusual for participants to have experienced numerous reorganisations in their NHS career and it was evident that the rate of change was a drain on individual morale within the organisation. As a result some participants advised that numerous people were considering whether they were prepared to work through another whole system change again, or if they would prefer to seek alternative employment or apply for voluntary redundancy. Further the drivers within the political culture were perceived to be at odds with the drivers of the NHS. This is illustrated through the terms 'patients' versus 'constituents' in the quotation below, which highlights the contrasting perspectives of doctors and politicians respectively.

"Well my advice is: think it through and commit to a longer term strategy. But think it through, that's the big thing. It's great to go on 24 hour TV with a nice sound bite and it's nice to sort of hammer doctors and it's nice to criticise PCTs [...] the bottom line is if they don't deliver those essential services then you're going to have a massive backlash from your – we call them patients, you call them constituents in politics – and that's something that I think hasn't yet been thought about."(ID22)

This quotation provides further support for the notion that commissioners feel devalued by politicians and policy makers, as discussed in section 6.3.1 which discussed the lack of commitment generated by the White Paper proposals. It also highlights the perception that the policy was rushed and not well thought through, which is described in the following section.

6.4.2 Pace of change

Participants reported unease with the pace at which the changes associated with the White Paper proposals were being administered, in particular as the proposals had not yet received royal assent and so in theory had potential to be revoked. There was a sense that the proposals had been rushed and none of the participants identified the timing as appropriate to introduce system change. Participants identified the practical challenges in dealing with the changes proposed by the policy. In particular PCT staff identified that they were unable to conduct elements of handover to consortia, because consortia had not all formed, and these activities were entirely beyond the control of the PCT. In addition to struggling with the pace of change, participants criticised the change as being too soon.

> *"I think we've just done it too soon, then you end up with a lot of disillusioned managers who then have to try again to pull their socks up and you think well actually we were going, we were heading off somewhere; we were going to really do something good for patients because it's the patient at the end of the day." (ID21)*

Participants acknowledged the importance of progression, continual learning and adaptation. However, they advised that commissioning was just beginning to develop under the previous WCC policy, and that progress was being made until the introduction of the White Paper proposals stalled activity. It was suggested that the changes would lead to managers feeling disillusioned, suggesting that the changes were a set back to the progress which had been underway. They validated this concern by linking it to service performance for patients, intimating that the changes would have negative implications for patients.

6.5 Local climate

In addition to the national political context, there were certain conditions which influenced the political environment at a local level. Participants tended to discuss the local climate with reference to two main themes of: relationships between doctors and managers; and the local political culture.

6.5.1 Relationships between doctors and managers

When exploring the working relationships between managers and doctors, four issues emerged, these were: communication, historical tension, conflicting values, and hybrid clinicians which will each be considered and discussed in turn.

Communication

Participants acknowledged that there was scope for improvement in the quality of communication and engagement between managers and clinicians at the case study site. They reflected that the PCT had obtained their lowest WCCC score for the competency 'engagement with clinicians' in their assessment by the WCC panel: '*it was obviously one of weaknesses in world class commissioning*' (ID16). A number of contributing factors were seen to impact communication, for example one participant related that the leadership style and communication techniques of the PCT Chief Executive were strong but this appeared to be interpreted negatively. It was suggested that this created a barrier to 'connecting' with GPs and was described as a stylistic issue which could be resolved.

Part of the communication and engagement issues could be ascribed to lack of interest and/or inappropriate communication methods. One participant indicated that e-mail correspondence from the PCT was often ignored by GPs. This may have been for a variety of reasons including resource constraints; however the suggestion appeared to be that GPs would rather allow someone else to deal with commissioning issues '*let somebody else get on and do it*.' (ID22). Finally, problems were identified in the lack of common language between parties:

> *"There is a language out there, that people use, but there are so many different dialects in that language that it becomes very difficult for people internally to communicate, and fully understand each other. There's a lack of, of rigour in people really getting to grip sometimes with issues and I think sometimes dealing with them at a very superficial level" (ID18)*

It was suggested that there was a lack of rigour in defining terms and ensuring shared understanding of meaning, which led to a variety of interpretations which created barriers to fully addressing issues.

Historical tension

It was evident that *'relations were somewhat strained'* (ID23) and a number of tensions had developed over the course of clinicians and mangers working together. Over the course of PCT commissioning clinicians had engaged both as providers and commissioners; the latter through practice based commissioning which was introduced in 2005. Much of the tension appeared to be linked to issues of control and blame, with each party having an issue with the other.

The PCT were seen to have exerted a level of control over GPs, and were perceived to be aggressive in their management of GP practices in the past. Grievances against the PCT were voiced by clinicians who recounted historical decisions which left them financially worse off. Participants expressed their dissatisfaction with previous decisions made by the PCT which had negative financial consequences for GPs and specifically practice budgets:

> *"I've no sympathy for the PCT… my practice lost £180,000 recurring every annum due to [name of PCT Chief Executive]'s culling of the PIs budgets which has been chaos I've just taken another £500 a month pay cut you know there is very little sympathy for this building from providers so you'll not get people you know out there saying I want to help these people stay in a job it's just not going to happen." (ID14)*

Although this incident had occurred in the past, it was evident that it influenced relationships and reduced GP trust of the PCT and subsequently the relationship was not immediately conducive to integrated working.

Separate identity and values

Managers and GPs were considered to have separate identities, it was apparent throughout the interviews that each group was associated with different values, attitudes and mind-sets.

As clinicians, GPs were described as having little interest in commissioning, being financially motivated, and poor at team working. Firstly it was perceived that clinicians did not have a strong interest in commissioning, but rather by the nature of their

training preferred to focus on clinical work: '*they're not terribly interested in […] things like commissioning*' (ID19). It was noted that clinicians also perceived commissioning processes to be bureaucratic and time consuming; and these were suggested as disincentives to becoming involved with commissioning.

Second, it was suggested by both managers and clinicians that clinicians were probably financially motivated. This in itself is perhaps not worthy of note if both clinicians and mangers were financially motivated, and thus the suggestion appears to be that clinicians are more financially motivated than managers. Participants noted that clinicians would only participate in commissioning work when they were getting paid. Further there was suggestion that the underlying motivation for early involvement in consortia work was financial. Concerns were raised that in the transition of commissioning services GPs would endeavour to '*cherry pick the good bits*' (ID23) with the indication being that these would be financially lucrative aspects of provision.

Third GPs were described as highly independent, which presented as a source of tension between the PCT and the GPs involved in practice based commissioning as GPs were not accustomed to working under instruction or authority from other individuals. A number of participants used the phrase '*big fish in small ponds*' (ID14) to describe GPs indicating that GPs were accustomed to being powerful personnel within a confined local context. It was suggested that the individual independence of GPs will make it difficult for them to collaborate effectively and agree on united local commissioning decisions.

> *"basically saying that you know this is a recipe for disaster which it is because take the case of GPs as a whole can't agree you know and, and that's just how it is, it's like herded cats and that's a GPs if you give a GP a protocol to work a way around, around it, give a nurse a protocol she'll follow it to the letter" (ID23)*

Managers perceived themselves to be responsible and to have a broad, whole population focus, although clinicians perceived managers to be process driven. First, with respect to the commissioning budget managers perceived themselves as the ones with responsibility for the budget, and considered clinicians to take limited heed of the financial implications of their decisions. The quotation below relays the opinion that

GPs as providers are afforded the freedom to practice without being bound by the financial constraints that guide commissioning. The implication was that management were responsible for having to ration and make priority setting decisions, whilst GPs were able to adopt a more carefree approach to service provision.

> *"I think wholly getting GPs to be responsible for the decisions that they take in their surgeries, to realise that they can't sit there with a blank cheque book and that, you know, they're just sitting there with a blank cheque book writing cheques, they've got to understand that the cheques that they write are being drawn from a limited resource, and I don't think there is that, understanding."(ID18)*

Second, managers perceived their work as having broader implications than that of clinicians, for instance they were more prone to identify public health issues and considered their work to be for public good, and were concerned with values such as leaving a legacy.

Hybrid clinicians

A number of clinicians also held roles which included a higher degree of commissioning involvement, responsibility or management than a traditional full time clinicians. The term hybrid clinicians is used here to describe those who held such a dual role, this includes roles such as practice based commissioning leads, professional executive committee members, PBC clinical directors and medical managers, however does not extend to full time PCT staff that had previously had clinical training but were no longer practising, such as an Executive Nurse Director; these are described as managers. These positions were identified as unique roles, which experienced rejection from both managers, due to their clinical role, and fellow clinicians, due to their involvement with management; this is described below.

It quickly became apparent that these hybrid clinicians were exiled from their clinical colleagues upon becoming more involved with commissioning at the PCT and were perceived by clinical colleagues to be forming an allegiance with the PCT. These participants reported a sense of being stuck in the middle, between traditional clinical colleagues and PCT management. There was speculation from traditional clinicians

that these hybrid clinicians were *possibly feeding the PCT with information'* (ID22). One participant recounted the animosity experienced due to his role as a hybrid clinician, despite having practiced solely as a GP for a substantial number of years. The term 'poacher turned gate keeper' was used to illustrate the perceived betrayal of previous colleagues which has led to this separation and contention.

> *"R: They saw me as a bastard from the PCT*
>
> *I: Even though you'd been GP for twenty eight years?*
>
> *R: Absolutely, I was all that was evil because I was the poacher turned gate keeper"(ID 23)*

It was also suggested that PCT management did not acknowledge the adversity that hybrid clinicians had faced in order to become involved in commissioning, intimating that the role was pursued for reasons of financial gain. However hybrid clinicians rebuked this suggestion highlighting that there are many other more lucrative activities which clinicians could become involved with, and advised that their motivation was to contribute to improvements in commissioning.

6.5.2 Local political culture

The local political culture was clearly influenced by that at a national level, and the pace of change at this level was identified by participants as creating a challenging work environment. Participants recounted that the pace of change and particularly the frequency of new changes introduced meant that much of the organisational energy was distracted to managing the change process rather than implementing changes and developing the system. Participants reflected on their own history and job in the NHS, advising that their organisation had been subject to such constant changes that it failed to achieve sufficient organisational stability to effectively plan progression. The local political culture at this case study site appeared to be particularly marked by two main facets of engagement with other commissioning stakeholders and common priorities.

Participants reflected that prior to the introduction of the White Paper proposals there were limited incentives to encourage clinicians to engage with commissioning. The

local clinical population was portrayed as unenthusiastic in its engagement with the PCT and with other clinical partners. The PCT reported that commissioning involvement was limited to the 'politically engaged GP population'. Regional relationships between the PCTs and other key stakeholders had developed and iterated over time as organisations changed and transitioned between policy changes. A number of tensions in relationships were identified and when explicit examples were provided these held financial consequences. Participants highlighted strained working relationships, and indicated that these were linked to historical events with phrases such as *'they've never forgiven us for It'* (ID20). Working relationships between the PCT and Foundation Trusts were described as tense, and a lot of energy and sensitive management was required to successfully maintain the relationship. It was suggested that challenges were also linked to the health economy landscape in particular the limited number of independent providers, which meant that each was responsible for a substantial amount of provision and consequently had considerable negotiating power when it came to commissioning decisions.

> *"an aggressive management style with them wouldn't work, they'd probably pull the drawbridge up and that would be that […] I think we're in a very difficult position in […] they're two massive providers so it makes it very, very challenging." (ID21)*

There appeared to be a lack of common priorities and participants reported a lack of simplicity and clarity of goals described and suggested that too many organisational objectives created a complicated and fragmented organisational vision. This was also considered a feature of the local political culture regionally between organisations as these were subject to a variety of competing objectives and different agendas. Similarly this resulted in a lack of clarity, and participants advised that it was very difficult to generate a united purpose. An inability to generate cohesive working and to unite on a shared focus was reported as detrimental to organisational health and effectiveness.

> *"just seems to be so many different agendas in the NHS. So much going on that there is a real lack of clarity […] it's still very difficult, to get a collective bunch of people in the NHS to focus on a direction I believe, from what I have seen." (ID17)*

6.6 Organisational context

Organisational context, as used here describes the working environment at the case study site, and in particular within the strategic commissioning team (as described in section 4.5.2).This section considers how aspects of the organisational structure and culture contribute to the working environment and context as experienced by participants. Some aspects of the organisational context appeared unique to the period of transition necessitated by the White Paper proposals and are described as such. When describing the organisational context, participants described four main issues related to: organisational vision, hierarchy, ways of working, and transition these will each be discussed in turn.

6.6.1 Organisational vision

Challenges were identified with relation to the number of organisational objectives, and of the management and alignment of these objectives. It became apparent that a clearly identified and agreed organisational vision for the PCT was lacking, indeed it was suggested that the organisation's purpose, was not widely understood by others including the public. It was suggested that this was a problem nationally for PCTs, and it was suggested both the evolution of the NHS and the expanse of time over which it has existed and developed was one agent in distorting organisational priorities. It was perceived that the NHS has been subject to numerous phases of evolution since its inception, and now contained so many subordinate components that it was difficult to keep track of the role of each organisation.

Within the case study site a superfluous number of objectives and inconsistent management of priorities were considered to cloud organisational vision. When recounting the development of the strategic plan one participant admitted that the organisation had a tendency to specify too many objectives, which was blamed for fragmenting any sense of shared organisational vision. Participants recalled that initial versions of the PCT's strategic plan contained forty initiatives. The number of initiatives was later reduced to seventeen, in response to suggestion from management consultants recruited to review the plan. There was suggestion that the number objectives could have been further reduced to a substantially smaller number

of initiatives. This suggests that a process of considering and prioritising goals and initiatives for the organisation had not been undertaken effectively.

"the original plan was, so you know one mission, three objectives, six goals, seventeen initiatives, and because originally we had forty initiatives and it was just too many […] we could have gone to market with just six or seven initiatives." (ID16)

Participants reported both conflicting individual priorities, managers described a lack of control of PCT priorities as creating challenges for a united vision. Independent priorities were identified as clouding organisational vision, as departments were afforded remit to work on their priority area. As detailed in section 1.1 the number and variety of policy directives, including the announcement of new policy proposals appeared to impact on the organisational focus, distracting attention from the work that was being undertaken successfully. Although participants did not explicitly identify the need for coherent organisational focus, concerns about the detriment of not having a shared organisation perspective were expressed. It was suggested that the implication of numerous different perspectives or foci, was reduction in organisational productivity and efficiency.

6.6.2 Formal hierarchy

There was evidence of a formal and distinct hierarchy between NHS organisations: this was described as beginning with the Department of Health to SHAs to PCTs and in some cases then to GPs and acute trusts. This was depicted as clear hierarchy with a command and control style relationship. This formal structure appeared to be dominated by finance as illustrated through phrases such as holding *'the purse strings'* (ID16). The notion of a relationship based on command and control, whereby instruction from upper levels is obeyed by lower levels was described by numerous participants. This control is illustrated for example, through the use of the phrases like 'jumping to the tune' suggesting that compliance was mandatory, which is further reinforced by the description of the relationship as 'top down'.

"It's difficult to know, but my impression was that the PCT was jumping to the tune that the SHA played it to jump to and that they were jumping to the tune the Department of Health set and it was their process not - it was very top down, it wasn't a bottom up process." (ID19)

This formal hierarchy between NHS organisations appeared to be replicated within the PCT organisation itself from the chief executive to directors, to management staff. Participants discussed this with regard to issues of power and separation within this hierarchy, and with regard to the suitability of the structure for organisational function.   Participants did not perceive this internal hierarchy to be supportive, rather described upper levels as making unreasonable requests from subordinate levels. Participants used interesting language to depict this such as the word 'upstairs' to describe those in authority above them. This helps capture the perception of the divide between levels within the hierarchy, highlighting the perceived power and authority which is held at higher levels and suggesting that the division is distinct. In this instance, the directors in question were physically located on the floor above the participant. In the quotation illustrated below the participant goes on to support their perception with a historical example of a request. This is described as an unreasonable expectation, requested by a senior colleague; the pause indicated at the end of their explanation, appears to illustrate a lack of words to express their feeling and may indicate exasperation with the situation.

"On an ad hoc basis we get a sudden demand for information from somebody upstairs [...] it could be a director or an associate director [...] saying 'by tomorrow please give me three examples of procurements in family care and how they have met the competencies' and you just think (pause)..." (ID20)

Participants raised concerns about the structure of the organisation, with some suggesting that the organisation had too many levels of senior posts. The number of layers of senior management was perceived as levels of bureaucracy and criticised by some. In particular a layer of associate directors between senior managers and directors was considered unnecessary, these senior roles provide strategic input and scrutiny which were senior, and were seen to be costly relative to those employed to do the practical commissioning work. These practical, or operational, commissioning staff identified themselves as competent and motivated and appeared to resent an

additional layer of scrutiny. These reflections were not offered by associate directors themselves and indeed it should be noted that this opinion was held only by those above or below this rank. Others described the PCT organisation as unusual in the number of senior posts for functions usually supervised by less senior levels. It was suggested there was opportunity for this to be reviewed and in particular, director level positions for information and ICT, for communications and engagement and a full time board secretary were cited as roles which might be conducted by lower grades.

6.6.3 Ways of working

When describing how things are conducted at the organisation, there were some values and behaviours which appeared to have become embedded within organisational practice. Participants described organisational habits, values, and behaviours which had become accepted as organisational norms over time. Participants used the term 'ways of working' to describe these behaviours which included, 'eleventh hour working', 'feeding the beast', 'silo working' and 'public sector ethos'.

Participants recounted with some frustration, that everything in the organisation was conducted in an 'eleventh hour' fashion. It emerged that often there were so many issues clamouring for the board's attention, that it wasn't until items reached a critical state of urgency that they were successful in vying for a place on the agenda. It was noted that this approach to working, and managing priorities, created additional work and stress for participants.

> *"because everything became eleventh hour as per usual when you're not an eleventh hour person then it creates a lot of hassle and stress which I found unnecessary" (ID13)*

A large amount of organisation time and effort was described as being absorbed by non- value adding activity. This was frequently described as 'feeding the beast' by participants, and was often attributed to activities such as meetings and providing information outputs to higher levels of the organisational hierarchy. The two concerns raised were firstly that much of this activity is not useful or valuable, and secondly that other activities are being neglected because of the energy which is directed towards

satisfying performance management and reporting requirements. This reflects the notion of a command and control based system, which is identified in Chapter five (section 5.5.2). Concerns were raised by participants that a long term drawback of feeding the beast was that opportunities for creating system change were not being exploited. Participants reflected that because of organisational distraction caused by feeding the beast they had failed to aptly use the presenting opportunities to make sustained organisational improvements. Indeed some suggested that part of the organisational role and vision had been overlooked because of a tendency towards feeding higher levels of bureaucracy had resulted in an introverted management, which had begun to distract from the core driver of organisational purpose.

> *"Services are guilty – or have been in the past – of developing a more introverted management, a management that feeds the higher levels of bureaucracy rather than necessarily looks at what the organisational role and vision is…"(ID22)*

Numerous participants described the notion of silo working, which they reported as prolific among the organisation. A sense of disconnection between directorates was identified as was a tendency to work separately rather than in teams. The term 'silo' was used to depict individuals and groups of individuals working in isolation from each other. Participants acknowledged a lack of free and open communication between the groups and identified that difficulties arose when these were not well networked with each other which created challenges when working across boundaries. The lack of links between silos was considered to have created a gap in organisational effectiveness.

> *"I think we worked in silos […] but the biggest gap from my perspective was the linkages between them" (ID13)*

Participants reported that despite many of the challenges of working in a changing policy environment sufficient motivation among colleagues and the sense of contributing to a public service compensated for this. Colleagues were perceived to share an enthusiasm for their particular area and personal contribution to wider organisational goals and improving population health. It was similarly reported that colleagues were both hard working and committed and this enhanced the working conditions for staff.

"One of the reasons I've enjoyed working for the PCT and stayed with it despite all the disruptions and problems that there've been is because I feel that my colleagues are in the main very hard working, intelligent, committed people and I've never worked in an organisation where there was such a high concentration of high-calibre people and that makes it a good place for me to work." (ID20)

Observations indicated that although many participants appeared to enjoy working in the NHS and had good working relationships with other colleagues the organisational context was marked with a number of undesirable features. Participants described high levels of scrutiny and performance management as well as 'eleventh hour' ways of working, as unhelpful and creating additional pressure in the working environment. Scope to improve collaboration and integration between teams was identified, and current working relationships were described as 'silos'. Despite this participants demonstrated and expressed higher order motivation to improve services for patients, and this has been described as public sector ethos as it is akin to the description of this concept as identified in the literature.

6.6.4 Transition

As noted above, in order to enact the changes within the proposals a period of transition would be required. During this phase both organisations would continue to operate; as GP commissioning consortia would emerge and develop with the support of the PCT which would eventually dissolve. The features which are discussed here appeared to be relevant to the period of transition and not necessarily reflective of the existing organisational context of the case study site. The energy required to manage the change, and maintain momentum amidst the transition was noted to add to the challenges facing the PCT. The issue of managing multiple priorities during the transition was not limited to PCTs, and it appears that GPs were being overwhelmed by a spectrum of stakeholders impressing their commissioning area as a priority. The issues that were raised around the transition were largely to do with uncertainty, power and accountability, and a fear of losing knowledge.

Participants voiced uncertainty regarding a number of functions during this transitional period, '*at this point there are too many imponderables*' (ID12). These were with

regard to issues such as the commissioning of exceptional treatments, and the continued application of the beneficial aspects of WCC. It seemed that a number of issues lacked thorough detail and as such participants were deliberating the operational implications of the new order arrangements and how these could be practically implemented. It was evident that there were numerous issues which participants were finding it difficult to understand or to anticipate how functions might continue in the future. Further uncertainty was created by issues of job insecurity and both the PCT and SHA were noted to be functioning with a potentially insecure workforce; that is many staff had opted to apply for redundancy or employment elsewhere given the demise of the organisations as outlined in the White Paper proposals.

The style of interaction and perception of power between GPs and PCT managers began to change in anticipation of new commissioning arrangements. For example it appeared that GPs were readily afforded greater access to and influence within commissioning meetings and decision making at the PCT. Management were regarded as having become more accepting of the role of GPs in recognising their input and scope to inform commissioning decisions. Clinicians readily noted that there was a higher level of respect and that there was an increase in managers listening to clinician input, this was attributed to a perceived shift in power. However, it appeared that the complexity of commissioning was not immediately apparent to clinicians, who previously had not been involved with commissioning processes or commissioning decisions in conjunction with the PCT. The consequences of increased involvement and responsibility, was seen to be accountability and this was described with negative connotations as illustrated through terms such as *'they're going to be in the firing line'* (ID18). It was evident that a majority of GPs were not fully aware of the work undertaken by the PCT. In response to the new information for GPCC on their roles, responsibilities and statutory duties, one GP asserted *'you know, I have a day job!'* (ID23). This quotation appears to verbalise the GPs ruminations on how GPs might be expected to take on these commissioning responsibilities going forward.

A consequence of the transition which was both anticipated and feared by participants was that of lost learning, that is to say that some of the skills, knowledge and

equipping which had been developed and gained over the course of PCT evolution including through initiatives such as WCC would be lost. It was anticipated that some of this would be at the hand of new GP commissioners, given the combination of their previous lack of engagement with the PCT and their newly devolved power. It was expected that their lack of awareness of the roles and functions underpinning much of PCT commissioning would lead to a sudden and significant reduction in commissioning personnel.

"I think GP commissioners, when they are coming in, need to understand what goes on in this building (PCT) at the minute I mean I came up the stairs this morning and saw lots of people I don't have a clue who they are or what they do. The thinking is I think is that half of it can be just stripped out and not be missed - that's the rhetoric." (ID14)

Redundancies were also identified as a further concern and participants anticipated a resultant loss of tacit knowledge, and experience. The repetition of redundancies seemed to pose significant challenge and to drain the organisation of skills and experience. Additionally, practical challenges and losses were expected during the reorganisation of buildings and personnel during the transition which would serve to further inhibit organisational progress. This would suggest that caution should be exercised with the transitional arrangements.

6.7 Chapter summary

These findings have highlighted the challenges experienced by participants in responding to policy changes. Policy proposals were considered particularly challenging because of the perceived ambiguity of vision and lack of coherence. The proposals did not appear to achieve good buy-in from participants. The implications of the proposals require managers and clinicians to work closely together to ensure an effective transition, it was apparent that these two professions have separate identities, and perceive each other to have different values. Working relationships between these two groups have been shaped and influence by history, in particular conflicts and disagreements and the potential impact of this should be considered, especially when making recommendations to transfer responsibility between the two. The context of the organisation was described as marked by formal demarcation

between groups and to have a formal structure and hierarchy between roles. Some challenges were identified with the organisational vision, and it was reported that there was scope for the organisational focus to be sharpened. It is interesting to reflect that challenges existed both with organisational vision and with policy vision and it may be that the perceived lack of clarity within the wider policy context influenced the vision setting at an organisational level. The change agenda was described as particularly turbulent and strongly influenced by the national political culture. The transitional period proposed during the transfer of commissioning responsibility to GP commissioning consortia was described as fraught with uncertainty and concerns about accountability and fears of losing valuable tacit knowledge were evident.

Chapter 7 Part B:2 Results

7.1 Chapter introduction

This chapter reports results from Part B:2 of the research, which entails the third phase of interviews. Interviews were undertaken with GP Commissioning consortia (GPCC) which emerged as a result of the White Paper proposals. An overview of the progression of commissioning policy leading has been detailed in the background and context section of this thesis (Chapter 2, section 2.5). By way of recap, the major implication of the policy proposals released during Part B:1 of the research was the abolition of the PCT and the transfer of commissioning responsibility to newly formed GP commissioning consortia (GPCC). As a result the interviews for this part (B:2) of the research were conducted with members of emerging GPCC that were formed from practices previously under the management of the PCT.

7.2 Participants

Within the PCT boundary five GP commissioning consortia initially emerged to assume responsibility for the area, which would previously have been commissioned by the PCT. All consortia were invited to participate in the research through their GP lead or chief executive, and three GPCC participated in the research. In analysing and reporting the results to no attempt is made to contrast or make comparisons between the separate consortia. This was for two reasons, firstly the sample size was not considered sufficient to make meaningful comparisons and second these organisations were still in the process of emerging and as such individual features were likely to be fluid and change as they develop.

The interviews explore participant responses to the changes proposed by the Health and Social Care Bill, the formation of GPCC, the transition of commissioning responsibility from the PCT to these emerging GPCC, in order to understand how organisations respond and adapt to policy changes. As members of GPCC the majority of participants had a clinical background, and were working as GPs, however a small number had a management background and held management positions at GP

practices. Interviews (n=11) were conducted between 30th March and 15th June 2011. Interviews were conducted at a location convenient to the participant, in most cases (n=9) this was at a GP practice; however one interview was conducted at the PCT, and another was conducted at a participant's home. As in Part B:1 interview questions included probes related to Pettigrew et al's (1992) eight factors of receptivity. Interviews were conducted between 29th March and 15th June 2011, a breakdown of participants by role and consortia membership is provided in Table 7.1.

Table 7.1 Part B:2 Interview Participants

Phase	Site	Role	Gender	ID
B:2	GPCC 1	GP	F	24
B:2	GPCC 2	Manager	M	25
B:2	GPCC 3	GP	M	26
B:2	GPCC 1	GP	M	27
B:2	GPCC 3	GP	M	28
B:2	GPCC 1	GP	F	29
B:2	GPCC 3	Manager	F	30
B:2	GPCC 1	Manager	F	31
B:2	GPCC 1	GP	F	32
B:2	GPCC 3	GP	M	33
B:2	GPCC 2	GP	F	34

The same *a priori* codes which were developed deductively from Pettigrew et al's (1992) presentation of the eight factors of receptivity model for Part B:1, were used to guide analysis of the interview data in this part. The dual use of deductive and inductive approaches to thematic analysis is explained fully in the methods chapter (section 4.6.3). This analysis generated 27 codes which were then collated into 15 sub themes and from this four broad themes were generated. These broad themes of policy, organisational context, system issues and change agenda are presented in Figure 7.1 which also illustrates the sub-themes within each. This figure is followed by an in-depth discussion of the findings.

Figure 7.1 Map of Themes (Part B:2)
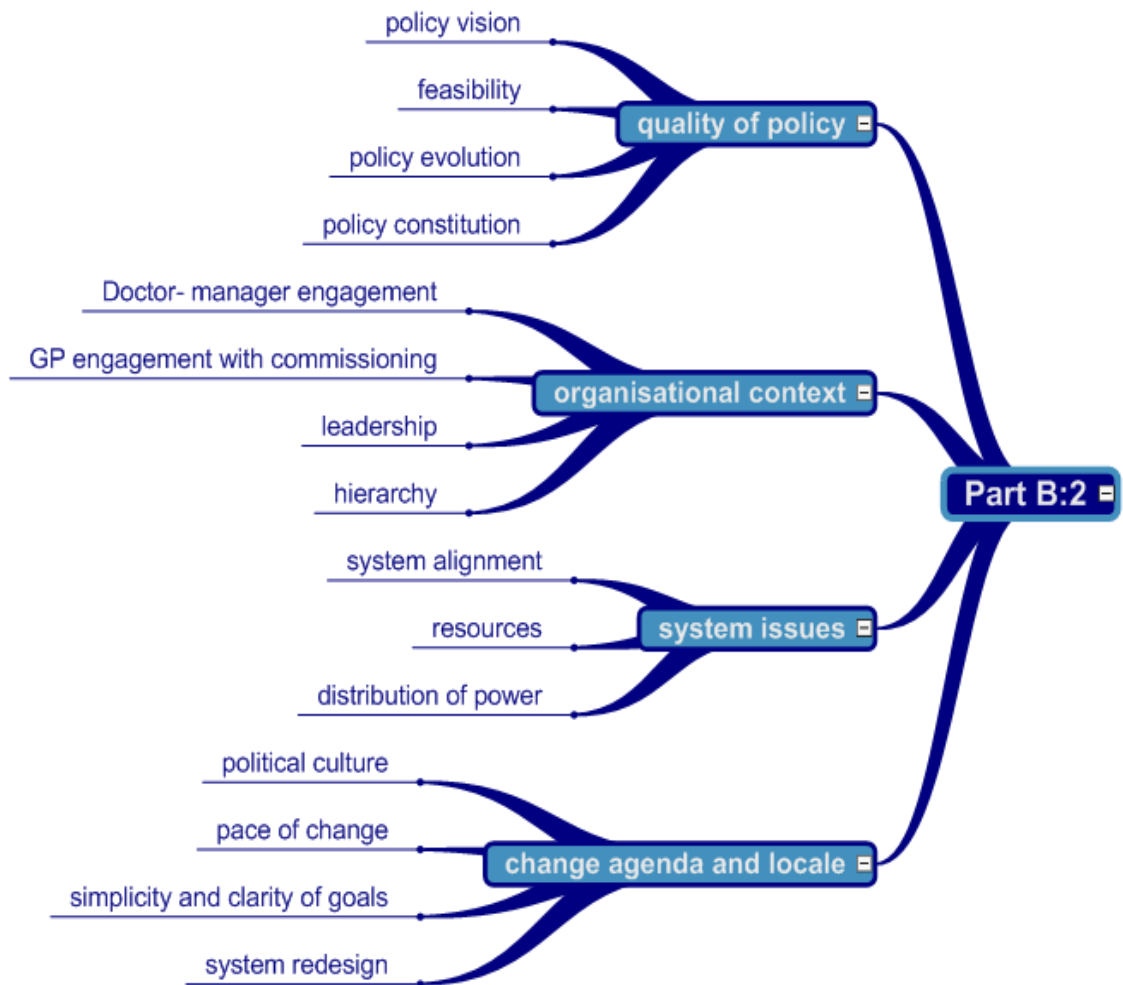
The findings presented here are described in terms of four broad themes of policy, organisational context, system issues and change agenda. The first theme describes responses to the White Paper proposals and describes participants' perceptions about the vision, feasibility, evolution and constitution of these proposals. The second theme describes features of the new organisational contexts which were forming. This theme focuses on issues of doctor-manager relationships, GP engagement with commissioning, leadership and hierarchy. Features relating to the wider NHS system are described within the third theme which considers alignment within the system, resources and distribution of power. The fourth and final theme describes the change agenda and describes key influences including: political culture, pace of change, simplicity and clarity of goals and the need for system redesign. The remainder of this chapter describes each of these four themes in turn.

7.3 Quality of policy

Participants identified both challenges and opportunities within the proposals; a variety of opinions and responses were expressed and this section describes these in terms of policy vision, feasibility, evolution and constitution.

7.3.1 Policy vision

This section presents participants' reflections on and perceptions of the policy vision, that is aims and goals of the White Paper proposals, and early expectations of what the policy may deliver. Opinion on the proposals in general was divided, not just between participants, but participants themselves also expressed mixed feelings. Opinions tended to fall between perceptions of the proposals as a welcome development versus as an unhelpful disruption. Part of this can be attributed to the fact that the policy was wide ranging in its scope, and thus participants who may have expressed agreement with the policy at large, may also express disagreement with discrete portions. Elements of the policy were also considered ambiguous and this naturally impacted participants' ability to either support or refute the proposals.

A number of participants considered the change as a development of the existing structures, with a shift in influence, or as an evolution from current clinician

involvement in commissioning. In this manner they appeared to support the initiatives as a welcome progression describing it as an *'an evolution from practice based commissioning'* (ID27). Others who welcomed the initiative cited their agreement with the shift in accountability to GPs, in particular citing support for increasing the influence of GPs, advocating that as the first point of contact for many patients GPs were well positioned to have more input into secondary care.

> *"Yes largely I think the theory is a brilliant one, because the people who deal with the public day in and day out are the GPs […] the GP is very often the first point of contact, and it does make sense for the doctors, GPs, to have a large amount of input into secondary care."(ID30)*

Despite welcoming some aspects of the proposals, the majority of participants voiced opposition towards the policy proposals. These appeared to be linked with concerns about the abolition of the existing NHS structures, the extent of the reforms and the pace of the change. Participants raised concerns that NHS structures as developed over the last few decades would be destroyed and that attempts to replace this with doctors spending a few sessions a week on commissioning would ultimately fail.

> *"it is an absolute fantasy to think that you can abolish this entire NHS management structure which has been built up over the last twenty to thirty years and replace it with a couple of doctors doing two sessions a week -while they patients the rest of the week" (ID25)*

Further participants were sceptical that it would be possible to hand over commissioning responsibility whilst maintaining and improving frontline services in the midst of management cuts. The proposals were described as unfeasible and too extensive to fathom. Some criticisms of the proposals also contained suggestion that those generating policy were detached from the implementation of commissioning, lacked lived experience of policy implementation and didn't have a full grasp of the policy implications. This indicates a perceived separation between those developing policy and those required to implement it, which is identified by the literature presented in the introduction chapter (Chapter one). Those who had experienced previous structural changes reflected on the effects of repeated reform and the morale drain which such policy regurgitations can create. They criticised the White Paper

proposals advising that they are '*a waste of money and a waste of time and de-motivating again*' (ID33). It was evident that there was some disparity in opinion, and this appeared to be reflective of the wider population, and to echo on-going debates within the broader GP community as participants contrasted their opinion against others, or against the general 'rhetoric' surrounding the policy. Participants noted that other colleagues thought the proposals were excellent and that some were preparing letters to newspapers to this effect and gathering signatures of support, and highlighted their own reservations with the proposals advising that they, personally, felt unable to support most of it. Others contrasted their expectations of how the proposals would unfold with the rhetoric and concerns among the broader population, in particular relating to GP fears about conducting large amounts of administrative work in PCT offices. One participant also highlighted that whilst much of the discussion has been related to GP involvement in commissioning, the introduction of any willing provider, is more likely to cause substantial changes to the system. This reflected opinions within trade and health care literature in general which indicated an expectation that opening commissioning tenders to any willing provider was higher risk, in contrast to existing preferred provider model which favoured bids from NHS services. In particular, concerns were raised about the introduction of numerous new providers into commissioning pathways during transition, and about the role of social enterprises which were considered more vulnerable to the volatile economic climate than established NHS providers. There was an expectation that applications from social enterprises would feature prominently in relation to community services, as these are not sufficiently financially lucrative to entice established private companies to tender.

7.3.2 Feasibility

When discussing the proposals, a number of concerns were raised about their feasibility. These issues largely related to the potential for the policy to create change, and achieve its aims. The majority of participants were able to identify some potential for the policy to create positive change, or at least provide opportunity for improvements to be generated, largely through strengthening clinician involvement and authority in commissioning and decision making. Some areas which were identified as key areas requiring improvement were reducing unplanned care,

improving prescribing and developing community services. A shift in the positioning of GPs, to a role where management support them, rather than working in isolation or in limited consultation with GPs was also considered a useful development in improving commissioning systems.

"I was quite excited by the fact that we could have an input: we could do things differently, we could improve things […] I still feel if it is managed the right way, we have the opportunity to do that." (ID30)

It is worth noting that these quotations relate the potential for future benefits to be generated from the policy, rather than benefits which were being realised. The expectation was that if the policy was implemented effectively, these benefits may come to fruition. Participants raised two main concerns with the feasibility of the policy, and thus its ability to deliver these anticipated benefits; these included concerns about the lack of detail in the policy, and concerns about the implementation of the policy. The White Paper proposed substantial changes to the current operational state of the NHS, however many of the proposals were deemed incomplete or at least shrouded in uncertainty. Participants advised that the proposals created more questions than it provided answers for, and thus significant uncertainty remained around how the policy would be implemented. Participants had concerns regarding the lack of specific detail required to implement the proposals. For instance, it was still not clear how areas like public health would be commissioned, or what the legal process would be to register consortia as statutory bodies. Many of the participants who were optimistic about the potential benefits of the proposals limited their optimism with conditional comments or held it in tension with concerns about the potential negative consequences of the proposals. For instance there were concerns that the counter to positive aspects of competition would be a disorderly collection of services which are not well connected. Thus the service would gather a fragmented collective of low cost services which are not well co-ordinated or connected and fail to work well together. Similarly, counteracting the benefit of increasing GP involvement in the management of commissioning was the risk that adopting increased management responsibilities would cause them to become removed from practice. This would remove many of the benefits of engaging those involved in the provision of care, who have close association with patients in

commissioning decisions by gradually removing them from their initial role and thus qualification for involvement. Participants advised that personnel involved in NHS commissioning were being '*bashed about emotionally, psychologically and financially*' (ID24). It appeared that the implementation of the policy had caused detrimental impacts for current commissioners and the destruction of the existing structures was frequently cited as harmful and imprudent:

> *"I think absolutely its madness […] the Government have just torn apart they literally have taken away, they've set the, the aircraft off and they've taken away the landing pad and they haven't begun to build another one." (ID29)*

The quotation above illustrates one participant's perception that the transition from current practice to new emerging consortia is a particularly risky endeavour. The perceived shortfall in synchronisation of implementation time scales was likened to the removal of the landing pad for an airborne aircraft, by the Government.

7.3.3 Policy evolution

The White Paper was subject to numerous changes, as detailed in the context chapter (Chapter two). Participants did not fully support all iterations of the policy evolution and these changes were considered to be autocratic, iterative, politically charged and failed to achieve buy-in. These four issues will now be discussed in turn.

Autocratic

There was a clear indication that the policy had been imposed upon participants. Some GPs had begun to collaborate as part of a GP federation model proposed by the Royal College of GPs, among others, to improve the provision of patient services and suggested that these developments were somewhat ambushed by the White Paper proposals. Participants reflected that the extent of the proposals were far greater than the original aims of GP federations. Thus a federation which had been designed with a particular aim had been subjected to seemingly unintentional development to consortia to fit the ends of the policy proposals.

"Suddenly our GP federation which had been set up to protect it's group of practices, suddenly became oh by the way you're going to be running the NHS and that caught us quite by surprise because we did not set ourselves up to run the NHS […] I think both of us had this, this model forced upon us involuntarily you see, so there's been a dawning realisation that 'oh my god this is absolutely massive'"(ID25)

Further when other regions were developing consortia they noted additional constraints were stipulated in a top down fashion, in this instance with regard to employment of NHS staff. Consortia were instructed not to employ any NHS staff, with an indication that relevant personnel would be allocated to the consortia in due course. This indicates a degree of top down hierarchy to both decision making and subsequent flow of information. It appeared that participants were familiar with top down initiatives, and there was some suggestion that it was best to conform before being forced to comply, indicating scepticism that an alternative solution to the policy being implemented would be identified. This perception of autocracy appears to relate to the experience of the PCT as described in Chapter five, which discussed issues such as top down control and a formal hierarchy.

Iterative

A further issue was the iterative nature of the proposals and this is perhaps related to the top down nature of the policy. The proposals were noted to have evolved and developed over time and a series of letters and briefings from the Department of Health were used to clarify or build on proposals. Similarly as further documents provided the next stage of information and detail some participants acknowledged worry, as they noted that these updates brought with them a shift away from the original 'freedoms'. The iterations were seen to create conflicts and contradictions, raising questions from participants about responsibilities and freedoms. This seemed to have created some animosity as aspects of the proposals which people were keen to implement were removed in revisions.

"They were wanting (sic) to employ people, but then the paper came out saying actually you're not allowed to employ people [...] so can you do it the way you want to or can't you do it the way you want to? [...] that consortium that was all excited about getting on and employing its own people, its support, its locality and to provide stability into the future you know will have its rug pulled out from under its feet." (ID24)

Similarly the number of iterations added to the uncertainty surrounding the proposals and numerous participants acknowledged the ambiguous policy context, and were undecided about whether or how the White Paper would progress to a bill.

Politically charged

The White Paper proposals were considered to be politically charged and concerns were raised that the extent of the changes may be linked to political agendas or for the sake of change, as a change in government was associated with a need to instigate change. Participants challenged the political rationale of changes such as elimination of the SHAs as regional oversight for commissioning. Participants noted that there was a risk that existing successful elements of commissioning would be overlooked in the drive to achieve radical change.

"because in response to the criticisms about the model, instead of winding it back, the Department of Health and the Coalition Government are actually saying 'oh well what we'll do is we'll make sure, we'll tie these consortia down and we'll make sure that they all have greater accountability and they must do this and they must do that' " (ID25)

Terms in the quotation above such as 'tie down' and 'must do' indicate the perception of authoritarian progression of the proposals. The top down nature of the change was described as being further compounded by Government decisions to continue to progress the proposals, when participants thought it may be more appropriate to revise or withdraw some elements of the proposals.

Buy in

Participants also highlighted particular aspects of the policy which they did not fully 'buy into', three main issues were identified: the removal of a regional level organisation for commissioning, the shift of GP roles toward management, and

consortia membership. Participants who had experienced previous iterations of NHS restructuring challenged the rationale for removing SHAs. Participants advised that previous policy initiatives which had sought to do this resulted in a similar equivalent body being established in due course and explained that the system of commissioning requires certain functions to be conducted at a regional level. The contention about the issue of shifting GPs from their clinical role was largely with respect to two aspects. In the first instance the medical profession was considered vocational in that GPs had spent considerable time becoming medically educated and to divert their time to other activities would likely not be in their interest, and secondly that management of commissioning was complex and requires a certain level of management competencies which wouldn't have been included in a typical GP education. These concerns reiterate those expressed by PCT staff in Chapter six of the thesis.

"I wouldn't like to see it go too far the other way […] if people go into being a doctor in the first place and then being a GP it's because that's the role they want, not because they want to be managing practices and finance and consortia." (ID30)

With regard to consortia membership opinion was divided on whether the initial proposals for GP commissioning or the later amendment to commissioning consortia which would include representation from hospital based clinical staff including nurses was most appropriate. In the first instance it was suggested that GP commissioning was too exclusive and the proposals would have benefitted from wider buy-in among other professionals, however a minority opposed this notion advising that involving wider players who were not gatekeepers of spend in the same manner that GPs were and that wider involvement would create additional work with little added benefit.

7.3.4 Policy Constitution

The findings in Chapter five, discussed issues of policy coherence, firstly in terms of the articulation of how to fulfil the policy vision, which was found to be lacking, and secondly in terms of the appropriateness of the proposals for the health economy. The findings for this part tend to dwell on the latter issue, and consider the constitution of the policy. The constitution of this policy and previous commissioning policies were not considered sufficient to adequately tackle key issues and improve commissioning. To

this end concerns were raised that the commissioning policy to date was not fit for purpose, that it had unintended consequences and that this policy risks reproducing existing system flaws.

Not fit for purpose

Current policy making cycles were considered too short to provide the long term strategy which health care commissioning requires. In particular the need to prioritise preventative initiatives to reduce future health care costs was highlighted. Participants advised that it was not possible to generate the required savings, within such a short time frame. Short term strategies with a focus on current savings were seen to be in tension with the need to invest in prevention which would likely not realise savings in the short term, this was further complicated by an awareness that available finances would not necessarily be available to sustain this.

> *"to me you can't save all this money without doing prevention but you can't save it all in one year you've got to be thinking of five or ten years ahead and I don't know if the White Paper helps us to do that […] we can't just keep doing the same that we are doing now, but it's difficult to see how we could make things different now for ten years' time we have to wait, but the finances are running out." (ID34)*

Others reflected that the costs of running the NHS would continue to rise, and that patient expectations would continue to rise as medicine and technology develop. They noted that this provides a stimulus for a major overhaul, but advised that in the past this has been addressed by bolt on approaches which have not been sufficiently successful.

Unintended consequences

The Government was criticised for its attempt to introduce competition between providers. This was noted to have limited feasibility particularly in regions which had a limited number of providers, and thus the notion of competition was a fallacy which couldn't be realised. If anything, a consequence of the introduction of competition was seen to be 'gaming' and lengthy on-going negotiations with hospitals over nominal amounts of money.

"The market structure that the Government has tried to impose to make us you know to try and get hospitals to compete with services is, it's actually madness and we're forever trying to penny pinch with the hospitals, hospitals are forever trying to squeeze more money out of us, and the gaming that goes on with budgets is stupid, so and so whatever it was set out to achieve it has utterly failed," (ID25)

The collaboration and clinician engagement which PBC structures were intended to establish, appeared to cause frustrations and created animosity between management and clinicians. Clinician freedom to lead and enact initiatives was stifled by opinions from staff at the PCT and SHA. Clinicians were unable to implement initiatives without approval from the PCT as they were accountable for commissioning of services, and delivery of budget.

Repeats existing system flaws

Participants raised concerns about the organisation and alignment of current structures within which organisations were expected to collaborate. In particular, alignment of freedoms, responsibility, accountability and incentives was noted as lacking. The existing management model for PCTs was considered flawed, they were also recognised as being burdened by numerous statutory duties and governance related bureaucracy. The decision to transition this flawed model to newly formed organisations, with the additional requirement of a reduced operating budget was considered impracticable, in particular given the suggestion that the current PBCs were unable to successfully manage their current budgets. It was also highlighted that transition in itself was not sufficient, and that the savings to be generated combined with the reduced operating capacity allocated to commissioning would need to be compensated for, or addressed somewhere in the system.

"The PCT have an awful lot of statutory responsibilities [...] there is an awful lot of bureaucracy involved in that, and to just cut the PCTs by whatever means- whether it's saying you have to cut 40% off your budget or saying you're going to be phased out altogether – somewhere somebody has to take up the slack on that." (ID30)

There were concerns that the new system would essentially be a recreation of the existing system, and that the opportunities for change contained in the proposals

would not be exploited. Participants noted that without significant system redesign the statutory responsibilities, currently satisfied by the PCT, would still need to be completed, and the expectation was that this would fall to the new commissioning consortia. Participants were doubtful that bureaucracy and flaws which prevailed in the current system were adequately addressed by the legislation, and thus conceded that consortia would essentially be the equivalent of the PCTs they replace.

> *"So, if it really is liberating us to do our best for the patients that would be great, but obviously an anxiety is that as soon as the commissioning boards are set up, we'll be just back to square one anyway. And I don't know whether they really mean it or whether they just want to be more controlling but from central" (ID24)*

These concerns were coupled with scepticism about the political rationale for the proposals and suspicion about the drive for central control. Indeed the use of the phrase 'if it really is' in the quotation above suggests that the participant is doubtful that the proposals will actually liberate GPs sufficiently to enable them to overcome the commissioning challenges faced by PCTs.

7.4 Organisational context

Organisational context was discussed with respect to four issues of: doctor – manager engagement, GP engagement with commissioning, leadership, and hierarchy.

7.4.1 Doctor – manager engagement

It was evident that the background and training of GPs and managers was substantively different, and that they each had differences in values and different ways of working. It was clear that GPs and managers had quite separate identities, each had also formed perceptions of the 'other' group and this could be perceived or portrayed as a division. For instance, one participant commented that he was '*very fortunate in that I have equal status with our doctors*' (ID25) indicating that this is not the usual level of status afforded to other managers. GPs in particular appeared to relate to a collective identity and frequently used 'we' or 'us' to indicate that they expected widespread agreement with their comments.

With regard to money there appeared to be a variety of values among GPs, at one end of the spectrum there was a focus on service provision and patient care with limited interest in the budget, to the other end of highly motivated by income and saving money. Participants indicated that some GPs had elected to form community interest groups as these were deemed to have less of a profit motive that the alternative of a limited liability partnership, whilst others noted that practices were frequently aiming to save money. GPs appeared to be used to a fee for service type arrangement and expressed contempt toward the PCT for the expectation that they should adopt an increased workload without additional reimbursement.

> *"I don't think they understand that for us (GPs) doing extra work if it means extra cost is not acceptable." (ID32)*

Despite this variation in expressed values relating to money, GPs noted the need to include wider non-monetary values such as public involvement and quality of care, this was expressed as a representation of participant values, however may also indicate the need to fulfil public expectation of GP values, or to reflect the values of the profession which were expected to include quality, prevention and public involvement. Management also appreciated that GPs were also motivated by non-financial incentives, and being able to obtain status as a not for profit entity was highlighted as one such motivational factor.

Management, and the PCT by association, were perceived to place a high value on complying with guidelines and following process at the expense of outcomes. Participants voiced frustration that managers' anxiety about a commissioning service which currently did not comply with the stipulated provider model would hinder the potential to achieve wider benefits from services. The central drive on fulfilling objectives and abiding by statutory requirements clearly influenced some individuals' perceptions of the PCT and they criticised the PCT as merely completing a 'rubber stamping exercise' and deemed the PCT contribution of little value. It was evident that there was some contention between the disciplines of management and clinicians and one participant suggested that GPs were particularly uncomfortable with overtly business orientated values, as illustrated in the quotation below:

"a number of local practices consider (area name) surgery and myself to be predatory, I think I've actually heard the word used before, because of the fact that we are business orientated you see, and somebody actually once said 'well of course (same area name) surgery has always had a strong manager […] that wasn't said as a compliment, it was like an insult" (ID25)

There was some suggestion that engagement was influenced by the culture and ways of working among GPs and that this would create both challenges and opportunities for the next era of commissioning. GPs admitted that culturally they weren't used to implementing aggressive or unpleasant strategies in order to achieve their desired outcome, and it was anticipated that this would create challenges when working with Foundation Trusts:

"We would have to play real hardball because the FTs do and that's not culturally what we do and I think that's the problem it's not a matter of negotiation, to a degree." (ID33)

However, despite this other opportunities were anticipated from the styles of GPs working, for instance participants predicted that GPs would ensure a focus on the budget, and reducing spend on referrals to ensure that commissioning was undertaken in a cost effective manner.

Historical relationships

The relationships between GPs and managers were described as having been shaped or impacted by history, and historical ways of working. For instance, tension and animosity between the two parties were noted to have been on-going for some time. Areas which had developed better relationships advised that this had not always been the case and that previous negotiation, which had led to reduction in GP pay via contract, had resulted in particularly fractured relationships and considerable efforts had been invested to restore this relationship since.

"We've had good relationships, it's been really- it's not just been luck its 'cause we had a massive problem between GPs and managers in the, when we did the PMS contract negotiations […] I mean that was rock bottom actually. Since then, I think that the PBC leads have been working really hard to improve relationships." (ID24)

This separation was seen to impact communication and working relationships, and it was noted that there was limited dialogue between managers and GPs. More effective dialogue and collaboration was considered a vehicle to more effective decision making which would stand up to audit and scrutiny but which were also clinically informed.

7.4.2 GP engagement with commissioning

The level of engagement of GPs with commissioning and with the PCT, beyond those who held PBC roles, was noted to be poor. Concerns were raised that GPs were for the most part unaware of the challenging business negotiations that underpinned commissioning, indicating that previously any involvement with commissioning was of a superficial nature. It appeared that PBC had not successfully achieved its aims of engaging GPs with commissioning, and it was suggested that this was due to inadequate resourcing of roles at the PCT, staff turnover, lack of PCT commitment and lack of resources to fund clinical time for engagement.

> *"No, it (PBC) was rubbish, it was rubbish. It was just a tag-on. Nobody in PCT cared about it. […] we had about four or five different people over three years, all moving on and it's all just tagged onto their other roles. There was no real commitment to it from the PCT. Not… there was on paper but, but it wasn't a priority." (ID24)*

Reflecting on their experience of engaging with PBC, participants suggested that levels of engagement were superficial, describing them as 'a tick box exercise'. Participants were sensitive to the expectations and requirements imposed on PCTs, noting that considerable time and work was undertaken to supply data to the wider system. It was suggested that existing ways of working were, to an extent, constrained by the current performance management system. This also reflects the perceptions of PCT participants as described in Chapter five.

Given the nature of the White Paper proposals there was a marked increase in the levels of GP engagement with the commissioning agenda and thus with the PCT, in preparation for the transition of commissioning responsibility. This appeared to be largely facilitated by, if not led by the PCT and they widely received favourable feedback from the GP community on their endeavours to educate GPs on current

commissioning processes and functions. GPs understood that PCT staff might reasonably be apathetic towards assisting GPs with the transition, as many may expect to lose their job at the end of the transition. However at large, staff were praised for being supportive, keen to help and commended for ably facilitating GP involvement in decision making. Challenges were presented however, by the fact that many people had already left the organisation, either through obtaining alternative employment or through redundancy and thus it could be challenging identifying the correct staff to contact about certain issues.

Post White Paper, GPs also reported a much higher interest in the commissioning agenda, this was clearly aligned to their new responsibilities as outlined in the proposals and reflected their need to become involved in commissioning decision making and in developing an understanding of commissioning processes. In particular they were keen to begin the shadowing arrangements which were suggested by the proposals, and to see the 'hard end' of negotiations to gain better insight into how commissioning currently functions. As well as GPs having an increased interest in commissioning, it was acknowledged that numerous external companies had also taken an increased interest in commissioning and were reported to be approaching GPs and their emerging consortia, advertising their services and commissioning skills in a bid to gain contracts to work with GPs in the future commissioning landscape.

> *"Well there are endless, external companies, you know touting their wares at the moment, I think the PCT haven't actually done that. But I mean we do see the expertise within the PCT and, and you know perhaps, perhaps going forward these people we have already got established relationships where we already know what they do, we already know the standards of, of work and services and things." (ID31)*

Although an increased interest in commissioning was acknowledged, much of this was directed towards future requirements and a need to increase engagement. It is perhaps worthy of note that although the proposals offered potential for an increase in GP involvement, there appeared to be few people who were keen to take on any formal role. Participants were all involved with GP commissioning consortia and the majority of participants had been engaged in previous guises of commissioning such as PBC, or executive roles with the PCT. This was aptly highlighted within one region

which found that the number of applicants was not greater than the number of positions available, indicating that interest was not yet widespread among GPs who were 'new' to commissioning.

7.4.3 Leadership

Although the policy indicated a two year period for transition, it was apparent that during these two years there was a requirement for the consortia to work with the PCT. The PCT would retain accountability for the budget until the end of the transition period, but GPs and their consortia were expected to take over some of the responsibility for commissioning and decision making during this time, as indicated in the context chapter (Chapter two). This was noted to muddle the role boundaries regarding who would have control of decision making, although some were adamant that GPs would still have the final say on some commissioning decisions.

> *"it's not settled who's in charge is it? It's kind of, its, is it PCTs is it consortia it's kind of both and if they tell us to do stuff that we don't buy into then it's not going to happen anyway- it's not." (ID34)*

Despite this ambiguity, however it appeared that some consortia were working together with the PCT to collaborate and plan the trajectory for the handover of commissioning to consortia.

The eventual transfer of responsibility for the commissioning budget to GPs appeared to absorb much of the initial focus, and participants advised that sensitive leadership was required to manage tension regarding budgets during the formation of consortia. The need to adopt a collaborative mentality which considered amalgamated performance across a group of practices was acknowledged. It was expected that this would reduce condemnation of individual practices and that similar magnitude benefits could be realised through widespread responsibility for small scale reductions across the region. As consortia emerged those interested in taking on leadership roles volunteered or were nominated and elected by colleagues to assume key roles, as demonstrated by the following quotation:

*"So we had a series of nominations seconding and thirding by practices [...]
but we didn't want it just to be a popularity contest and then we had a series
of external interviews, which were, there was a local medical council
representative, county council representative, one of the actual members of
the council was on it [...] and PCT representation. [...] so it was seen as a
hybrid model, so that there was an element of popular mandates for each of
the candidates but there was also a competency based assessment that went
beyond that." (ID27)*

Further, this quotation illustrates an awareness of the need for support or 'buy-in'
from a variety of stakeholders, as well as the need for specific competencies. It follows
that a discussion of leadership within this context related to qualities of leadership, in
contrast to Part A (section 5.4.1) where it tended to relate to structural roles.
Consortia leadership appeared to be optimistic about the opportunity to change and
improve the current commissioning process; they placed a high emphasis on clinical
leadership and patient and public engagement. They were mostly positive about the
opportunity for increased involvement and in particular shaping the commissioning
agenda, and informing future commissioning priorities. Leadership had already begun
to facilitate and engage in discussions regarding setting commissioning priorities and
strategies for collaboration.

7.4.4 Hierarchy

Whilst this section is dealing with organisational context, it was readily apparent that
this couldn't be considered in isolation from the issues associated with being part of
the wider health economy and the existing NHS structures in particular. Although a
subsequent section (7.4) will deal with issues which are explicitly related to the system
more broadly, this section will highlight some of the challenges experienced by the
consortia, which were related to hierarchy and the roles of other stakeholders, in
particular the Department of Health, the SHA and the PCT.

Participants advocated the importance of clinical leadership, but expressed concerns
that the Department of Health had an agenda to have commissioning decisions ratified
by consortia leaders. This was considered a secondary issue to the need for practice
level engagement with the commissioning agenda and to achieve collaboration among

practices. A shift towards an integrated model of leadership which promoted collaboration of personnel and disciplines such as economics and ethics was advocated. However others suggested that hierarchy would prevail in the new structures and noted that considerable energy had been consumed in the formation of a consortium board, and deliberation of its membership.

> *"we will have a hierarchy cause we will have the, the board of directors […] a lot of the work has been about setting up that board and who is going to be on it." (ID24)*

Part of the rationale offered for shifting commissioning responsibility to GPs, was that they are 'closer to the patient'. Whilst participants agreed that better quality engagement with the public was required they advised that this engagement should already have been instigated, and the fact that it hadn't was perceived to be causing detrimental impact to patients' attitudes to service use. Participants considered that public engagement to date had been superficial and politically driven. It was suggested that patients were unaware of the costs associated with provision of NHS service, and of the impact of patient behaviours and actions in accessing services and participating in treatment. Thus participants were keen to generate meaningful engagement about the finite nature of NHS resources and the financial implications of certain patient behaviours. Specifically, the example of prescriptions for Paracetamol was used on more than one occasion, a poignant example because the dispensing cost is higher than the cost of the drug. This was considered to be an issue that should be being dealt with at a national level by the Department of Health; however some GPs perceived it to be thrust upon them to lead on, as it was imminently necessary to raise awareness of this issue:

> *"But also it needs to change from the patients' perspective, which is going to be the difficult bit […] that they don't just walk up to Casualty, that everything isn't free at the point of origin, there is a cost, it may sound free but there's a cost to every consultation they have whether it's here or at the hospital […] I think we're probably going to have to lead it whether we want it or not. I mean realistically that should really be led from the very top, but people have got to have explained to them that there are implications of coming in here for your Paracetamol instead of spending 16p at the chemist." (ID32)*

The existing hierarchy, which would remain during the transition, was noted to be troublesome with regard to the flow of information. Participants noted that personnel at the SHA and PCT had adopted a positive front, given the magnitude and nature of the change. However they noted that the flow of information was not consistent, and attributed this to potential problems higher up in the system.

"With regard to PCT and SHA disseminating information, that doesn't seem to be quite so good. We get emails saying this has changed and this is where we are, but it's, again, it's down to timescale as much as anything else, and higher up than that the information is coming through in dribs and drabs as somebody deems it necessary to let us know that this change is being put in place." (ID30)

The feeling of being at the bottom of a centrally driven change was denoted through the use of phrases such as '*deems it necessary to let us know*' (ID30), indicating that participants did not feel fully engaged with the change agenda, and much of the decision making was being conducted at levels above them in the system hierarchy. This is a particularly interesting, given that earlier findings (section 7.4.1) suggest that clinicians were accustomed to having a higher degree of autonomy and perceived higher status than managers.

7.5 System issues

This section considers issues which were identified as relating to 'the system' this term was often used as a catch all term to refer to issues with the wider health economy, or the interaction between wider stakeholders, and between various policies. Three key issues emerged; these were system alignment, particularly of incentives and penalties, resources in terms of funding, staff and skills as well as the control of resources, and the distribution of power in general.

7.5.1 System alignment

Participants suggested that the structural overhaul proposed by the White Paper was not necessary and advised that many of the commissioning issues could be addressed through creating more appropriate alignment within the system.

"Personally I don't think that it has to be, you know, a complete structural change: I think it's a sort of realigning of, um, incentives really, so I mean, I don't think it has to be a complete start again." (ID28)

In terms of commissioning processes, it was suggested that much of the commissioning performance management had attracted undue focus at the expense of developing commissioning functions. This strongly echoes some of the concerns expressed by managers in relation to WCC, presented in Chapter five (section 5.3.4). Participants indicated resistance to the substantial structural changes which are advocated by the policy proposals and advised that it was feasible to realign incentives and avoid complete structural change.

Poor alignment of incentives within the system was discussed with reference to either particular initiatives or stakeholders. In terms of initiatives both PBC and payment by results (PBR) were identified as arrangements which had failed, or partially failed, because of poor alignment within the system. Firstly PBC was noted as poorly aligned with PCT incentives and it was suggested that increasing GP involvement and responsibility in commissioning created conflict of interests for managers who were effectively doing themselves out of a job. Other explanations as to why PBC had failed were offered and included staff turnover and lack of investment, (section 7.5.2), and conflicting power dimensions (section 7.5.3). Secondly, payment by results (PBR) was considered to create unintended consequences by incentivising activity:

"I think the whole systems out of play in terms of aligned incentives 'cause PBR doesn't align incentives in a way that I perceive a health economy should. You've got the primary care which is in effect a block contract and you've got PBR which is a payment by activity rather than result because it's not a results monitored system and so the incentives between the two aren't in alignment." (ID27)

The contracting processes were considered to be out of alignment with the monitoring processes which measured activity rather than results and were thus criticised for incentivising activity rather and outcomes.

In terms of stakeholders it was evident that the lack of alignment within the current system design meant that actions or decisions made by a number of stakeholders were

not adequately linked to responsibility or repercussions of those decisions. This was described as problematic for GPs, Foundation Trusts, and hospital consultants. For instance, GPs and the GP contract in particular was identified as somewhat removed from the rest of the system, and thus responsibility for tasks including writing GP contracts was contained within their microcosm and thus fell to GPs. This was considered flawed and highlights a lack of accountability within the wider system, neither is there any notable incentive to encourage a construction of a competitive contract. GPs advised that they were not held accountable for their prescribing budget, and noted that neither meeting nor exceeding the budget had any meaningful impact on the practice. Thus aside from a concern for the NHS budget at large, or perhaps a particular interest in cost effectiveness there was no incentive within the system to encourage GPs to moderate their prescribing budget. Others cautioned that this lack of incentives was having detrimental consequences to the NHS, advising that technically GPs can increase their number of hospital referrals thereby reducing their clinical and administrative workload, without any financial penalty to the practice and suggesting this was contributing to the increase in the number of unplanned hospital admissions:

> *"At the minute we (GPs) can do what we want and with impunity really send all of our patients to the hospital and go home which is you know being cynical its happening more and more which is why unplanned care is going up, so that was a way of we changing that around and actually giving general practice a bit of purpose but as I say I'm not sure that that's, that's going to happen still with the way things seem to be going now." (ID33)*

Foundation Trusts were seen to be profit focused and their drive to maximise profits was considered incongruous to the wider agenda of the whole health economy. One particular area of contention was unplanned admissions, and this was attributed to four hour accident and emergency targets for Foundation Trusts which require that patients are seen within four hours. It was speculated that this incentivised unnecessary admissions, which had a significant associated cost.

"the number of unplanned admissions and in this area (area name) is like 48% higher than nationally or something […], I put that down to our Foundation Trust I think it's the way that they code it because everything goes through A&E and so they don't want anybody to be in any A&E more than three hours and fifty five minutes so there is an admission." (ID34)

Other participants were less accusatory of the Foundation Trust, suggesting that a lack of appropriate incentives within the system to promote more appropriate management was responsible for existing practices. It was recommended that processes which required individuals to act in a particular manner for the benefit of the health economy should be made explicit in contracts to ensure compliance. Specific opportunities for cost reduction were identified which included requiring hospital consultants to reject inappropriate referrals. It was acknowledged that in conjunction with contractual measures, education of both GPs and consultants would be required to manage that inappropriate practice.

Alignment in new system

Participants were sceptical that the policy would be sufficient to fully align incentives within the new system and expected that additional alterations would be required. Current funding systems for primary and secondary care were identified as problematic and it was not expected that the policy proposals were adequate to address this. The regulation of the system through guidelines and performance management were also described as a hindrance which stifled freedoms within the system.

"It won't happen till a) you alter the funding system of primary and secondary care and b) you lose this frenzy for performance management and standards, you know the guidelines industry has become a sort of a straitjacket." (ID29)

Others postulated that the comprehensive provision of patient centred care required complete alignment of economic drivers and needs drivers, to ensure that patients were managed well in the most suitable environment. They were not confident that the policy proposals had gone far enough in making this a central focus, and considered this as something which would require development. Similarly the policy proposals provoked a need to restructure through the transfer of commissioning

responsibility to GPs who also have a role as providers. Participants noted that this meant that commissioning would need to be undertaken differently to the PCT, and would require a restructuring of general practice in order to achieve this. The need to implement these changes, alongside developing commissioning skills, and maintaining current provision and access was identified as a challenge particularly given the timeframe allocated for the transition.

Aligning incentives for GPs

Participants highlighted that financial incentives were imperative to achieve GP engagement in consortia and with the commissioning agenda. Thus in developing the new system going forward, participants were keen to ensure adequate incentives were provided to entice and maintain GP involvement in consortia and commissioning.

> *"Some of us are quite keen that it's actually an incentive for the practices to do the work so that we can actually try and get them to do it 'cause if you say 'here's some money for doing it' they're more likely to think about it." (ID32)*

Changes to the GP contract were expected and it was anticipated that these would induce a shift in GPs working priorities. Some regions had already agreed that they would use financial incentives with funding allocated for the transition period to incentivise GP participation with the consortia.

7.5.2 Resources

The issue of resource, and resource use, was raised as a system issue as it did not appear to be contained to one organisation type within the health economy. Resources such as money, staff, skills and data were all explicitly identified; and will be discussed in turn below. However it is worth noting here that the term 'resource' was also used as an umbrella term for any combination of these, similarly catchall terms such as capacity were used indicating that these categories are often interrelated.

Money

Comments relating to money fell into two main categories of; lack of money, and the need to restructure funding mechanisms for the future. Participants perceived that

the system was currently underfunded, they were quick to voice their concerns that there would not be enough money available for commissioning in the next era, and anticipated that the situation would be even more challenging in the future. In fact, lack of money was identified as one of the main challenges for consortia as they prepared for the transition of commissioning responsibility, participants recognised that the NHS did not have sufficient funding to support the level of growth it was experiencing and therefore was unsustainable:

> *"I think the main challenge is there won't be anywhere near enough, there's never enough money but I think there'll be even less." (ID26)*

It was acknowledged that the current methods for funding the NHS contained challenges, and mechanisms such as cost and volume contracts, or fixed funding, were considered to impose restrictions on commissioners' ability to flexibly manage the range and volume of service provision. Participants highlighted that demand for health care was increasing, both through rising public expectations and because of medical and technical advances increasing the breadth of health care treatments. This rise in expenditure was not expected to be matched by an increase in funding, thus viability of future service provision was questioned. Participants expressed awareness that the system would require redesign, however were concerned that this need for change was coupled with a declining economy and waning financial resource.

Staff

A lack of people available to manage the implementation of the policy and in particular the transition was raised as a concern. Issues about availability, and in due course, transfer of relevant skills and a general lack of human capacity were raised as key issues. Given that the White Paper proposed dismantling PCTs by April 2013, many PCT employees had sought employment elsewhere, taken up free-lance roles, redundancy or early retirement:

> *"the people that are totally hacked off, totally cynical, you know those that are taking it, that can have taken early retirement, those that can't have gone free-lance, I think it'll take, well, I suppose it will, I am just fearful we will ever be able to build you know the, be able to get anywhere" (ID29)*

The consequences of this were that GPs had a drastically reduced body to work with for the transition period, and noted that there were insufficient people in place at the PCT to conduct the work required during transition, likening the near empty building to the 'Marie Celeste'.

Skills

There were concerns that the system wouldn't be furnished with sufficient commissioning skills, this was attributed largely to two challenges. Firstly that much of that organisational memory was not being retained and secondly that GPs have not yet developed the necessary skills for commissioning. Organisational memory and tacit knowledge were seen to have been developed with and through staff as the organisation evolved and matured. It was clear that participants supported GP involvement in commissioning and advocated that they were well positioned to inform decision making, and to scope out areas for improvement. However, concerns were raised at the expectation that GPs would conduct commissioning; participants were unsure that it would be a beneficial use of GP time and advised that others were better skilled to undertake commissioning.

> *"So GPs influencing the future of the NHS, yes definitely, GPs running the NHS, no […] they're not furnished with the knowledge to be in charge, the GPs should be managing it with their managers […] between us we have this cobbled together group that really doesn't have quite enough knowledge of all resources to be able to do what is supposedly going to do." (ID25)*

Similarly, certain skills which were deemed necessary for commissioning appeared to be lacking in the existing system, for example disinvestment. This was identified as a skill that would be required for the future of commissioning, given the austere financial climate which consortia were expecting to operate in.

> *"We will have to start decommissioning we have never done that so we will have to stop doing stuff […] I have never seen something stop but I would love to and I think there are things that need to be stopped." (ID34)*

Participants reflected that disinvestment was an activity that had not previously been done in the NHS, and expressed support for effective disinvestment of some services.

Data

Multiple concerns were raised in relation to data and information, these included issues of access, quality, timeliness and interpretation. Participants raised concerns that much of the amalgamation of data at area and regional levels was collated by the PCT, and cumulative data reported back to GPs. It was acknowledged that integrated data was required at these levels to inform commissioning, and provision for that would be required beyond the forecast date for termination of PCTs, and there were concerns about how this function would continue to be provided:

> *"the data that we hold here will be – at the moment, I mean, it is picked up by the PCT and it's put into their different systems […] they do it for the whole of (region name) and probably wider than that. That will have to continue […] in order to get the information that we need there has to be some amalgamation of data across different areas." (ID30)*

Many of the comments relating to money, staff and data describe a perceived lack of resource, however participants also noted that need would always outstrip supply and thus the effective allocation of resources is key in addressing system issues.

7.5.3 Distribution of power

The distribution of power within the current system, both within the existing system and during the transition period, was considered problematic. Three main issues were identified and these are; central control, transfer of power and the opportunity to challenge the existing power base which are discussed in turn below.

Central control

The NHS was described as following a traditional hierarchical organisational model with a marked and explicit distribution of power throughout the system. Central control was seen to sit with Parliament and authority was delegated to each subordinate level through Department of Health, Strategic Health Authorities, PCTs and GP practices sequentially. The White Paper proposed eliminating two levels of this hierarchy to have the Department of Health delegating authority directly to GP consortia. Participants were sceptical that this was feasible and suggested that

Parliament would introduce increased levels of legislation as a means to control and regulate the degree of commissioning autonomy exercised by GPs.

> *"I suspect that what we're going to end up with is a much more sort of heavier sort of legislative stuff of what we're going to do […] because they're not going to want us to stray too far, that's a lot of money to have wandering around the country. So I suspect that they'll probably have fairly strict, […] I think some of it will be centrally driven. I suspect that we'll do that then we'll be able to have freedom once we know beneath that level." (ID32)*

The iterative nature of the policy is discussed in section 7.3.3; participants perceived some aspects of these iterations as tightening of central control, and restrictions on the independence of consortia. Iterations included updates regarding the status of consortia, and advice that they would not be able to employ staff independently of the PCT. These revisions or adjustments to the initial policy proposals appeared to increase the perception of increasing central authority, and terms such as 'the powers that be' indicate that GPs did not consider themselves to be well positioned in terms of driving or shaping the proposed changes.

Transfer of power

The power dynamics featured during the transition from PCTs to consortia was noted as problematic. Participants reported that it was difficult for consortia to become involved in leading commissioning as the PCT retained commissioning responsibility. Other related challenges have been discussed earlier with respect to responsibility and control (section 7.4.4) and role boundaries and leadership (section 7.5.3). This transitional lull was termed a 'hiatus' which may indicate that commissioning activities were perceived as stalled. Many of the comments regarding the transfer of commissioning responsibility related to who was 'in charge' between PCTs and consortia.

> *"The PCT is still running the show and that's the part of the problem in a sense but it's also its necessary because we couldn't do it and we are in this hiatus at the minute," (ID33)*

Participants highlighted the need to work in partnership whilst debating whether the PCT or consortia will be more powerful. Concerns were raised that the consortia will not be able to shape service redesign if the PCT are still controlling commissioning. This notion of challenging the on-going authority of the PCTs reflects the concerns raised around leadership, as in section 7.4.3.

At the time of the White Paper proposals the PCTs were also implementing management cuts, as part of a previous policy initiative, in addition to any reduction in staff they were making as part of the ramp down to transition. Consortia raised concerns that the dismissal and redundancies of PCT staff were being implemented without consultation with consortia. This functioning as separate entities was identified as worrying for GPs as they were unable to influence decisions which had consequences for the remainder of the transition and potentially thereafter.

> *"We went through a very difficult stage when the PCT were shedding lots of staff thinking 'whoa we don't actually have a say in this' and I think we were thinking you know 'we're going to end up where a lot of good staff have gone and who are we going kind of going to be left to pick from?'" (ID31)*

This echoes anxieties regarding the loss of skilled staff as identified in section 7.5.2. Others raised concerns that the transition of control would not be a simplistic transfer from the PCT, noting that the PCT had been instigated and developed as one organisation over time, and the proposals required the amalgamation of a number of smaller established companies, and advised that this was a challenging endeavour.

Opportunity to challenge power base

It was widely reported that Foundation Trusts were the most powerful stakeholders in commissioning. Participants frequently reported instances when Foundation Trusts implemented services and then requested payment in lieu of services, or designed service packages and were unwilling to negotiate on content. They appeared to be in this position of power as there were a limited number of suitable alternative providers and thus commissioners were unable to negotiate better value for money as they were unable to pursue other options for provision. Participants noted that in order to

advance commissioning they would require more detailed dialogue and balanced negotiation with Foundation Trusts.

One participant reflected on the relative stability of the Foundation Trusts, noting that their independent status has meant that they were not subject to the same degree of changes as SHAs and PCTs have been. Loss of organisational memory was identified as an issue for PCTs in section 7.5.2, however Foundation Trusts were noted to have evaded this, and were perceived as dictating terms and conditions of contracts to the PCT and GPs. Participants expressed their concern that neither PCTs nor GP consortia had the skills to challenge these powerful organisations.

> *"The only organisations that have ridden through this without any major casualties are the Foundation Trust management systems, […] they're not having the, the total implosion that the PCTs and the SHAs are having, so they've still got people in place, they've got all the organisational memory still in place and I went to two meetings, […] you really did get smacked in the face with the whole process you see and I came away thinking from that we've got no chance here because in the room there was nobody with the skills to challenge them." (ID25)*

Participants were also aware that although GPs may enjoy good working relationships with Foundation Trusts currently, that this was not an indication that the Foundation Trusts would be less ruthless in their negotiations just because they were now contracting with medical professionals.

In spite of the relative power of Foundation Trusts however, participants were optimistic that the restructuring proposed by the White Paper could be used as an opportunity to challenge the power base of Foundation Trusts. They advised that GPs would be prepared to challenge Foundation Trusts and demand to see contract detail in a bid to achieve value for money. Others attributed some of the power imbalance to a notion that secondary care had the moral upper hand in negotiations. They advocated that as clinicians, GPs would be on a more equal par with the Foundation Trusts, thereby commanding a greater level respect than was afforded to PCT managers and thus potentially better position to offer challenge.

The need to work together in order to improve population health and address public health objectives as well as health care needs was noted by some participants. They suggested that a recent revision to the tariff for acute hospital readmissions could serve as an incentive for Foundation Trusts to work in partnership to manage care out of hospitals and avoid unplanned readmissions within 30 days of discharge. The revision described removed payment at tariff for any patient who was readmitted with the same condition within 30 days of discharge. The expectation appeared to be that more careful consideration would be given to discharge as if the patient returned there would be no financial remuneration and it was envisaged that this would reduce unplanned readmissions.

7.6 Change Agenda and locale

The change agenda and locale was noted to be impacted on by a number of components including political culture, the pace of change, simplicity and clarity of goals. These are each discussed in turn and followed by participants' reflections on the ability of the change agenda to deliver system redesign.

7.6.1 Political culture

The national political culture was described as unstable, with frequent policy changes, reforms and restructuring. The experience of an unstable political arena manifested in a reluctance to act on or commit to becoming involved in certain roles as indicated by the proposals due to a fear that the agenda might be dropped, or change direction suddenly. For others, this instability appeared to encourage their commitment to the policy; this participant noted the need to maintain some continuity of direction and thus considered pursuit of these proposals favourable to the potential of further turbulence and uncertainty. This appeared to be driven by an underlying desire to achieve some level of stability for the NHS, rather than particular support for any specific proposals of this policy.

"For me the fundamental thing is trying to find some stability in the NHS, so we don't have the reorganisation every two or three years, because that's disastrous and nothing happens for two or three years and nobody knows where they are and providers don't know what to do and it's just... disaster. So for me the main thing is trying to have something that will stay and trying to make sure it does work, and that it doesn't all just get pulled to shreds." *(ID24)*

Change in the NHS was acknowledged as being very politically charged; participants suggested that pursuit of a rational change agenda could be superseded by the need to save political face. The national political culture was considered to generate additional uncertainty for the policy, and participants hypothesised about how the political management of the policy would impact the NHS. Participants acknowledged that there was a political agenda to avoid allowing the Secretary of State to appear foolish as well as to not renege on original manifesto statements, such as disbanding the SHA.

Participants thus expressed a level of suspicion and distrust toward the Government, challenging the notion that they could be trusted to act in the best interests of the system. GPs in particular were somewhat cynical that their new position in the system was contrived so as to frame or incriminate them for an anticipated increase in privatisation of the NHS, and for instigating cuts to NHS service.

7.6.2 Pace of change

Part B:1 of the thesis identified concerns among PCT participants that the pace of change was both untimely and hasty, with many activities outside the scope of the PCT as they relied on the formation of GP consortia. Although by the time this part of the research (B:2) was being conducted the majority of GP consortia had begun to emerge, concerns about the pace of change remained.

GP participants considered that organisational changes, establishing consortia and developing the necessary finance skills for managing commissioning would take much longer than the time period allocated within the proposals. The pace of change was considered hurried, participants advised that the timescale was unrealistic and perceived that there was too much to do in too little time. Again, as in Part B:1

participants identified the changes as untimely for a number of reasons: PCTs were noted to be undergoing change, in particular management cuts, as part of a previous policy mandate, and this change was seen to complicate and further add to the challenges of addressing the changes outlined in the most recent proposals.

> *"The PCTs are decimated you know over the last few months then this today presumably there's even fewer of them there and but my understanding is this is the result of the last lot of cuts before the election, this isn't the new cuts […] this is the catch up from the last lots of cuts before the changes that's coming next." (ID26)*

Similarly the suggestion of implementing drastic structural changes at a time when substantial financial cuts were being made was highlighted as an unrealistically high expectation and one that raised significant concerns.

7.6.3 Simplicity and clarity of goals

As noted in the introduction to this chapter, participants were implementing the policy recommendations although they had not yet been approved by parliament and attained status as an Act. As participants implemented the policy a number of concerns developed with regard to the simplicity and clarity of the policy objectives. Three main issues prevailed in this discussion which indicated: a lack of clarity about consortia role and regional responsibility, that GPs were not fully informed about PCT functions and uncertainty about the extent to which the proposals would be revised or executed.

The lack of clarity of goals was also evidenced by the uncertainty that surrounded the proposals; for instance it was not clear how commissioning consortia would function and whether GPs would be commissioning, involved in commissioning or advising others on commissioning decision making. This was seen to be partially optional according to which practice members had an interest in commissioning. Further, there was ambiguity about regional level commissioning functions which were currently being conducted by the SHA, and how these would be undertaken in the future. Participants queried where these functions would be undertaken and by whom, noting

that there was still a requirement for many activities to be organized at a regional level.

It was evident that most GPs were not familiar with the work which was currently conducted by the PCT and thus the transfer of commissioning responsibility was complicated by a lack of awareness of existing commissioning activities. It was suggested that detail related to the downsizing of commissioning organisations, from PCT to consortia was not well explained, and GPs commented that there were still many functions of the PCT which they did not yet understand.

> *"I think the difficulty is that so much is being done by the PCT that GPs are not aware of, have not been aware of, and legislation also needs to catch up with what's going on." (ID30)*

In terms of strategy, participants advised that the policy should have considered the current state of the health economy, the end goal, and mapped out a set of aims to try and achieve the goals. Rather their experience of the policy was of a more muddied nature, this was seen to be inefficient as it was anticipated that many of the features which had been removed would return in virtually the same format. This reiterates concerns which participants voiced regarding the constitution of the policy (section 7.3.4). Participants gave the distinct impression that they did not consider the proposals to be well thought through. Indeed, the lack of decisiveness and turbulence associated with the policy proposals were cited as contributing towards the uncertainty of aims and objectives, with some participants highlighting that they would be surprised if the proposals, specifically the abolition of PCTs, came to fruition:

> *"Since the great, now debate 'oh gosh we've given the GPs all this money, oh we shouldn't have done that', yeah so I think, yeah I'd be surprised if PCTs went altogether now I think that's [...] that would probably be a terrible move, [...] I think to disband them altogether, would be a terrible move however, I think that reducing the PCTs won't have been a bad move." (ID31)*

Again, the need for a complete structural overhaul was disputed and participants advised that there was scope to capitalise on many efficiencies and benefits within the current system, which would have evaded the need to demolish existing structures. This was further endorsed by other participants who were optimistic that the

Government had begun to realise that the proposals were too drastic, and were *'gradually winding it back'* (ID25). This indicates an expectation that the proposals would be revised to be less ambitious in their plans to reform the system.

7.6.4 System redesign

Participants recognised that there was a requirement for changes to the current system for NHS commissioning and raised three main concerns. Participants were concerned that: the Health and Social Care Bill would not achieve this redesign; there was a reliance on changing structures; and that the implications of the proposals may be difficult to contain.

Participants were concerned that the change agenda in itself would not be sufficient to address key challenges to ensure the system is sustainable for the future. A change in philosophy and ways of working were advocated, in particular the with regard to issues of communication and distribution of power between Foundation Trusts and commissioners. However, it was not clear if this was something that the policy proposals attempted to or were well placed to deliver. One of the main challenges currently presented by the system was considered to be control over and effective allocation of resources. In particular the need to consider resources more broadly across budgets was noted along with strategic planning, and disinvestment to ensure that available resources are utilised to maximum benefit. This was not considered to be a key component of the proposals, and participants advocated new ways of working and an emphasis on managing patients in the community as one potential way of improving resource allocation.

> *"My feeling was that we should be looking at the bigger strategic picture which was about you know spending the, freeing up resources and things like that [...] that that whole change in the culture of the NHS would be that was working differently and you know managing more stuff in the community." (ID33)*

The identification that existing processes required improvement led participants to reflect on the historical Government approaches to developing the NHS in general. Participants cautioned that system redesign could not be instigated by changing

structures solely and noted that consideration of operational process and financial flows was also required. Frustrations at the disruptive aspects of the change were voiced as the rearrangements were considered costly and detrimental to the development of the NHS. Participants were keen to maximise the opportunity brought through the proposals to achieve meaningful benefits for the system and exploit the opportunity to change practices for the better. However participants also recognised their reliance on the PCT for knowledge and information related to commissioning. The dependency on the PCT, in conjunction with the steep learning curve in a short period of time was identified as a risk which hampered the ability of consortia to reflect and plan meaningful change. Finally the scope of the White Paper to contain the implications and enactment of the proposals was queried, as participants once again reflected that the policy had been enacted before it had been approved by Parliament.

> *"It's very interesting that a bill has been basically enacted long before it has been through Parliament." (ID29).*

This suggests that the scope to contain the progression of the change was limited. Such that once the policy intentions had been announced, many of the implications were out with the control both of the Government and of the organisations within the change locale. This is particularly interesting as it raises questions about the nature of control, and process between policy making and implementation, which may not be as linear as models such as the 'rational model' (see Chapter one) suggest.

7.7 Chapter summary

This chapter presents the findings from Part B:2 of the research, which captured the perceptions and opinions of the new GP commissioners as they prepared to take on their new commissioning role. Thus this chapter fulfils research objective three which sought to examine the organisational context of a commissioning organisation during a policy change (as introduced in Chapter one). Further, objectives four and five have been achieved through the identifcation of factors influencing the management of policy change and through the application of Pettigrew et al's (1992) eight factors of receptivity model respectively. The findings have been presented in terms of four main issues of policy, organisational context, system issues and the change agenda. These

findings build on some of the concepts identified during Part B:1 of the research, although it should be highlighted that the interviews in this chapter were conducted with a different set of participants from Part B:1. As such although they may reflect shifts over time, they do not demonstrate shifts in perspective amongst the same participant group.

Despite the different organisations researched in Parts B:1 and B:2, some common issues prevailed as the policy progressed and presented in both PCTs and GP consortia. These included issues related to policy, organisational context and the fit of the change agenda with the locale. Issues related to the policy included concerns about the feasibility of the proposals and the trend for short term policy making. The autocratic manner of policy evolution and the politically charged nature of policy making were identified by both B:1 and B:2 participant groups. Discrete identities were described between doctors and managers, and the associated professional values held by both of these groups were noted to have independent values, status and styles of working. The presence of organisational and inter-organisational formal hierarchies and in particular a performance management type approach was noted by both groups. Although the consortia were not fully responsible for commissioning during Part B:2 concerns that this management style would prevail within consortia were raised. The change agenda was considered hurried by both organisations and duration over which the policy was developed created significant uncertainty and a lack of clarity of goals for organisations during the transition period. With respect to the change locale it was apparent that commissioning organisations have historically been subject to regular re-organisation; the magnitude of these proposed changes led both organisations to raise concerns about the potential loss of organisational memory.

The next chapter (Chapter eight) provides an analysis of the collective findings from the case study site and discusses these with reference to the receptivity model proposed by Pettigrew et al (1992) and the wider literature. Chapter eight also presents a new model, devised from the cumulative findings of the case study, to guide organisations in developing receptivity to policy change.

Chapter 8 Synthesis of results and proposal of new model

This chapter presents a synthesis of the findings reported in Part B of the thesis. Two phases of data collection were conducted within Part B (Chapters six and seven) these findings will be critiqued in relation to the receptivity model proposed by Pettigrew et al (1992) and with reference to the wider literature. The overarching findings from these phases as reported in Chapters six and seven will be considered in turn. The findings from each chapter are summarised and compared and contrasted with the factors presented in the Pettigrew et al (1992) eight factors of receptivity model. Four key factors were identified as influencing organisational management of health policy changes, in the context of this thesis. A new model illustrating these factors is presented and these key factors are discussed with reference to the literature base presented in Chapter three.

8.1 Critique of Chapter 6 findings with respect to Pettigrew

Chapter six presents the results from the data collection in Part B:1, which was conducted with the PCT site. Four main challenges to responding to health policy changes were identified, these were concerned with: policy, relationships between managers and clinicians, organisational culture and change agenda. In summary, challenges related to the policy highlighted contradictions in policy initiatives, a lack of feasibility and a failure of the policy to generate commitment among members of the organisation. It was apparent that relationships between managers and clinicians were affected by organisational history, as well as present tensions and differences in attitudes and values. The PCT was a management organisation, although it also had a small number of clinical management appointments that were held by practicing clinicians. These clinicians have been described in this thesis as 'hybrid clinicians' to illustrate their dual role as holding both a clinical position and a level of management responsibility. Consequently they spent part of their working week in clinical practice and part at the PCT. Thus the factor of manger- clinician relationships depicted the relationships between this largely management base, including a small number of these 'hybrid clinicians', and with the wider GP population.

The PCT culture was marked with behaviours and ways of working that were not always conducive to managing policy change. Finally, the change agenda and locale, were noted to be negatively influenced by politicised cultures, in particular between the PCT and Strategic Health Authorities and Foundation Trusts. In order to consider how these factors relate to those proposed by Pettigrew et al (Appendix 1, Figure 8.1) illustrates these factors superimposed unto the eight factors of receptivity model. Pettigrew et al, offer their framework as a dynamic set of eight factors of receptivity to change linked by a 'pattern of association' (1992, p268). They suggest that these elements of receptivity relate to more successful strategic change. In Figure 8.1 the factors of receptivity from the Pettigrew model (1992) are presented in the background in grey, and larger highlighted circles are used to indicate the factors which were most prominent for the case study, and depict the main challenges which were identified and presented in Chapter six.

Figure 8.1 Part B:1 with respect to Pettigrew et al (1992)

It is worth noting here, that no attempt is made at this stage to indicate the direction of relationship between these factors, and thus the patterns of association proposed by Pettigrew et al (1992), remain in the background of this diagram.

8.2 Critique of Chapter 7 findings with respect to Pettigrew

Chapter seven presents the results from the data collection in Part B:2, which was conducted with GPCC, that had begun to emerge in response to the White Paper proposals. Four main challenges of managing health policy changes were identified, these were concerned with policy, organisational culture, change agenda and management of system issues. In summary, challenges related to the policy highlighted concerns about the vision and constitution of the policy as well as challenges experienced by the evolution of the policy. In terms of the organisational culture, GPCC were almost exclusively clinician based; with only a few managers engaged at the time the research was conducted. In these early stages any working relations between managers and clinicians were between clinicians and their practice managers. By definition these were managers who had been selected and appointed by clinicians to work with their practice, and these working relationships were well established. At this stage although clinicians were aware they would need to work with managers, there was some suggestion that this would only be for the handover, 'until the clinicians were able to run commissioning themselves'.

Subsequently the issue of manager-clinician relationships was not central to participants' discussion on the implementation of policy. There was however, some reflection on previous relationships and some comments anticipating future working relationships and thus this aspect was considered to be a sub-factor and has been illustrated as a component of the 'organisational culture' factor. The change agenda was noted to be very politically charged and the locale was marked by a particularly unstable national political culture, the pace of change was considered hurried, and GPCC reported confusion about the clarity of change objectives. These findings are illustrated in Figure 8.2 below.

The three factors of: policy, organisational culture, and change agenda and locale, identified in these results, for GPCC, were also highlighted as prevalent for the PCT. In addition, a further factor which is not included in the Pettigrew et al (1992) model was identified: 'system issues'. This factor was used to capture issues which participants attributed to the broader system of the NHS, this encompassed aspects such alignment of incentives and penalties, distribution of power, and resources. Some of these elements may have some overlap with some of the sub factors identified by Pettigrew et al (1992) for example, within the factors of simplicity and clarity of goals and priorities, and co-operative inter-organisational networks. However, collectively in conjunction with the other data attributed to this factor, they represent the challenges which participants recognised as being inherent in the management of the commissioning system and NHS.

Figure 8.2 Part B:2 with respect to Pettigrew et al (1992)
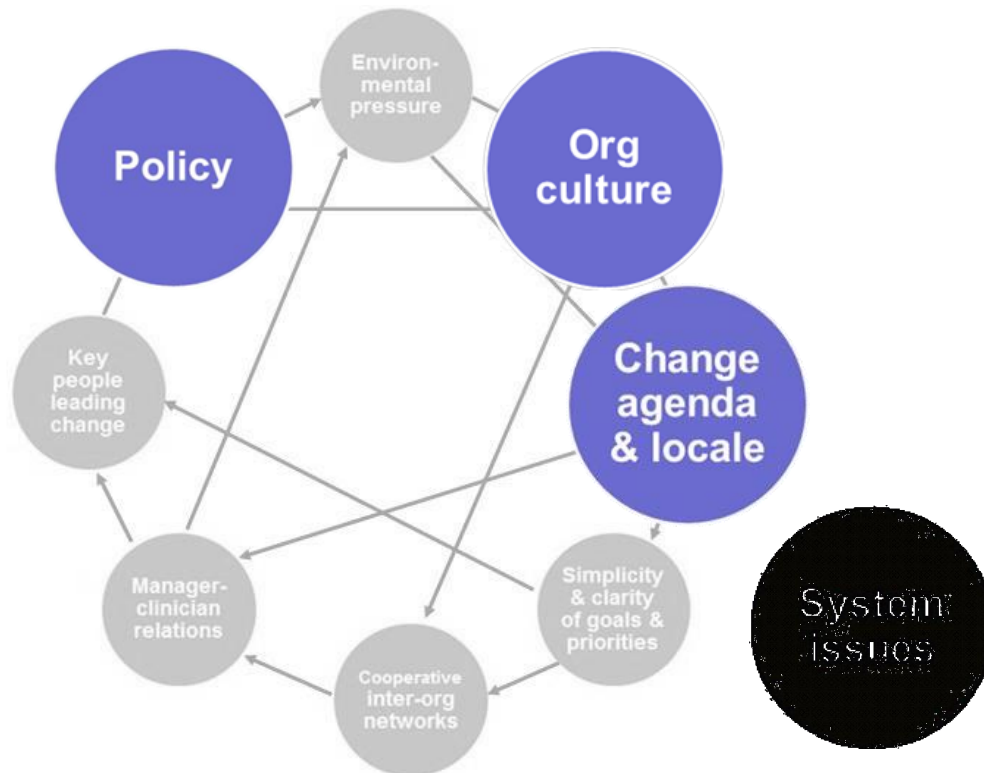
As previously noted, no attempt is made at this stage to indicate the direction of relationship between these factors, and thus the patterns of association proposed by Pettigrew et al (1992), remain in the background of this diagram. The following section explores the factors that were included by Pettigrew et al (1992), but did not feature prominently in the data generated in this thesis, and offers suggestions for why this may have occurred.

8.3 Presentation of new model

A conceptual model is described by Reichel and Ramey (1987) as a set of broad ideas and principles taken from relevant fields of enquiry and used to structure a presentation. The purpose of creating a conceptual model in this thesis was to produce a more powerful or comprehensive model of relevant phenomena than has been previously available in order to highlight the key variables which need to be addressed (Eisenhardt, 1989; Shields and Tajalli, 2006). It is hoped that this will allow the problems associated with managing changes in health policy to be better articulated and understood. The explication of a structure can provide focus to subsequent

research and inquiry, providing a template from which to chart variables and their relationships, thus enabling further insights and a progressive complex exploration into these phenomena (Klein and Zedeck, 2004; Sekaran and Bougie, 2009).

The purpose of this section is to present a new model, which has been derived from a synthesis of the findings from Part B. The model is presented in Figure 8.3. This new model illustrates four factors which influence how commissioning organisations manage policy change. These are: quality of policy, change agenda and locale, system issues and organisational culture. These are briefly summarised here, and are more fully discussed in turn, in the next section. First, aspects of policy vision and coherence were noted to create challenges for leaders and commissioning organisations, the policy achieved mixed levels of buy-in across stakeholders, with many concerned that policy aims were not feasible. Second, the change agenda and locale, in particular the national political culture was considered problematic. Third, a number of issues related to system management; alignment of incentives and resources within the system were identified as challenging. Fourth, the culture of the commissioning organisation was recognised as having a central influence on the management of change; this was impacted by elements such as engagement, history, and leadership. Within each of these factors sub-components which inform the main factors have also been identified, these are illustrated by bullet points in boxes overlapping with the factor they relate to.

Figure 8.3 Factors influencing organisational management of health policy changes

- Coherence
- Vision
- Buy-In
- Feasibility

- Political Culture
- Pace of Change
- Simplicity of goals

Quality of Policy

Change Agenda & Locale

System Management

Organisational Culture

- Resources
- Alignment of incentives
- Power distribution

- Hierarchy
- Engagement
- History
- Leadership
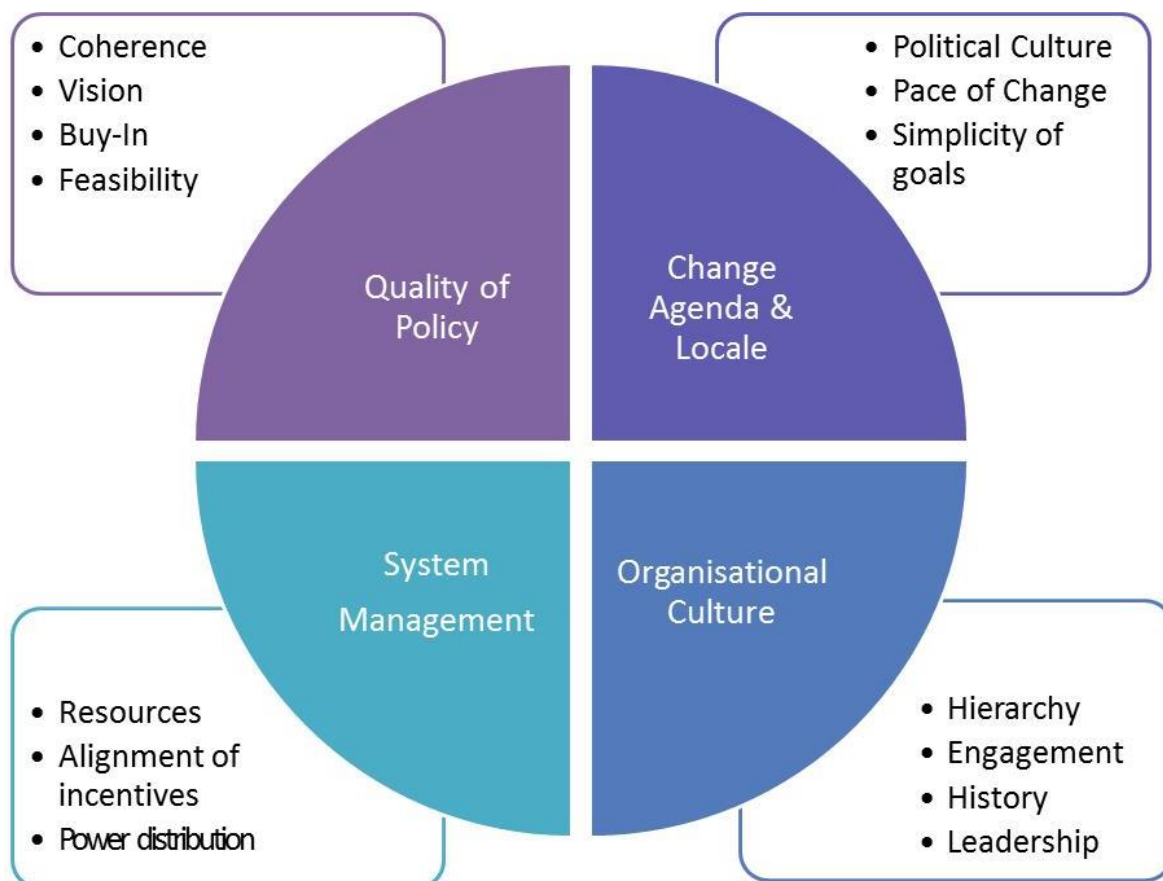
8.4 Synthesis and explanation of factors

The purpose of this section is to present a synthesis of the findings from Part B as summarised above (sections 8.1, 8.2). An interpretive process was used to determine how these findings are related through identification of key concepts and by comparing and contrasting these between the two parts (B:1 and B:2). This process used elements of thematic synthesis, which involves the translation of principles of thematic analytical methods for use in the synthesis of the two sets of findings. This process has drawn on the judgment and insight of the researcher, and has been informed by their role in observing, generating, collecting and analysing the data (Thomas and Harden, 2008). This synthesis offers an overarching interpretation of the findings and provides a fully integrated description of key concepts identified in this research as influencing how commissioning organisations manage policy change. Similarly in generating these conclusions and considering the implications for the research questions, verification and conclusion drawing processes as described by

Miles and Huberman (1994) and Berkowitz (1997) were employed to ensure sturdiness of conclusions. These techniques have been detailed in the methods chapter (section 4.8).

The purpose of this model is not to provide a definitive or restrictive list of all the criteria which must be addressed in preparing health care organisations to respond to policy changes. A conceptual model is intended to assist the researcher to develop awareness and understanding of the situation under scrutiny and to communicate this. A clearly articulated conceptual model provides a flexible framework which itself can be scrutinised, tested and refined with further cycles of investigation and study (Guba and Lincoln, 1989). This model has the potential to guide consideration of challenges and barriers which may present to the organisation, thus acting as a stimulus to enhance management of policy change by commissioning organisations. Additionally some of the criteria may be out with the control of management, but awareness of their state and any potential influence they may have on the organisation may be helpful.

The new model presented in Figure 8.3 illustrates the major factors which were identified as the four most salient issues affecting the management of policy change by commissioning organisations, in the context of this thesis. This section will describe the four main factors in turn, and discuss these findings with reference to the studies by Newton et al (2003) and Stetler et al (2009). A description of these two studies is provided in section 3.4.2. By way of recap, the study by Newton et al (2003) retrospectively applied the Pettigrew et al (1992) model to data evaluating a pilot of personal medical services at a general medical practice in the UK. The study by Stetler et al (2009) applied the eight factor of receptivity model (Pettigrew *et al.*, 1992) along with the essential dimensions of change identified in earlier work by Pettigrew et al (1991) in their USA based study which sought to evaluate quality improvement through institutionalization of evidence based practice. This study compared two contrasting sites, one high performing, role model site, and one low performing, beginner site. When making reference to this study comparisons are made with the high performing site as this site indicated higher levels or receptivity. For ease of comparison Table 8.1 summarises the level of salience or importance, as identified by

the studies conducted by Newton et al (2003) and Stetler et al (2009), and reported in this thesis. This is followed by a discussion of each factor which draws on wider literature, and describes the comparative salience with the findings of each of the other two studies.

Table 8.1 Summary of findings of factor importance

Factor	Qualitative level of importance of factor as identified by:		
	Stetler et al (2009)	Newton et al (2003)	Thesis
1. Quality and coherence of policy	***	***	***
2. Key people leading change	***	***	**
3. Environmental pressure	*	*	*
4. Supportive organisational culture	***	**	***
5. Manager- Clinician relations	***	**	**
6. Co-operative inter-organisational networks	*	**	**
7. Simplicity and Clarity of goals	***	**	**
8. Change agenda and locale	*	*	***
System management	N/A	N/A	***
Key:*** high importance; ** medium importance; *low importance			

8.4.1 Quality of policy

Policy was identified as a key element influencing receptivity to change in both the studies by Newton et al (2003) and Stetler et al (2009). In this thesis participants advised that policy proposals were not clear or explicit and lacked detail, with many aspects requiring further explanation, particularly with respect to operational aspects of implementing the policy. In part A participants described challenges related to the quality of the policy, in terms of appropriateness of WCC for PCTs, and its coherence in terms of alignment with other policy objectives. Participants felt that the policy was ambitious and they did not expect the policy to fulfil its aims within the prescribed time frame. Participants also advised that the WCC policy provided a lack of guidance on implementation, there was some hesitancy that WCC would generate benefits. These factors in conjunction with the experienced administrative burden of

performance management aspects of the policy limited the level of buy-in achieved by the policy.

In Part B, the quality of the White Paper proposals were discussed mainly with reference to issues of vision and coherence. In terms of vision it was considered to be in contradiction to the direction of previous commissioning policy initiatives and achieved varied buy-in from those expected to implement the policy. The policy was considered to have significant gaps namely with regard to skills required for commissioning and the timing and time frame for implementing the policy and thus many participants raised concerns about the feasibility of the policy. Concerns about the coherence of the policy included the ambiguous articulation of aims, perceived contradictions posed by the policy, as well as a lack of detail regarding the practical aspects of implementing the policy, such as employment protection for incumbent commissioners.

The context to this study, presented in Chapter two highlighted that policy has induced repeated reforms in the NHS maintaining a frequent state of upheaval for commissioning organisations. It is perhaps to be expected that quality of policy would emerge as a major factor influencing how organisations respond to and manage policy change. Within the health policy literature more broadly, the need for coherence has been recognised in the field of development (OECD, 2009), in post conflict regions (Macrae, 1997), in low and middle income countries (Gilson and Raphaely, 2008), in the USA (Weil and Scheppach, 2010) as well as the UK (Gifford *et al.*, 2012). These studies suggest that there is still progress to be made in generating coherent policies, as many of these studies identified a lack of coherent policy as creating challenges for organisations. Indeed health policy scholars have reflected that within the UK although national policies are the main method the Department of Health uses to influence the NHS their nature tends to be advisory and often ambiguous (Ham, 2009).

Researchers investigating health policy within the NHS in the UK have identified a number of challenges from policy making process to the implementation of policy by practitioners. Indeed a critical review of policy making in the UK concluded that there was little evidence that public policy has been informed by democratic interaction

between policy makers and policy users (Parsons, 2002). Many studies have attributed the challenges of policy implementation to the gap between those responsible for developing policy and those who enact it. Weaknesses have been identified in the content and coherence of the policy (Brownson *et al.*, 2009), a lack of careful policy design (Greenberg *et al.*, 2003), the issue of coherence being implicitly transferred to the 'meso-level', and simplistic models which fail to acknowledge complexity (Nutley *et al.*, 2002). Similarly the notions of feasibility and 'buy-in' (also termed 'support for the policy' or 'acceptability') identified in this study are not new, and have been identified as determinants of successful policy by other scholars (Elliott and Popay, 2000; Hallsworth *et al.*, 2011; Buse *et al.*, 2012).

8.4.2 Change agenda and locale

In contrast to this thesis Newton et al (2003) found this factor to have weak or no influence, likewise Stetler et al (2009) reported no discernible data regarding the presence or influence of that element at their case study site. This difference is most likely attributable to the difference in contexts, and in particular the novel consideration of policy changes in this thesis. Two factors are likely to explain this difference. First the nature of the change being implemented; the other two studies explored receptivity to changes which the organisation had volunteered or applied to participate in and which were suggested to be beneficial by emerging evidence. Thus, these changes were potentially less likely to be politically sensitive, or disrupt the nature of the local workforce, relative to the policy changes considered in this thesis. The second factor which may contribute to this difference relates to the scope of change. In these two studies the change was contained to practice or hospital level, with little implication to neighbouring organisations, partners or stakeholders. The locale of where the change was to occur was therefore limited to the scope of the organisation being studied. In the case of this thesis, the national policy change had not achieved buy in, was perceived as controversial, and politically charged. The scope of the change agenda was wide reaching and held significant implications for other

regional and national stakeholders, many of whom were being abolished or substantively reformed.

This theme was one which emerged over the course of the research. In Part A the political culture was noted to influence decision making and the time frames for WCC were considered ambitious. These issues of political culture and pace of change became much more apparent in Part B with the introduction of the White Paper. In particular, the iterative and evolutionary nature of the policy change agenda created complications. Participants were not always clear about organisational goals and reported overload in terms of managing the changing agenda, and the accelerated pace of change. Relationships with local stakeholders were influenced by proposals and there was a noted shift in power from PCTs to GPs as they began to gather to develop GPCC and prepare for handover of commissioning responsibility. The local political culture was agitated by management redundancies which were perceived to have been introduced under a political impetus to 'remove bureaucracy'. It was evident that the political cultures impacted the change agenda. These extended beyond local political culture and included NHS political culture and the national political culture, which were described as unstable and marked with turbulence and uncertainty.

Policy making has long been recognized as having a significant political dimension, across all countries and independent of funding mechanisms or organisational structure (King's Fund, 2002). Indeed Ham has been writing about the relationship between the substance of health care policy in Britain and the politics of the policy making process for a number of years (Ham, 2009). Collins and colleagues (1999) reviewed research on policy systems internationally and identified that policy systems respond to and are conditioned by a series of stimuli including political processes and structures. Cook (1997) notes that a politician's goal is to be re-elected, rather than take account of the research evidence. Kogan, (1999) echoed this perception and advised that governments will only seek to legitimise polices with an evidence base, when it is in their favour, that is, it already supports priorities which are politically driven. Over a decade ago the King's Fund (2002), recognized the intense political pressure on the NHS and identified the over-politicization of the NHS as a key problem

which needs to be tackled. Politics continues to create challenges for the NHS. The pace of change in the NHS has also been scrutinised, and the frequency of reorganisation and redesign has been identified as challenging (Ferlie, 1997; Webster, 1998; Harrison and Wood, 1999). Walshe (2003) noted that the NHS has experienced continual restructuring for over two decades, during which the pace of change seems to be ever increasing.

Commissioning has been in no way exempt from these changes and the World Class Commissioning programme for example was considered "too new for its impact to be determined" in a February 2010 report (Brereton and Vasoodaven) but by July the same year, the initiative was abolished thus removing any opportunity to realise its potential benefits. Recent research, on aspects of commissioning, in England found that the political climate was a powerful influence on organisational success and found that turbulence caused by changes in the external political environment, impeded the organisation's ability to commission successfully (Robinson *et al.*, 2011). In summary, such frequent changes have been found to be disruptive to relationships and to organisations across the change locale and thus efforts to protect the NHS from turbulent politics would be recommended in future.

8.4.3 System management

The management of system issues is a novel factor identified in this thesis. It is not included in the eight factors proposed by Pettigrew et al (1992) and the distinction between this factor and 'environmental pressure' is articulated in section 8.6.2. The literature review in Chapter three highlights that the eight factors of receptivity model incorporates most of the concepts identified in other common change models, except structure. It is perhaps unsurprising that this research identified system issues as a factor. However this was not identified by either of the studies by Newton et al (2003) or Stetler et al (2009), thus it is possible that this issue is more relevant to the context of policy change. The term system management is used here to describe issues which involved other stakeholders, processes and mechanisms which arbitrated outside the organisation and which were perceived to be outside the scope of individual control. Stakeholders who are deemed part of the 'system' are those which the commissioning

organisation is required to work with in order to fulfil their commissioning responsibility and in order to satisfy policy directives.

In this thesis three key challenges in responding to the policy appeared to be related to issues attributed to the NHS system. These were system alignment, particularly of incentives and penalties, resources and control of available resources, and distribution of power.

Firstly, with respect to the alignment of incentives, it was evident that incentives are not well aligned within the system as it presented during the course of this research. The significance of this factor again appeared to develop over the course of the research. In Part A it was suggested that there were insufficient incentives in place to stimulate GP engagement with practice based commissioning (PBC) or for the PCT to champion PBC as an initiative. In Part B the incentives for Foundations Trusts were considered out of alignment with other NHS stakeholders and that there was a lack of incentives for them to develop partnerships with the PCT. Additionally, the Foundation Trusts were perceived as benefiting from a payment by results initiative, which was described as incentivising additional activity to increase profits. With respect to GP prescribing, PCT participants perceived lack of appropriate incentives to manage hospital referrals and prescribing activity. Goodwin and colleagues have recently urged the Government to align incentives in a drive to improve outcomes through joined up approaches (2011). Liddell and Welbourn (2012) similarly advocate the need to incentivise all parts across the system to unite in a single shared purpose if the NHS is to improve efficiency and quality. The need for considered alignment of local incentives, including for example alignment of financial incentives with professional values have been identified by Harrison et al, (1999) Mannion et al (2007) and McDonald, et al (2007). Others noted competing agendas between PBC and PCT commissioning and raised concerns about the lack of alignment of resources with PCT strategic objectives(Brereton and Vasoodaven, 2010). Adverse incentives were noted by Street and Maynard (2007), including a 'payment by results' initiatives which was deemed to provide an incentive to increase activity rather and outcomes and diverted resources away from primary care.

Secondly, issues related to the management of resources were identified as a constraint to managing policy change. Within Part A, participants identified a lack of resources as impeding progress with WCC, citing a lack of suitably qualified personnel, time and finance as constrained. With respect to finance, frustrations were expressed with both a lack of control of the available money, and secondly insufficient funds to fully resource the commissioning agenda. In Part B, insufficient money to support the commissioning agenda remained a key issue, and participants perceived challenges with the existing funding mechanisms. These challenges led to the recommendation of restructuring funding mechanisms for the future, which is in part related to the need to align incentives, noted above. In Part B in addition to using the term resource or capacity as catchall terms, participants explicitly identified money, staffing, skills and data. These concerns are also reflected in the wider literature. Budget constraints have been acknowledged since the 1980's (Day and Klein, 1991) and funding pressures on the NHS have been described as continuing to rise (Roberts *et al.*, 2012). Laing (1995) identified that tight budget constraints and limited staff capacity were main factors impacting on service delivery. Although many participants reported a lack of resources, other constraints related to the nature of resource management, in particular control over resources and resource allocation. Checkland et al (2009) found that PCTs and GPs often lacked the experience, skills, time and resources to support PBC, which was deemed to be under-resourced as an initiative. Research on the WCC programme also identified issues of resources and resource management as a barrier to successfully implementing policy (McCafferty *et al.*, 2012).

The third and final issue noted attributed to the nature of the system was distribution of power. Participants reported a perception of imbalances in power, and a top down diktat model of central control. In Part A, participants perceived the system to be centrally controlled by the Department of Health, with control diminishing with each subsequent layer of hierarchy. Challenges with the distribution of power were described mainly with respect to the powerful position which foundation trusts were perceived to hold, relative to the PCT. Power differentials were also noted between the SHA, who were noted to hold a higher rank that the PCT, within the formal NHS hierarchy. In Part B, issues in the distribution of power were noted in the changing dynamics between managers and doctors. These challenges developed as the

implications of the White Paper proposals in terms of shifting responsibility from managers to doctors became apparent. Central control was seen to reside in the Department of Health and the notion of a formal traditional hierarchy, with explicit ranks of power continued to be expressed here.

The challenges of a highly formalised hierarchy and distribution of power have been observed by many who have studied the NHS or reviewed its history (Harrison and Wood, 1999; Stevens, 2004; Smee, 2005; Abbott *et al.*, 2008; Hill, 2008; Hunter, 2009). In the policy literature academics have noted how the structure of NHS finances has created power differentials between PCTs and Foundation Trusts. PCTs were also noted to be responsible for commissioning activities which were outside their control, in particular GP referrals (Smith *et al.*, 2010; McCafferty *et al.*, 2012). Concerns have been raised about the transition of this power from PCTs to new GP consortia (Ford, 2010). Policy makers should endeavour to account for and address wider system issues, when developing future policy.

8.4.4 Organisational culture

Newton et al (2003) did not provide the ranking for this factor in their study, merely indicating that it lay somewhere between the most and least salient factors. Stetler et al (2009) found this factor to have high predominance in their role model case, indicating that presence of this factor was associated with higher organisational receptiveness to change. Given the context being investigated in this thesis, relationships between managers and doctors contributed to the organisational culture. Consequently, this element has been incorporated into organisational culture factor. In this thesis organisational culture was noted to be informed by history, engagement, hierarchy and leadership. It was evident that the organisational culture had evolved over time and was influenced by organisational history. Within Part A, relations amongst GPs and between GPs and Managers were seen to be influenced by historical disagreements regarding practice, or budgetary issues. Clinical engagement with commissioning was limited to a few 'token' board members as stipulated by existent policy directives. The PCT was situated in a formal and distinct hierarchy and their culture was marked by statutory duties, targets, assessments and evidencing

performance and this was described as 'feeding the beast'. A number of other cultural working behaviours were identified in Part B, such as 'silo working' which was a term used to describe unhelpful separation between teams or directorates which meant occasional duplication of work and missed opportunities for shared working. Another was 'eleventh hour working' which was used to illustrate that issues did not always get worked on in a planned organised manner, rather only obtained priority status when the deadline was urgent. The organisational culture was marked by unclear responsibility -especially during the transition responsibility and accountability were unclear and thus created challenges for leadership. Clinicians were also perceived as difficult to lead and manage, this was partly attributed to their independent status, which is related to the alignment of stakeholders within the system as identified in system issues.

Within the academic literature the role of an organisational culture, and sub-cultures, has been noted to influence the ability of organisations to change, adopt new ways of working, enact policy and implement reforms (Schein, 1984; Gagliardi, 1986; Parker and Bradley, 2000; Ferlie *et al.*, 2003; Johns, 2006).

The negative impact of continual restructuring and the challenges this creates for leadership has also been acknowledged in the wider literature (Mannion *et al.*, 2010). Organisational reorganisations are noted to be disruptive, to negatively affect performance and to attract large transactional costs (McKinley and Scherer, 2000; Walshe, 2010). A high rate of reorganisation, and the consequential discontinuity and disruption to organisations have been cited as a contributing factor to the failure of healthcare commissioning in the NHS (Health Committee, 2010). Commitment to a longer term strategy would likely be helpful in reducing the frequency of restructuring. Participants anticipated significant loss of local and tacit knowledge during the transition from one system to the next. This clearly has an associated cost implication, in terms of time, money and expertise. This research thus highlights the need to attentively manage transitions, in order to minimise these potential losses. This need was also identified by the Chief Executive of the NHS who, acknowledged a significant period of risk during the transition and, advocated for an increase central support in order to best manage the transition (Nicholson, 2010a). Specific need to retain

competencies and skills developed within PCTs, across the transition has also been highlighted (NHS Confederation, 2010). It is likely that better management of the political culture surrounding the NHS would lead to a reduction in the rate of restructuring and thus this factor is related to the change agenda. Walshe (2003) notes that structural reform is intertwined with the dynamics of political control, providing health ministers with a way to be seen to be doing something, offering the appearance of immediate and substantial change even if their actions have little actual value. Indeed, the NHS is noted to have been subject to almost continuous restructuring for two decades (Webster, 1998; Harrison and Wood, 1999; Walshe, 2003). Structural changes have been criticised for failing to account for the dynamism between the organisation and its context, and between the organisation and individuals with in it (Fulop *et al.*, 2005).

8.4.5 Sub-components

One of the limitations of the eight factors of receptivity model (Pettigrew *et al.*, 1992) was related to ambiguity of factor definitions, and with regard to what each factor constituted. In order to avoid this issue limiting future application of the model presented in this thesis, an explanation and definition of each of the sub-components in the model is presented in Table 8.2. This table describes the components as understood through this research and thus reflects the meaning which has been generated and ascribed to these criteria during this research. Similarly, rather than intending to limit or impose restrictions on these terms, this explanation is provided to enhance reader understanding of the criteria, and relate these to the findings presented in Chapters six and seven. In line with the reflections in section 8.3 on the nature of conceptual models, these descriptions offer a starting point for discussion and further research may add to or refine these definitions.

Table 8.2 Description of model factors and sub- components

POLICY	Vision	Policy vision is used here to encompass the aim, scope and concept or direction which the policy articulates. Thus the nature of the content of the White Paper proposals, but also how these were necessary and relevant for the future of the NHS.
	Coherence	Coherence is used here to describe the articulation of the policy document, in particular the coherence between the operational objectives and the strategic aims. That is the narrative detailing the purpose of the reforms, and the rationale underpinning them. Describing the actions proposed by the policy and the explanation/ argument underpinning how and why these will achieve the articulated policy aims.
	Feasibility	Denotes how the policy is broken down into actionable pieces, and furnished with adequate resources, including for example: matched to an achievable financial framework. Perception on whether the proposed timescales are achievable within the restrains of the system and current context are also included.
	Buy-in	This term is used here to indicate the level of support the policy attracted from participant, and the extent to which they would aid the policy cause, or act as an advocate for the policy. It is likely that buy-in is inherently informed by how people perceived the policy vision, whether they were convinced that it was coherent and feasible.
CHANGE AGENDA & LOCALE	Political Culture	The NHS is undoubtedly situated in a highly political context. Political culture was used here to capture both the local and national political cultures. National political culture was noted to include trust or distrust of Government, party specific agendas, notions of political stability, reforms and restructuring. Local political culture was used to depict the political relationships between locality stakeholders, including GP practices, latterly consortia, local authorities and providers.
	Pace of Change	This component indicates and describes the pace at which change was administered and perceptions on the appropriateness of this, in particular with respect to the amount of time afforded to this. It also captured aspects of change timing and contextual fit with in terms of scheduling and fit of timing with other policy and initiatives.

	Simplicity of Goals	Denotes the clarity and simplicity of change goals; in the case of policy change this will likely be influenced by management skill and ability in reducing the complexity of policy initiatives by translating them to a manageable set of organisational objectives. As such perception of the simplicity of policy goals, will likely be influenced by the ability of organisational managers to adequately narrow or distil the change agenda into key priorities.
SYSTEM MANAGEMENT	Resources	This section was used to capture discrete resources such as money, staff, data and time, as well as, as a catchall term for more general combinations of these such as capacity and capability. This section also extended to the issue of resource management and control over resources.
	Alignment of Incentives	Alignment of incentives considers the appropriateness of incentives provision with reference to policy aims. Incentives included financial incentives and monetary flows, but were not restricted to this, and were considered broadly as factors that promote change. This included reference to both initiatives and stakeholders, considering the impact of unintended consequences, conflicting priorities, and the alignment of actions or decision makers coherently with repercussions and accountability.
	Power distribution	This section was used to capture power dimensions within the system, for example, issues of central control, issues with transfer of and distribution of power throughout the system, and the presence of opportunity or mechanisms through which to challenge the powerbase.
ORGANISATIONAL CULTURE/ CONTEXT	Hierarchy	Hierarchy is used to describe the ranking of individuals and organisations, according to their authority, grade, or status. This included both formal hierarchy as prescribed by system and organisational structures, such as rank, but also informal hierarchy where this existed

	Engagement	Engagement here describes the quality of relationships and level of mutual respect across a number of interfaces, and is used here as a catchall for this between GPs and the PCT, inter GP practice engagement and engagement with the local community.
	History	The role of history in shaping the organisational culture was noted. This included unresolved tensions, historical events, and historical ways of working and organising which had become embedded in practice.
	Leadership	The role of leadership can be considered, at organisational, locality and national levels, and included both managerial and clinical leadership. Leadership was not confined to those in formal leadership positions, but included for example individuals who were credited with exercising leadership initiative. Thus this criterion encompassed leadership qualities where these were identified as such.

8.5 Patterns between factors

The four factors identified in this model are considered to be highly inter-related, and interwoven, characterised by the complexity of health care organisations and the fluid nature of the context in which they operate. It is evident from the descriptions of sub-components provided above, that each of the sub-components are closely linked and likely to be influenced by one another. For example policy 'feasibility' is highly likely to be influenced by available 'resources' within the system and how these are managed. Similarly aspects of 'history' and 'engagement' at an organisational level are likely to inform or be informed by the local political culture and so on. There was deemed insufficient data collected in this research to warrant generating hypothesis about the direction and/or strength of these links, and/or to map the interplay between them. A decision was therefore made to present all four factors together, indicating that there are strong links and associations between the factors.

Newton et al (2003) similarly found the factors of policy, and organisational culture to be highly interrelated. Stetler et al (2009) identified a pattern of positive connections

between key contextual elements, and found that this varied between their high performing site and their beginner site. Both these patterns were different to the pattern identified by Newton et al (2003). Neither of the two studies identified the pattern proposed by Pettigrew et al (1992). Pettigrew et al (1992) highlighted the dynamic nature of change, and noted that the links between the factors are likely to change over time within a given context. In light of this, there is perhaps limited value in expending additional effort to identify these directions, without any indication of how this information would inform the application of the model in practice. Stetler et al (2009) suggest that further research is required to identify the significance of this pattern and to ascertain if particular patterns indicate greater potential for success.

However, before recommending further research is undertaken to explore the relationships or patterns of association between these factors, the researcher would argue that due consideration should be given to the practical value that this finding would add. That is to consider that value of information that would be gained, in terms of how it would add value, how it would be applied and what it would change. Given the findings of this research along with the recognition that change is dynamic and temporal, and the disparity in the findings by Newton et al (2003) and Stetler et al (2009), it is not clear what additional value this would create. The researcher suggests that the value to be gained from ascertaining patterns of association is likely to be of lesser value than the cost of activity required to generate this information, and consequently would not raise this as an agenda for future research.

Each factor is illustrated as an equally sized portion of the model; however it is not yet clear if each of these factors has a comparable impact. Further research may find that there is a hierarchy within these factors, and thus the model may benefit from revisions to alternative proportions, to indicate corresponding 'size' of the factors in relation to impact. Although, as noted above the researcher advocates due consideration about the value that would be gained from identifying any variation in significance between these factors.

8.6 Extraneous Factors

Four factors included in Pettigrew et al's model (1992) did not emerge having a significant impact on organisational receptivity to change in this thesis. These factors were: key people leading change; environmental pressure, co-operative inter-organisational networks, and simplicity and clarity of goals and priorities. Each of these are now considered in turn, and compared and contrasted with the findings from these two studies by Newton et al (2003) and Stetler et al (2009). Suggestions are offered for why these factors may not have emerged as predominant factors within this change context and what the broader indications may be for their relevance to a health policy context.

8.6.1 'Availability of key people leading change' (Factor 2)

This factor did not emerge from the data collected in this thesis which contrasts with the findings of Newton (2003) and Stetler (2009). Pettigrew et al (1992), did not rank their factors in terms of importance, however Newton et al (2003) found this factor to be the second most important in their study and Stetler et al (2009), identified it as the most influential element in their findings. A number of variables may have contributed to this finding; three suggestions for why this may have occurred are discussed below.

One contributing factor may have been lack of salience; that is limited data was coded to this factor due to an absence of notably strong or notably weak leadership qualities. This suggests that when recounting their perceptions of the organisational context participants tended not to comment on issues related to the availability of key people leading change, or leadership generally, in the absence of any particularly salient issues or recollections. As such, unless there were examples of situations where leaders were perceived to be excellent at ensuring their availability, or in contrast notably poor at making themselves available that participants would have no cause to describe this factor above the others.

The semi-structured interviews included probes about leadership, although subsequently when participants talked about leadership, they tended to correlate this with those in generic leadership roles. For example, if an open question was asked

about the 'leadership of the change', the respondent would generally use the Chief Executive as the immediate point of reference for the notion of 'leadership'. Thus although Pettigrew et al's (1992) description of this factor refers to concepts such as subtle leadership and pluralist leadership, participants' perception of leadership appeared to be very closely associated with formally appointed positions within the organisation.

A third and final observation concerned the perception of the role of organisational leaders in managing policy change. That is to say, policy was perceived as a top down directive, presented as fait accompli, with limited scope for negotiation or re-shaping. Subsequently organisational leaders may not have been perceived as well positioned to 'own' or 'lead' change, or as holding the necessary authority or autonomy to be able to change or influence policy direction or decisions. Thus many of the comments which likely would have been directed to the factor of 'key people leading change' in a more traditional organisational change have been directed to 'policy'. As such it is anticipated that, in the context of this study, comments which may have relevance for the availability of leadership would be coded to the policy factor. Thus, arguably this data is not missing, per se, rather has been perceived by participants to be more relevant to policy and have been captured within that factor. Subsequently fewer comments were attributed to the organisational leadership of change. Additionally, it was noted that some aspects related to organisational leadership which were not directly applicable to policy were captured and noted to have contributed to the organisational culture. Thus comments related to leadership within the organisation have been presented as a sub-factor within 'organisational culture' as detailed in Figure 8.3.

8.6.2 'Long term environmental pressure' (Factor 3)

Pettigrew and colleagues (1992) did not explicitly define 'long term environmental pressure'; rather they referred to the literature to indicate that large scale environmental pressure has been identified as a contributing factor to radical change. They noted that long term pressure can drain energy out of the system, and suggest that the way in which long term pressures are mobilized depends on existing

distribution of power, history and local assumptions. Newton et al (2003) cited Pettigrew et al (1992) as the source for the definition they used of: 'awareness of external factors in triggering change', and Stetler et al (2009) provided their study definition for this factor as 'the intensity and scale of pressures from influential agents external to the organisation'. As detailed in the methods chapter (section 4.6.2) the coding template for this factor, served as the study definition for this factor and included all items which Pettigrew et al (1992) indicated may be linked within this factor in their explanation and reflections on it. This thesis did not find this factor to be frequently cited, which echoes the findings of both Newton et al (2003) and Stetler et al (2009) who also described this factor as less relevant that the others. Stetler et al (2009) advise that this was not a key theme, although they cited a variation in predominance between the two cases they studied. Newton et al (2003) identified this factor as the least salient in terms of coding frequency, and found that when they investigated the pattern of the factors that it had no –inter-relationships with the other factors. Two suggestions are made below as to why this factor did not emerge from the data in this thesis.

First, it is possible that the variation and ambiguity of definition of this factor affected how it has been interpreted by researchers. This may have contributed to the readiness of studies to ascribe coded data to this factor or to identify this as a prominent factor. Indeed, Stetler et al (2009) note that differences identified by users of the model may be due to variation in how they interpret each term. It is possible that within this study, it was difficult to identifying the boundary between what constituted a current pressure or what could be attributed to long term pressure, given the environmental context was subject to frequent iterations. Within the business literature environmental pressure is described as external elements which affect the operations or growth of an organisation (Willcocks and Fitzgerald, 1994; Porter, 1996). Externally induced pressure may arise from for example: changes in the market, economy, natural environment or technology. Market pressures may arise from issues such as the entry of new competitors, a threat of substitute products or a change in the importance of the product to the buyer. Financial pressure may be created by changes in the national economy, exchange rates, or export/import taxes. Environmental issues such as climate change, resource depletion or natural disasters

may force organisations to change their operations. A revolution in another sector, for example technology, may also force an organisation to adapt or change in order to maintain its position in the market.

The issues of system management, as detailed in section 8.4.3, were deemed sufficiently distinct from 'environmental pressures' to warrant the generation of a new factor. This was because the issues of resources, alignment of incentives and power distribution tended to be with respect to other organisations which were part of the NHS at large, for example general practitioners, the strategic health authorities, the Department of Health.

Second, some data were initially coded to the sub-factors within this factor, as derived from Pettigrew et al's (1992) reflections on items linked to 'long term environmental pressure' which may impact on receptivity. However iterative waves of inductive analysis indicated that the underlying theme of comments attributed to these sub-factors would be better aligned to other factors. For example, although participants described issues related to 'energy drain' such as 'feeding the beast' and 'continual restructuring' they tended to link these issues to problems with managing the demands of 'the system' more broadly, or to better managing policy respectively. Similarly issues such as 'financial pressure' were considered to be inherent within 'the system'. These perceptions were contained by acknowledgements that there will never be 'enough' money, and so described implications for resource allocation and disinvestment. Thus these data were not considered to reflect an explicitly external environmental pressure as participants did not attribute them to long term environmental pressures such as an economic crisis. As a result in subsequent iterations of data analysis, and merging and dividing codes, these aspects were considered to fit better within alternative factors, in the context of this thesis.

8.6.3 'Co-operative inter-organisational networks' (Factor 6)

This factor did not emerge from the data collected in this thesis, similarly Newton et al (2003) did not cite this factor as having a high level of salience nor did Stetler et al

(2009) find this factor to have high predominance at their role model site. Three suggestions are offered as to why this may have occurred are described below.

First this may have been related to a variance in the definition of this factor. Rather than providing an explicit definition per se Pettigrew et al (1992) describe some of the features of effective networks which were subsequently used, to populate the coding frame for this study, (section 4.6). Stetler et al (2009) extended this description to incorporate 'values, norms and expectations' and Newton et al (2003, p144) summarised Pettigrew's indications to 'productive relations with related organisations such as social services and voluntary organisations'. Second, the main networks within the NHS, namely between the Department of Health, Strategic Health Authority (SHA), PCTs appeared to be largely established through heavily prescribed policy or legislation. As such these relationships are not considered optional and are likely not subject to the traditional norms, expectations and mutual obligations which would be associated with organically occurring networks. A third reflection is that perhaps if the coding framework had incorporated elements of non –receptive contexts for this factor, more data would have been coded to each sub component. In reality, comments relating to networks tended to relate to positioning of organisations in terms of incentives and power, and as such were themed as issues related to 'system management'. Networks with GP practices were perhaps less formalised, or prescribed and thus more variable. Data describing the existence and quality of these networks tended to discuss relationships or engagement and as such were coded to these sub-categories accordingly.

8.6.4 'Simplicity and clarity of goals and priorities' (Factor 7)

This factor did not emerge from the data collected in this thesis. Stetler et al (2009) found this factor to have high predominance in their role model case, indicating that greater simplicity and clarity of goals was associated with higher organisational receptiveness to change. However Newton et al (2003) did not provide the ranking for this factor in their study, merely indicating that it lay somewhere between the most and least salient factors. Pettigrew et al, offer a definition of this factor as: 'ability to narrow the change agenda down into a set of key priorities and to insulate this core

from the constantly shifting short-term pressures apparent in the NHS' (1992, p285). The definition used in this study incorporated this definition, and included additional items as described by Pettigrew which would potentially impact this factor, for example 'persistence and patience in pursuit of objectives'. Stetler et al (2009) also incorporated additional items by Pettigrew. Newton et al (2003) did not articulate their definition, rather described the two questions which they used investigate this factor; these included agreement on priorities for achieving the aims of the change, and the presence of an action plan which was derived from key priorities. Within this thesis although participants discussed organisational goals and strategic aims and reflected on the clarity and simplicity of these, this was mostly with reference to the new era of commissioning and anticipation of the changing priorities for commissioning. Thus, the manner in which participants described the simplicity and clarity of goals revealed that it would fit better within an alternative factor. In this instance, most of the comments relating to this factor where discussed with regard to the transition from the pre policy environment to the proposed post policy context. As such this data was collated and attributed as a sub-component of factor eight 'change agenda and locale'.

8.7 Chapter summary

This chapter has presented a new model, which describes the key factors influencing organisational management of health policy changes, in the context of this research. The four factors identified are: quality of policy, change agenda and locale, system issues and organisational culture. An explanation of how this model has been developed from the findings in this research is provided. Findings have been discussed with respect to Pettigrew et al's model (1992), and with reference to the two studies by Newton et al (2003) and Stetler et al (2009) which applied this model in health care contexts. This chapter describes the sub-components which contribute to each of the four factors. Finally factors which were included in Pettigrew et al's model (1992), but were not identified in this study of health policy change are described. Some suggestions for why these factors may not apply to the context of health policy change have been offered and explanations for the inclusion of some elements as sub-factors have been outlined. The following chapter concludes the thesis and it identifies the

limitations of the research, considers the contribution of this thesis and the implications of these findings for policy.

Chapter 9 Discussion and Conclusion

9.1 Thesis summary

The research presented in this thesis was conducted within an NHS commissioning organisation in order to gain an understanding of the issues related to managing changes in health policy. Commissioning policy was selected as a research focus, and specifically the policy changes proposed through the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010). The eight factors of receptivity model developed by Pettigrew et al (1992) was used to inform the identification of factors which may facilitate or hinder commissioning organisations to manage health policy changes. Chapter one introduced the thesis research question and aims. The two related research questions that this thesis sought to address are: what factors influence how policy changes in commissioning are managed by health care organisations? And how do individuals in these organisations perceive and respond to commissioning policy? A case study design was adopted in order to address these questions. The research was conducted in two Parts, A and B. Part A was conducted to gain an understanding of current commissioning functions and organisational context in a PCT in a pre-policy change environment. Part B was concerned with the introduction of proposals for substantial policy change. Research in this part was undertaken firstly at the PCT and subsequently with emerging GPCC to observe and understand reponses to these policy changes.

Chapter two introduced the background and context to the thesis, and identified commissioning policy as a focus of the research. A historical overview of the NHS developments was provided with particular reference to commissioning. Recent commissioning policy developments were discussed, highlighting that the policy environment surrounding the NHS was marked by frequent change and reform. Chapter two reported that policy implementation is challenging and little consideration has been given to the effect the organisational environment has on success in policy implementation.

The third chapter explored the nature of change, its classification and its theoretical underpinnings. A review of the literature on change management identified several approaches; the majority of this work was found to be focussed on and derived in the private sector. Models which had relevance to 'understanding' change were reviewed and their potential for application to the thesis was discussed. The chapter identified policy as a mechanism which frequently induces organisational change, and established that how organisations respond to policy changes has been subject to limited study. This thesis seeks to address this gap and to identify factors which influence the management of policy change. The eight factors of receptivity model (Pettigrew *et al.*, 1992) was identified as a potential tool to understand how organisations respond to and manage policy changes. Although the model had not yet been applied to the study of organisational change in response to health policy changes, its potential utility to guide and develop research in this context was indicated.

In the methodology and methods chapter the arguments for adopting a constructivist research paradigm, and case study design were presented. Observational and interview based methods were chosen to examine the commissioning and organisational context within a PCT site prior to and post proposals of national policy change. A coding framework was deductively derived from the eight factors of receptivity model by Pettigrew et al (1992). This was used to guide the thematic analysis of collected data and to identify and examine emerging concepts. These methods of data analysis are congruous with the research paradigm adopted.

Chapter five detailed the findings from Part A of the research. The chapter provided an introduction to the case study site; presenting a snapshot of a 'pre-policy change' environment; that is midway through a relatively stable phase of policy and policy implementation. Although participants identified the World Class Commissioning policy as somewhat helpful, they perceived a lack guidance and support for the development of commissioning. Concepts of organisational context, including leadership and politics were described and participants identified challenges in managing the relationships with other key stakeholders. The need to develop further skills and expertise in commissioning was identified, but time and capacity were noted

to be constrained. Unhelpful influences from national politics were described as interfering with long term development of the NHS. These findings have been used to inform Part B of the research.

Part B of the research was conducted during a period of policy change and incorporated the eight factors of receptivity model developed by Pettigrew et al (1992). Key changes included the termination of the World Class Commissioning initiative, and the introduction of 'Equity and Excellence: Liberating the NHS', along with continued efficiency savings known colloquially as the 'Nicholson Challenge'. The implications of these changes are captured through data collection at two time points. Chapter six presents data collected during interviews and observations at the PCT site, Part B:1. The chapter identified four main factors which influenced the organisations response to and management of policy change as: policy constitution, manager – clinician relationships, organisational context and change agenda. One implication of the policy changes required the phasing out and transfer of commissioning responsibility from PCTs to newly emerging GP commissioning consortia (GPCC). Chapter seven presented data generated from interviews with GPCC and identified four main factors influencing the management of policy change as: quality of policy, organisational context, system management and change agenda and locale.

Chapter eight presents a new model which identifies four factors which influence the management of health policy changes, in the context of this research. The chapter critiques this model with reference to the eight factors of receptivity model developed by Pettigrew et al (1992). The development of the model is explained with reference to the eight factors of receptivity model (Pettigrew *et al.*, 1992), and to previous applications of this model. Each factor is explained, and sub-components for each are identified and described. This final chapter identifies the contributions of the research and discusses the implications of the research findings for future policy making. Strengths and limitations of the research are discussed and recommendations for future research conclude this chapter.

9.2 Contribution of the thesis

This section describes the contributions of this research in terms of addressing the research questions and objective introduced in section 1.4. The key contribution of this research has been the development of a conceptual model which identifies factors influencing organisational management of health policy changes. A conceptual model is a cognitive tool and framework of what has been learned to best explain the phenomenon that is being studied. This provides new perspectives to the knowledge base and can be used to guide future actions and research (Camp, 2001; Rojewski, 2002). This conceptual model was developed as existing models did not fully fit the context which was investigated in this thesis. This conceptual model was derived through consideration of the change management and health services literatures, and the application of change management models, to the context of health policy change. This research is the first application the eight factors of receptivity model (Pettigrew *et al.*, 1992) to national policy change in the UK and to NHS commissioning. Other contributions of this thesis include a thick description of the context of NHS commissioning, including the identification of barriers and challenges to conducting commissioning. This thesis has contributed to the advancement of qualitative research methods through the employment of a novel hybrid approach to thematic analysis. This included the development and use of a deductive coding framework in conjunction with inductive thematic analysis. The final contribution this thesis offers is a number of general lessons for the development of future policy and commissioning organisations.

9.3 Implications for policy

The discussion and synthesis of the findings presented in Chapter eight leads to the identification of four key challenges which influenced the ability of commissioning organisations to manage changes in health policy, in the context of this research. First, a lack of policy vision was noted to create challenges for leaders and commissioning organisations. Second, management of national political culture was considered problematic, and better management of this will likely generate stability in the change agenda. Third, a number of issues related to system management, in particular

alignment of incentives and resources within the system was considered problematic and previous policy initiatives have failed to adequately address these challenges. Fourth, the culture of the commissioning organisation is a central influence on receptivity to change; in particular it was noted that periods of transitions need to be carefully managed to avoid loss of valuable expertise. These implications are discussed here with reference to the White Paper 'Equity and Excellence: Liberating the NHS' (Department of Health, 2010), although can be considered to apply to other commissioning policy.

First it was noted that a lack of policy vision and coherence creates challenges for leadership. In this research this was further complicated by the iterative development of policy, and arguably the lengthy and substantive amendments which were made to the original policy proposals before it progressed to act status. Policy feasibility is influenced by participants' capacity to engage in implementing policy without negative consequences for existing role requirements. This was noted in Chapter six (section 6.3.1) where activity related to the White Paper (Department of Health, 2010) was perceived to be over and above existing role requirements and participants described policy related activity as in in addition to their 'day jobs'. This finding suggests that future policy should consider the implications for those responsible for implementing the policy, to ensure sufficient support and capacity to carry out new work associated with policy directives. Within the public health literature, a lack of policy clarity, and constraints at the level of implementation, as well as a lack of engagement in the production of policy, has been described as limiting the effectiveness of policies (Hunter, 2007).

Second, the national political culture was noted to be unstable, with frequent policy changes, reforms and restructuring, this generated additional uncertainty for the policy, and participants hypothesised about how the political management of the policy would impact the NHS. Change in the NHS was acknowledged as being very politically charged; participants suggested that pursuit of a rational change agenda could be superseded by the need to save political face. Participants thus expressed a level of suspicion and distrust toward the Government, and expressed reluctance to become involved in some aspects of policy directives, due to a fear that the agenda

might suddenly change direction or be dropped. Frequent organisational restructuring was found to be disruptive and efforts to protect the NHS from turbulent politics would be recommended. The results for this thesis would suggest that a united commitment to an overarching long term commissioning strategy would reduce the frequency of politically charged restructuring. In Germany, the high degree of policy and structural stability maintained by their national health care system has been credited with achieving substantial improvements in equity and quality. Although their system is insurance based these levels, of quality and equity, compare favourably with the UK and the USA (Altenstetter, 2003) . Provinces in Canada are moving towards longer term strategies, and developing up to 20 year plans in areas such as Public Health, although the benefits of this cannot yet be demonstrated (King, 2013).

Third, participants advised that commissioning policy initiatives to date have failed to adequately manage issues inherent in the wider system. Participants suggested that the structural overhaul proposed by the White Paper (Department of Health, 2010) was not necessary and advised that many of the commissioning issues could be addressed through creating more appropriate alignment within the system. Participants were sceptical that the policy would be sufficient to fully align incentives within the new system, for example funding systems for primary and secondary care were identified as problematic and the policy proposals were not considered to address this. The distribution of power within the commissioning system was described as problematic. Foundation Trusts were highlighted as notably powerful; PCTs described being weak in comparison and not adequately resourced to negotiate in contracting, procurement disputes and commissioning in general. Commissioners were perceived as being accountable and responsible for circumstances beyond their control. The regulation of the system through guidelines and performance management were also described as a hindrance which stifled freedoms within the system. Future policies should endeavour to address these issues. Others have noted that aappropriate alignment of incentives is necessary to enable an organisation to perform at a high level. Further, the enforcement of incentives without adequate consideration of their ramifications has been identified as particularly harmful (Garber, 2011).

Finally participants raised concerns about the anticipated loss of skills and valuable expertise, during the abolition of PCTs and transition of commissioning to new GPCC. Within the NHS, commissioning organisations have been repeatedly destabilized and reorganized, through top down restructuring and redundancy initiatives. This has undoubtedly fragmented organisational cultures, impeded engagement, and led to loss of skills and knowledge. A period of relative stability would enable organisational cultures to become developed. Careful management of future transitions is recommended in order to avoid loss of valuable expertise. Policy experts have highlighted the loss of experienced management staff, and commissioning skills, from PCTs as a significant risk during this crucial transition (NHS Confederation, 2011; Ham, 2012).

9.4 Strengths and limitations of research

As discussed in Chapter four, many of the limitations associated with this research are related to criticisms of qualitative research in general. Specific limitations related to the methods employed in this thesis are described in section 4.8. The purpose of this section is to appraise the methodology and specific application of the methods in the context of this thesis. Lincoln and Guba (1985) identified four criteria, of transferability, credibility, dependability and confirmability, for appraising qualitative research. These criteria were offered as an alternative to the traditional quantitative criteria which focused on domains of validity, reliability and objectivity. The criteria are noted to reflect the underlying assumptions in much qualitative research and better accommodate qualitative paradigms; they have been widely adopted to guide critique of qualitative research (Shenton, 2004; Trochim, 2006).

These four criteria are now considered in turn, with respect to the research conducted in this thesis.

9.4.1 Transferability

The findings in this research are based on the views, experiences and descriptions provided by participants based at one case study site, and thus it may not be possible to apply them to other commissioning sites, or make generalisations across England. This was unavoidable as the aim of the research was to make an in-depth exploration, which required the generation of context specific data. However, the researcher made efforts to overcome this in careful case study selection as detailed in section 1.3.2. The relatively small sample size (n=34), may lead to criticism that the participants may not have been representative of all individuals involved in commissioning. Purposive sampling was selected as the sampling strategy in order to ensure that most appropriate participants were approached for interview. Further the use of snowball sampling meant that the research design was open to including other participants who were identified as appropriate by current participants. As data saturation was reached in all phases, it is likely that an increased sample size would not have rendered any new data.

However one of the reasons that this research was conducted, and indeed research in general, is to build the evidence base in this case to inform policy making. Thus it is important that generalisations can be made from the results. Although there has been much debate about the application of knowledge generated through qualitative research, as argued in Chapter four, it is still possible to make careful generalisations from qualitative research. Initial feedback from presenting the results in different contexts and to different audiences, combined with the situation of the findings in the literature, suggest that the overarching findings identified in this discussion can be generalised to similar contexts. This judgment relies on interplay between the interpretation presented by the researcher and the interpretation of both the findings and the new context by the reader (Lincoln and Guba, 1985; Hamberg *et al.*, 1994). In order to facilitate this, a rich description of the case study context has been provided (Chapter five). Further a detailed account of changes in the organisational and policy context, including changes which occurred during the course of the research, is provided in Chapter two. The results are presented in depth, to enable the reader to judge if their setting is suitably similar and if these findings may be generalised to it.

9.4.2 Credibility

In order to establish the credibility of data gathered in the research, some of the limitations associated with the methods of data collection should be considered. Interviews rely on reported information, and one limitation is that interview responses are likely to report the views which participants wanted to portray. This may particularly feature in this research as the content of some of the interviews in this research, explored response to a policy change which was politically charged, and as such participants may have used interviews as a medium to voice their political opinions. In contrast, participants may have attempted to provide interview responses which aligned with their perception of the political views held by the interviewer. Efforts were made by the researcher to avoid projection of particular political views and to present a balanced and neutral position on policy. This was maintained by sharing viewpoints from previous interviewees at both ends of the political spectrum when probing for responses to policy, whilst not demonstrating agreement with either position. Triangulation was used to ensure credibility in the analysis of data, constant comparative approaches were adopted and supervisors assisted in checking interpretations against the raw data.

Observation were limited in terms of the scope of what could be permissibly and realistically observed in the available time. Researcher attendance was precluded from some meetings; further some meetings had high numbers of attendees, and processed large volumes of content some of which required previous knowledge to follow. Observation was thus limited to what could be successfully recorded in the researcher diary at that time, or recalled in later reflection. Further it is possible that participants acted in a different manner due to the presence of the researcher. The phenomena of participants modifying behaviour in response to being observed is known as the Hawthorne effect (Mays and Pope, 1995). Although this may have influenced the behaviour of some participants, the longevity of the observations, and the mix of participatory and direct observation suggests that the extent to which this could have occurred is minimal.

A number of steps were taken in order to prevent the researcher 'going native' during this study (Mays and Pope, 1995; Flick, 2009). This is crucial to ensure the researcher retains a critical external perceptive. Steps taken to avoid this included regular debriefing sessions, between the researcher and research supervisors, and physical separation three days per week which were spent working at the university. Nevertheless maintaining a respected and integrated presence within the organisation on occasion required: working beyond usual office hours; travelling to off-site events; and participation in social events.

The credibility of the research could have been enhanced by increasing the duration of data collection, in particular by extending the period over which the research was undertaken in order to capture the full operationalization of GPCC. Indeed it is acknowledged that there is a paucity of longitudinal studies researching change in health care (Fernandez and Rainey, 2006; Piercy *et al.*, 2012). These limitations were due to pragmatic and financial restraints, first with respect to the capacity of the research and second due to available research funds.

9.4.3 Dependability

Consistency within the methods in this research benefitted from the interviews, observation and analysis being conducted by one person. In terms of analysis and reporting the results necessarily represent a single and partial perspective. However the use of direct quotations from participants' verbatim accounts has been noted to increase dependability, by ensuring interpretation is grounded within the data (Johnson, 1997). Researcher experience, interviewer experience, knowledge of the research topic, and familiarity with modes of questioning are known to enhance the quality of the data generated through in-depth qualitative research (Kvale, 2007). Although the researcher had previously worked as a qualitative researcher, interview experience was limited prior to undertaking the research for this thesis. In order to address this, the researcher undertook in depth training in methods for conducting semi-structured interviews. Further the researcher conducted a pilot interview under the supervision of a senior researcher, which served not only as a mechanism to refine the interview schedule, but additionally enabled the researcher to gain comprehensive

critique on interviewing technique. The notion of dependability in terms of repeatability is more difficult to illustrate, rather it relies on accounts of the context and changes which occurred within the research. This research was conducted in a highly changeable context and a detailed account of these changes has been provided in Chapter two. The researcher has sought to facilitate repeatability of the methods through in depth explanations of data collection and analytic methods. A detailed description of the application and development of the coding template used in this research is included in Chapter five. The systematic use of recognised methods such as thematic analysis and constant comparison has helped ensure the research is grounded in and reflects the data generated within the specific context of this research.

9.4.4 Confirmability

Whilst each researcher will understandably bring a unique and individual perspective to their research, it is important that this does not unduly influence the research. In particular it is important that the findings are not reflective of personal motivation, interests or preferences. As noted above the interviews, observation and analysis were undertaken solely by a single researcher. As such, there is potential for limitations such as a narrow and individual interpretation by the researcher to the exclusion of other perspectives. In order to mitigate the risk of this limitation, interview schedules and coded data were shared and discussed with supervisors who had backgrounds in health services research, psychology and organisational research. Discussions were held regularly throughout the duration of the research and contributed to on-going analysis. Feedback was also received following presentations of interim and anonymised findings, from NHS personnel, managers and health service researchers outwith the case study.

The researcher developed good relationships with both clinicians and directors at the PCT. This is important as observation of participants is known to be affected by relationships between the research and those being observed (Lofland and Lofland, 1995). Relationships were established, in the usual manner through illustration of a common interest and background. The researcher identified with both clinicians and

managers by way of previous work as a physiotherapist and by holding an MBA respectively. Although efforts were made not to align with either professional group, this became more difficult as the political nature of change; in particular the transfer of commissioning between the groups became apparent.

9.5 Implications for further research

As a novel area of exploration, this thesis generates a number of avenues for further research. Four suggestions are offered below to build on and validate the findings presented here, and to develop research in the area in general.

First, the model presented in this thesis, was developed from one case study site. In order to validate the model further research would need to be conducted with other sites to determine its applicability to other settings. Further research may wish to consider contrasting sites, and compare the fit of the model in commissioning organisations which are considered to be performing well with those that are not. Additional research could be used to confirm or amend the themes in the model as required.

Second, the commissioning policy context during this research was noted to be particularly turbulent; conducting further research within a different policy window would further test the applicability and transferability of the model to different contexts.

Third, although this research is entirely based within the area of commissioning policy, it is anticipated that the implications of these findings could be extended to other arenas of public policy; the potential for this extrapolation should be explored through further research in another area of public policy.

Fourth, following appropriate validation of the factors in the model as recommended above, scope exists to identify how and by what means and processes organisations can develop and address these factors in order to enhance their ability of manage policy change. Similarly it would be useful to identify how policy makers can use these

factors to inform the development of policy to enhance the success of policy change being well received and managed by implementing organisations.

9.6 Concluding remarks

The results from this thesis conclude that management of policy change in the NHS is influenced by different factors from traditional management induced change or organic organisational change. It is argued that it is reasonable to expect these factors to be different as policy tends to involve an externally generated and top down directive, which the organisation is required to implement. Substantial research on the phenomenon of change has been undertaken by the business management and organisational development sectors. Although much of this literature has been derived from the private sector, it is likely that there is much to be gained from this experience, whilst exercising caution in understanding how these can be transferred and adapted for application in public sector and policy contexts.

Given the multitude of policies which NHS organisations are subject to, there is significant potential benefit to be gained from more effective management of policy change. Further research should be undertaken to confirm and refine the factors presented in the conceptual model presented in Chapter eight. Particular examples of avenues to be explored in further research are identified above in the implications for further research. These suggestions for future research along with the results of this thesis advances the knowledge base of management of policy change, as an exciting area of research with the potential to yield significant benefits to the public sector, and with ample opportunity for future exploration.

Appendix 1

Receptive contexts for change: the eight factors
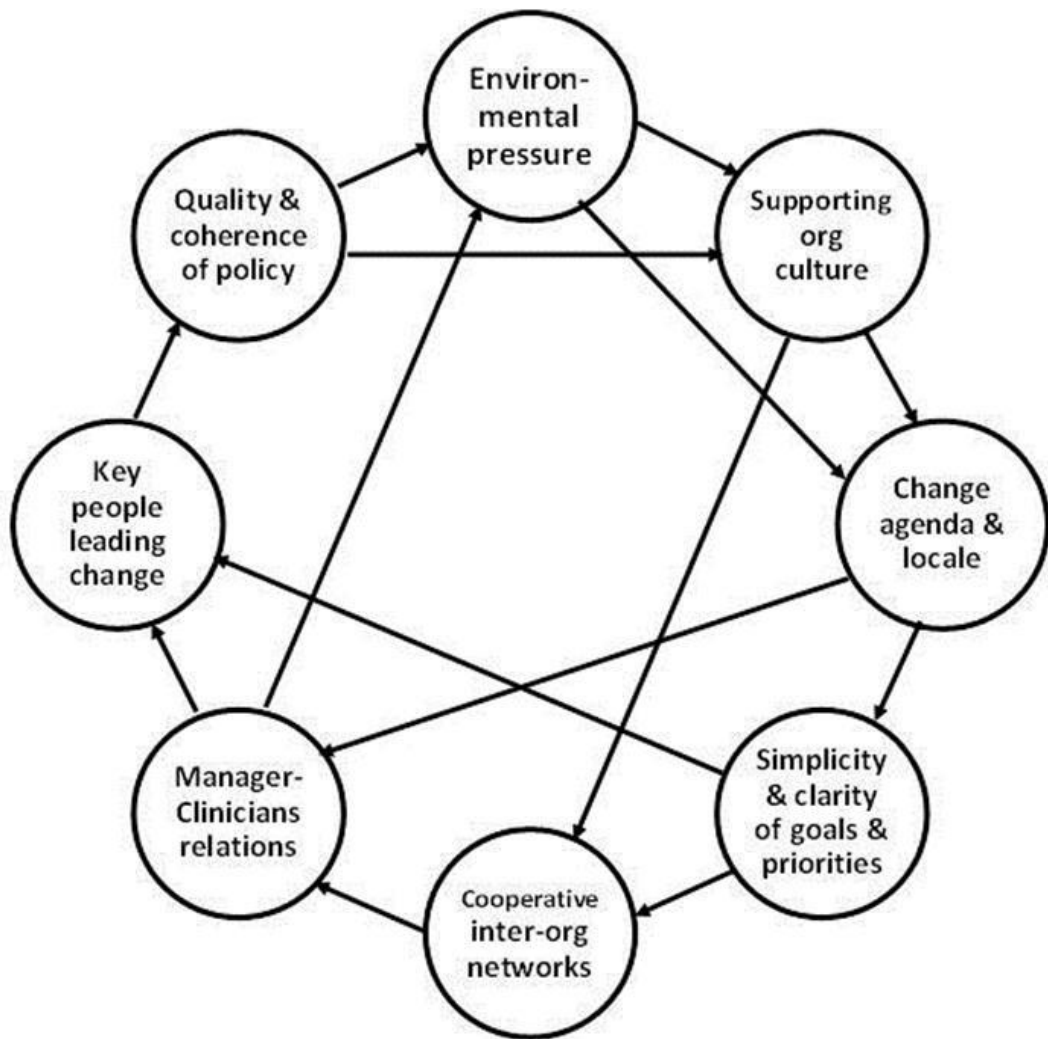
Adapted from: (Pettigrew *et al.*, 1992, p276)

Appendix 2

Eleven World Class Commissioning Competencies and sub-components

	Heading	Sub-competencies		
		a	b	c
1	Locally lead the NHS	Reputation as the local leader of the NHS	Reputation as a change leader for local organisations	Position as an employer of choice
2	Work with community partners	Creation of local area agreement based on joint needs	Ability to conduct constructive partnerships	Reputation as an active and effective partner
3	Engage with public and patients	Influence on local health options and aspirations	Public and patient engagement	Improvement in patient experience
4	Collaborate with clinicians	Clinical engagement	Dissemination of information to support clinical decision-making	Reputation as leader of clinical engagement
5	Manage knowledge and assess needs	Analytical skills and insights	Understanding of health needs trends	Use of health needs benchmarks
6	Prioritise investment of all spend	Predictive modelling skills and insights to understand the impact of changing needs on demand	Prioritisation of investment and disinvestment to improve population's health	Incorporation of priorities into strategic investment plan to reflect different financial scenarios
7	Stimulate the market	Knowledge of current and future provider capability	Alignment of provider capacity with health needs projections	Creation of effective choices for patients
8	Promote improvement and innovation	Identification of improvement opportunities	Implementation of improvement initiatives	Collection of quality and outcome information
9	Secure procurement skills	Understanding of provider economics	Negotiation of contracts around defined variables	Creation of robust contracts based on outcomes
10	Manage the local health economy	Use of performance information	Implementation of regular provider performance discussions	Resolution of on-going contractual issues

| 11 | Efficiency and effectiveness of spend | Measuring and understanding efficiency and effectiveness of spend | Identifying opportunities to maximise efficiency and effectiveness of spend | Delivering sustainable efficiency and effectiveness of spend |

Reference DH, 2007b, p3

Appendix 3

Interview Schedule Part A

Words in bold are topic headers. Questions are in normal font and are represented by Q and should be read out to the interviewee. Words in italics are instructions for the interviewer.

Introductions. Present participants with information sheet and consent form. Reiterate issues of confidentiality and anonymity, the purpose of the study, and what is going to happen with the data. Ask interviewee to read and sign the consent form.

[ ] tape on   [ ] volume level

Information on role

Q1. How are you currently involved in health care commissioning? (PCT&PbC)
Probe for: brief role description. Key relationships. How do they perceive their role? Relative pre/post WCCC launch.PbC/ PCT diff

Q2. What, if anything do you see as preventing you from fully performing your commissioning role?
Probe for: performing your role as fully as possible? Facilitators to doing this better?

Description of current process

Q3. Can you describe the commissioning process in this PCT? How do you see commissioning being performed generally?
Probe for: Good/poor pockets of commissioning? lead commissioner, responsibilities, structures, PCT/PbC diff, process well

Q4. Can you describe the current relationships underpinning your commissioning process?
Probe for: SHA, LA, DH relations, joint posts, NICE, other PCT networks, what's missing? What relationships need developed more?

Q5. What, if anything, prevents your organisation effectively performing the commissioning function?
Probe for: external (economy, change in government) and internal factors (leadership, poor communication, competing agendas)

Q6. As far as you are aware what tools, if any, are used to support commissioning in this PCT?
Probe for: Insight into popular/widely used tools…'depth' of use? Token? Real? FESC-problems?, JSNA, any PCT specific tools, valuable, need more/different tools, aware of available tools not used, challenges to use of tools

Competencies

Prompt: introduce as new topic… Provide list of 11 competencies as prompt for discussion.

Q7. What are your views on the 11 World Class Commissioning Competencies?
Q7b Do you think they are comprehensive? Is there anything you would add/ take away?
Probe for most/least useful – how do you think they will change commissioning practice? If at all?

Q8. Can you tell me about how these are utilised in current commissioning?
Probe for: How often do you refer to these? Do they dominate commissioning? PCT level focus? Please provide an example.

Q9. How do you think the competencies for World Class Commissioning impact commissioning?
Q9b … and will in the future?
Probe for: Do they help/hinder what you would see as 'better commissioning'? Do you think they will help deliver better health outcomes?
Please provide an example?

Q10. In your opinion how can the assessment process for the competencies be improved, if at all?
Probe for: is this reflective of actual activity on the ground? Is it sensitive enough to detect poor practice? Is it working? How are PCTs responding?
Q10b More broadly could you reflect on how the current commissioning process could be improved, if at all?
For example…can you describe a difficult prioritization or dis-investment decision you have recently had to make? How did competencies play out?

Final Remarks

Q11. How do you think other aspects of health care reform have impacted commissioning effectiveness? For example the Darzi next stage review, Choice Agenda, Payment by results, QIPP, CQUIN
Probe for: Levels/ Hindrances? Clashes with competencies? Will WCC work alone?

Q12. Are there any other points you would like to add?
Use of National Programme Budgeting Data, PBMA, Cost Effectiveness Analysis? Predictive Risk modelling tools, cost effectiveness, dis-investment.

Close interview. Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results.

Appendix 4

> **Words in bold are topic headers.** Questions are in normal font and are represented by Q and should be read out to the interviewee. Words in italics are instructions for the interviewer.

> *Introductions. Present participants with information sheet and consent form. Reiterate issues of confidentiality and anonymity, the purpose of the study, and what is going to happen with the data. Ask interviewee to read and sign the consent form.*

[ ] tape on   [ ] volume level

Information on WCC

Q1. Please tell me your thoughts about the WCC initiative?
Probe: what were its aims? Did it achieve these? Challenges? Did it lead to improvements in commissioning?

Q2. What did you think of the initiative in terms of quality and coherence of the policy?
Probe: fit with organisational goals, fit for PBC, suitable timing/ timeframe for commissioning agenda & PCTs? Feasibility?

Q3. Were there any barriers to achieving the competencies for WCC?
Probe: internal (culture, communication, control, leadership)
External (environmental pressure, policy, economy, political environment)

Q4. Can you identify any facilitators to achieving the competencies for WCC?
Probe: internal (culture, communication, autonomy, leadership)
External (environmental pressure, policy, economy, political environment)

Information about the organisation

Q5. Can you describe for me the organisational culture in the PCT?
Probe: supportive? Values? Ways of working? Hierarchical? Subcultures? Collective / individualism

Q6. As a commissioning organisation – do you think it is clear what your priorities are?
Probe: simplicity and clarities of goals and priorities? How are these defined and communicated? Buy in? Leadership?

White Paper proposals & change

Q7. What do you think of the proposals contained within the White Paper?
Probe: quality and coherence of policy? Specifically the shift from WCC to GPC? Do you think they will improve health outcomes? Or commissioning processes? How do you perceive GPs have responded to these?

Q8. What are your thoughts on the new management structures within the PCT?
Probe: Potential advantages / disadvantages? Please provide an example. Other's reactions? How this was communicated? Impact on existing organisational networks?

Q9 Can you describe current managerial – clinician relations?
Probe: change in relations? amount of interaction between two groups? Increased participation from a minority or spread of GPs? Power balance? Has any change been GP or management led?

Q10 How are these changes being led? (management restructure & White Paper)
Probe: key people leading change? Leadership/guidance? Communicated by Executives, top down or through networks? Fostering a climate for change? Positive/ negative change attitudes?

Final Remarks

Q11. Is there anything else you would like to add? Or anything that you haven't had an opportunity to share?
Probe for: *Parting comments or summary, recommendation of interviewees?*

Close interview. Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results.

Appendix 5

Interview Schedule Part B:2

Words in bold are topic headers. Questions are in normal font and are represented by Q and should be read out to the interviewee. Words in italics are instructions for the interviewer.

Introductions. Present participants with information sheet (read aloud) and consent form. Reiterate issues of confidentiality and anonymity, the purpose of the study, and what is going to happen with the data. Ask interviewee to read and sign the consent form.

[ ] tape on   [ ] volume level

Information on GPCC

Q1. Please tell me about the make up of GPCC that you are a part of and your role within that.
Probe: brief role description. Number of members, meeting frequency, number of managers, selection process for leaders.

Q2. How are the managers and clinicians working together?
Probe: separation of tasks/ roles, shared vision? Division or perception of roles, links with other GPCC in region.

Q3. Are you currently working with the PCT for handover etc?
Probe: relationship with the PCT, handover process, roles and responsibilities.

White Paper

Q4. What are your thoughts on the recent Bill for Health and Social Care 'Equity & Excellence: Liberating the NHS'?
Probe: has the policy generated commitment from GPs? Do you think it is well articulated? Any gaps?

Q5. Can you describe for me what you seen the main objectives of the policy to be?
Probe: Feasibility? Policy contradiction? Vision too broad? Are the priorities for GPCC clear?

Implementation

Q6. How are these changes being led?
Probe: nationally and locally, leadership, communication? Collaboration? Do you have any thoughts on what the stimulus for this shift was? How is this new arrangement different to previous arrangements? Will this be real change?

Q7. What do you expect the main benefits to moving to GPCC will be?
Probe: Is this what you would see as 'better commissioning'? Do you think they will help deliver better health outcomes? PPE? Please provide an example.

Q8. What do you perceive the main challenges of implementing the policy to be?
*Probe: current challenges? Anticipated challenges? FT position? Power? Do you foresee any **disadvantages**? Please provide an example. Resources?*

Q9 Do you think the time frames within the policy are well paced? Is your GPCC ready for complete handover in April 2013?
Probe: pace of change, now and April 2013 enough time for handover and training? Group dynamics? Norming etc

Q10. What do you think will be the major changes within the overall health economy in the next 2 years?
Probe: commissioning landscape, plurality or providers? Outsourcing? Increased presence of private companies? Resource constraints? Management of scarcity?

Final Remarks

Q11. Is there anything else you would like to add? Or anything that you haven't had an opportunity to share?
Probe for: *Parting comments or summary, recommendation of interviewees?*

Close interview. Thank respondent. Offer reassurance that all responses will be anonymised and the participant will not be identified in the dissemination of results

Appendix 6

Coding Framework devised from Eight Factors of Receptivity

1: Quality and Coherence of Policy

- **1.1: policy coherence**
  - **1.1.1: fully coherent**
  - **1.1.2: fragmented**
  - **(1.1.3: contradictory)**
  - **(1.1.4: notable gaps)**
- **1.2: policy vision**
  - **1.2.1 broad**
  - **1.2.2 narrow**
- **1.3: commitment building**
  - **1.3.1 buy-in**
  - **1.3.2 shared world view**
- **1.4: policy quality**
  - **1.4.1 articulate**
  - **1.4.2 vague**
  - **1.4.3 strategy broken into actionable pieces**
- **1.5: policy fit**
  - **1.5.1 in line with existing strategy/direction**
  - **1.5.2 divergent from existing strategy/ direction**
  - **1.5.3 matched to a realistic and achievable financial framework**
- **1.6: feasibility**
  - **1.6.1 implementable**
  - **1.6.2 limited feasibility**

2: Key People Leading Change

- **2.1: leadership**
  - **2.1.1: local/ organisational level**
  - **2.1.2: national (NHS) level**
- **2.2: leadership continuity**
- **2.3: leading change**
  - **2.3.1 planning**
  - **2.3.2 opportunism**
  - **2.3.3 timing**
  - **2.3.4 simultaneous resolution of issues**
- **2.4: team building**
- **2.5: personal skills**

3: Environmental Pressure

- **3.1: radical change**
- **3.2: financial pressure**
  - **3.2.1 history**
  - **3.2.2 distribution of power**
  - **3.2.3. local assumptions**
- **3.3: energy drain**
- **3.4: environmental buffering**
- **3.5: scape-goating and defeat of managers**

4: Supportive Organizational Culture

- **4.1: hierarchies**
    - o **4.1.1: formal hierarchies**
    - o **4.1.2: informal hierarchies**
    - o **4.1.3: focus on skill over rank**
- **4.2: openness**
    - o **4.2.1 to risk**
    - o **4.2.2 to research and evaluation**
- **4.3: value base (including rewards)**
    - o **4.3.1 deep seated assumptions**
    - o **4.3.2 officially espoused ideologies**
    - o **4.3.3: Challenging and changing beliefs**
- **4.4: ways of working (purpose designed structures)**
    - o **4.4.1 flexible working across boundaries**
    - o **4.4.2 leaders as role models**
    - o **4.4.3 general manager cadre**
- **4.5 positive self image and sense of achievement**

5: Managerial Clinical Relations

- **5.1: communication**
    - o **5.1.1: effective communication**
    - o **5.1.2: ineffective communication**
- **5.2: supportive relationship**
    - o **5.2.1 trust**
    - o **5.2.2 honesty**
    - o **5.2.3 early involvement of clinicians**
    - o **5.2.4 mutual respect**
    - o **5.2.5 relationship building**
- **5.3: Clinician attitudes**
    - o **5.3.1 hybrid clinicians**
- **5.4 Managerial attitudes**
    - o **5.4.1 use of incentives/ penalties**
    - o **5.4.2 identify clinician values/ needs**

6: Co-Operative Inter-Organization Networks

- **6.1: informal networks**
- **6.2: purposeful networks**
    - **6.2.1 trading and education**
    - **6.2.2 commitment building and energy raising**
    - **6.2.3 marrying top down and bottom up concerns**
- **6.3 organisational power/ influence**

7: Simplicity and Clarity of Goals and Priorities

- **7.1: key priorities**
    - **7.2.1 protection from constantly shifting short term pressures**
- **7.2: persistence in pursuit of organisational goals**
- **7.3: organisational agreement/ awareness of goals**
- **7.4 breaking the problem into more manageable and actionable pieces**

8: Change Agenda and its Locale

- **8.1: pace of change**
- **8.2: political culture**
    - **8.2.1: organisational/ local political culture**
    - **8.2.2: NHS political culture**

- **8.3: plurality of providers**
- **8.4: presence of teaching hospital (/foundation trust)**
- **8.5: relationship with local community**
- **8.6 change timing**

Appendix 7

Participant consent form Part B: 2

[Headed paper using University Logo]

CONSENT FORM

Title: A study to understand organisational change in response to Health Care Policy:

 A case study in the English NHS

Name of Researcher:

Please tick

1)   I understand that my participation in this study is voluntary and that I am

free to withdraw at any time, without giving any reason, without my legal

rights being affected. I have been introduced to the study and have been

given the opportunity to ask questions.   ☐

2)   I agree to take part in the above study.   ☐

3)   I confirm that I give permission to record this interview.   ☐

4)   I confirm that I give permission to use direct quotations   ☐

_____   _____   _____

Name of interviewee   Date   Signature

_____   _____   _____

Researcher   Date   Signature

1 for interviewee; 1 for researcher

Appendix 8

Patient Information sheet Part B: 1

[Headed paper using both University and Organisation Logos]

Participant Information Sheet

Study title: Using organisational change theory to analyse organisational responses to commissioning policy in the NHS

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The National Health Service (NHS) has been subject to significant change as a result of government priorities for efficiency and equity. These changes are aimed at strengthening local, sustainable health care systems that deliver better care and patient experiences, as well as better outcomes and value for money.

In the past few years commissioning has been subject to a number of initiatives and reforms including, World Class Commissioning, QIPP (Quality Innovation Productivity and Prevention). Yet, greater knowledge is required about how these policy changes impact local commissioning and what will be the real or perceived impact of these initiatives on policy objectives, outcomes, and on the local health care system.

The purpose of this study is ultimately to improve the practices of policy making and implementation. The findings will be used to devise informed policy making strategies, and recommend organisational strategies for maintaining flexibility and readily implementing policy. Results will actively be disseminated throughout policy, managerial and academic communities.

Why have I been chosen?

We would like you to participate in this study because we wish to seek the views of key GPs and managers with knowledge and insight on commissioning.

What will happen to me if I take part?

This is the second phase in a three part study aiming to understand organisational responses to commissioning policy. The first phase involved interviews and observations at (organisation name). The observations, which began in phase one, will continue as part of phase two. Organisational consent has been obtained for these observations, and an opt out procedure has been established, should you wish to refrain from being observed. Details of how to do this are available at (link to staff intranet page). Each interview will last, approximately 45 minutes and up to a maximum of 60 minutes. The interview will be conducted by Sara McCafferty, and undertaken face-to-face. We will endeavour to conduct the interviews at your workplace to minimise disruption to your schedule. If you decide to take part you are still free to withdraw at any time and without giving a reason.

Will my taking part in this study be kept confidential?

All information that is collected during this research will remain confidential; no responses from any interviewee will be directly attributed to any individual. Any digital recordings of interviews will be destroyed upon transcription. Transcripts will be anonymised and kept in a secure location until the study has been completed, when they will be destroyed. In the unlikely event of malpractice being discovered it will be dealt with according to standard procedures.

What will happen to the results of the research study?

Two of the principal research objectives are to provide policy-makers and emerging consortia with timely, formative feedback on good practice in implementation and actively disseminate findings within policy, managerial and academic communities.

How can I get further information?

Please ask Sara McCafferty (tel 0191 222 3824 email sara.mccafferty@ncl.ac.uk) if you have any questions or would like more information about this invitation.

Thank you for your help.

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