

**Health policy, the politics of governance and change:
The introduction of Clinical Commissioning Groups
in context**

A thesis submitted to the University of Manchester for the degree of
Doctor of Philosophy in the Faculty of Medical and Human Sciences

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Table of contents

List of figures	6
List of tables	6
Abstract	7
Declaration	8
Copyright statement	9
Acknowledgements and dedication	10
The author	11
List of acronyms.....	12
Chapter 1: Introduction.....	13
Chapter 2: Situating the Health and Social Care Act 2012 and the introduction of Clinical Commissioning Groups	18
2.1: The story of the Health and Social Care Act 2012.....	18
2.1.1: Equity and excellence: liberating the NHS – White Paper	19
2.1.2: The Health and Social Care Bill.....	21
2.1.3: The “pause”.....	23
2.1.4: The realisation of the Act.....	25
2.2: Structural and functional changes within the English healthcare system	29
2.2.1: Clinical Commissioning Groups	32
2.2.2: NHS England.....	33
2.2.3: Local authorities, public health, and health and wellbeing boards	36
2.2.4: Healthwatch England and local Healthwatch	37
2.2.5: NHS provider trusts.....	38
2.2.6: Monitor and the Care Quality Commission.....	38
2.3: A brief history of NHS primary care led commissioning initiatives	39
2.3.1: GP Fundholding.....	40
2.3.2: Total purchasing.....	41
2.3.3: GP Commissioning	41
2.3.4: Primary Care Groups	42
2.3.5: Primary Care Trusts.....	43
2.3.6: Practice-based Commissioning	44

2.3.7: Primary care led commissioning analysis	46
2.3.8: Conclusions	48
2.4: Chapter summary.....	50
Chapter 3: Problematising the policy	52
and the membership organisation concept	52
3.1: Equity and Excellence: Liberating the NHS White Paper.....	53
3.2: The Health and Social Care Act 2012	55
3.3: Towards establishment: creating responsive and accountable clinical commissioning groups	56
3.4: Problematising the membership organisation concept.....	57
3.5: Conclusion	62
3.6: Chapter summary.....	63
Chapter 4: NHS policy analysis literature review	65
4.1: Chapter summary.....	71
Chapter 5: Institutionalism.....	72
5.1: Introduction.....	72
5.2: Institutions and institutional theory: a brief survey	73
5.2.1: New institutionalism	73
5.2.2: Three pillars institutionalism.....	77
5.3: Institutional logics.....	80
5.4: Utilising and assessing the institutional logics perspective	89
5.5: The NHS and Health and Social Care Act 2012 from an institutional logics perspective ..	90
5.6: Chapter summary.....	94
5.7: The thesis so far	94
Chapter 6: Methodology	97
6.1: Aim, objective and research questions	97
6.2: Case studies and an ethnographic approach.....	98
6.3: Studying through	102
6.4: Fieldwork	103
6.4.1: Recruitment and negotiating access	104
6.4.2: Ethnographic observation	105
6.4.3: Interviews.....	106
6.4.4: Documentary analysis	107
6.5: Analysis.....	108

6.6: Ethical issues.....	110
6.7: Notchcroft CCG	111
6.8: Chapter summary.....	114
Chapter 7: The governing core	115
7.1: Chapter summary.....	119
Chapter 8: Membership organisation	120
8.1: Introduction to the results chapters	120
8.2: Being a membership organisation	121
8.3: Notchcroft history and CCG structure	125
8.4: Legitimacy, credibility, and reputation	131
8.5: Organisational identities and story telling	134
8.6: Conclusion	137
8.7: Chapter summary.....	141
Chapter 9: NHS England: authorisation, assurance, and collaboration.....	143
9.1: Authorisation and assurance	144
9.2: The “lever”: ensuring continuous improvement in primary care.....	146
9.3: Specialised service commissioning and collaboration	149
9.4: “Be brave and bold... but don’t step out of line”	152
9.5: Conclusion	154
9.6: Chapter summary.....	156
Chapter 10: NHS 111	157
10.1: NHS 111: a new, national urgent care telephone hotline	157
10.2: Local preparations.....	158
10.3: Service launch	162
10.4: Conclusion	163
10.5: Chapter summary.....	165
Chapter 11: Commissioning activities.....	166
11.1: “Do we think as GPs, as practices, or commissioners?”	166
11.2: Responsibilities	167
11.3: Competition and patient choice	172
11.4: Conclusion	174
11.5: Chapter summary.....	176
Chapter 12: Discussion	177
12.1: Introduction	177

12.2: How do those involved with the CCG conceptualise the organisation and enterprise in which they are expected to participate? (Research question one).....	178
12.2.1: “Buying in” to the membership organisation	178
12.2.2: Protecting responsibilities.....	179
12.2.3: Organisational structure	180
12.3: How do these conceptualisations shape action on the part of those involved with the CCG and manifest in the work of the CCG? (Research question two)	181
12.3.1: “Buying in” to the membership organisation	181
12.3.2: Protecting responsibilities.....	182
12.3.3: Organisational structure	183
12.4: The application of institutional logics	183
12.4.1: Reflections on the application of institutional logics	190
12.5: The problematised policy and the enacted policy	193
12.6: The governing core and the membership organisation	198
12.7: Researcher reflections.....	203
12.8: Strengths and limitations of the study.....	206
12.9: Policy implications	209
12.10: Practical implications	211
12.11: Future research	214
12.12: Chapter summary.....	217
12.13: Conclusion.....	218
References.....	222
Appendices	241

List of figures

Figure 1: Conceptualisation of the study as four concentric circles	16, 103, 194
Figure 2: Significant events in the realisation of the HSCA12 from 2010-2013 (adapted from The King's Fund 2012)	28
Figure 3: Accountability and funding dynamics in the post HSCA12 English NHS (The King's Fund 2011)	30
Figure 4: The English health and care system from April 2013 (NHS Choices 2013)	31
Figure 5: The structure of Notchcroft CCG	113

List of tables

Table 1: CCG authorisation assessment domains and criteria examples (NHS Commissioning Board 2012b)	35
Table 2: CCG assurance framework (NHS England 2014a)	35
Table 3: Timeline of NHS clinical commissioning initiatives (Miller et al. 2012)	39
Table 4: Characteristics of primary care led commissioning initiatives (Miller et al. 2012)	49
Table 5: Assumptions of the institutional logics approach	81
Table 6: Inter-institutional system ideal types (Thornton et al. 2012)	83
Table 7: Prominent institutional logics in the history of the NHS (Currie and Guah 2007)	91
Table 8: Prominent institutional logics of the HSCA12	92

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Abstract

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Thesis title: Health policy, the politics of governance and change: The introduction of Clinical Commissioning Groups in context

The Health and Social Care Act 2012 (HSCA12) represents one of the more dramatic reforms in the history of the English National Health Service (NHS) in terms of scope and pace. The flagship of the policy was the replacement of Primary Care Trusts with Clinical Commissioning Groups (CCGs): General Practitioner (GP) led “membership organisations” with responsibility for planning and purchasing most NHS care. A new “arm’s length” body, NHS England (NHSE), was created to authorise and oversee CCGs. The purpose of this research was to critically explore the ideational content of the HSCA12 and consider it in relation to social practices at the organisational level of a CCG: to provide a detailed, contextualised account of a CCG’s early operation, paying particular attention to the implications of its officially intended status as a membership organisation. By problematising the HSCA12, I have highlighted how CCGs and the GPs that constituted them were presented as an emancipatory force saving the NHS from ineffectual managers that lacked clinical and local knowledge about what patients needed; membership organisation status was bound up with this claim of local representation, and the policy attempted to orchestrate engagement from GPs as members through normative devices and governance systems including legislation and assessment programmes. However, the policy elided the difference between GPs as individuals and GP practices and left ambiguous precisely who or what constituted a member.

Thirteen months of fieldwork using ethnographic methods (meeting observations, interviews, documentary analysis) were carried out with a case CCG: Notchcroft. The policy delineated “the membership” and “the governing body” as sub-groups within the CCG, but I found many others were involved in CCG governance processes and created “the governing core” concept to describe them. Confusion in the policy over exactly who was a member was paralleled in the CCG. The governing core, many of whom were GPs, were involved in performance assessment processes of GPs in order to fulfil a legal obligation to NHSE. This represented a further redrawing of the GP/state relationship and was a source of identity dissonance. The governing core also actively transmitted national policy norms about what it meant to be a member to the broader membership. By trying to “sell” CCG membership and encourage engagement they were attempting to legitimate the organisation and their roles within it. Notchcroft CCG’s unusual structure, with two levels (districts and locales) below central committees, appeared inefficient. This structure developed as a response to previous national commissioning policies. The institutional logics approach—employed as an analytical lens—proved useful in explaining its endurance: districts were containers for identity and interests to be protected, whilst locales were established and maintained as local “self help” organisations to support quality improvement. The initial purposes of districts and locales thus represented different logics of action that appeared self-evident to those involved, although they were less obvious to an external observer. In time, these initial logics were eroded, and districts and locales were given additional functions. These findings illustrate the emergent tension between national policy and local enactment, and demonstrate how local socio-historical context plays an important role in shaping how policy is realised in practice.

Declaration

I declare that no portion of the work referred to in the thesis has been submitted in the support of an application for another degree or qualification of this or any other university or other institute of learning.

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Acknowledgements and dedication

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I would not be in this position were it not for the love and support of my family. In particular, I owe enormous thanks to my mother—Margaret—and brother—Dave. They have both done so much over many years to help me develop my abilities as an academic. Their patience and wisdom has truly been unending. My wife—Jen—has kept me going through the Doctoral process with kindness and encouragement and I am very grateful to her.

I would like to offer my sincere thanks to Notchcroft CCG and everyone involved with the organisation, particularly those people that took part in interviews, facilitated my access to meetings, and took time to explain things to me. This work would not exist if it were not for them, and I hope that those that read it find some value in it.

For my Dad: Paul.

The author

In 2008 I graduated from the University of Sheffield with a first class honours degree in Health and Human Sciences (BMedSci). I was also awarded the Edwards Prize for excellence in health and human related sciences. During the final year of my undergraduate degree I spent two months with a fellow student on a self-organised placement in Cambodia. I undertook fieldwork in a rural Cambodian village with high rates of arsenicosis caused by the drinking of groundwater from contaminated wells. I worked with a translator to elicit villagers' experiences of accessing groundwater and living with the disease. I also carried out interviews with senior members of major multi-national non-governmental organisations (NGOs) that had been involved in the sinking of the contaminated wells. This formed the basis of my dissertation in which I considered the policies of the NGOs in contrast to the experiences of those villagers whose lives were impacted by them. It was this work that shaped my decision to study for an MSc in Environmental Governance at The University of Manchester the following year. I graduated in 2009 with distinction. My MSc dissertation research was a mixed methods project. I carried out surveys with residents from two geographically proximal but socio-demographically distinct towns to explore differences in views about the environment and environmentally significant behaviour.

Shortly after my Master's graduation I took up a research assistant post within the National Primary Care Research and Development Centre (NPCRDC), as it was then, on the AMP research programme, led by Prof. Linda Gask. AMP was a multi-arm study exploring ways to improve access to primary care mental health services for under-reached groups, such as certain ethnic minorities and the elderly. I was involved in many aspects of the project, including: ethnographic observations of GP receptionists, interviews with service users, and focus groups with service providers. During my time working on the AMP programme I became increasingly interested in the role of policy in shaping the healthcare environment and the organisations populating it and decided to pursue a PhD with this focus.

List of acronyms

A&E	Accident and Emergency
AQP	Any Qualified Provider
BMA	British Medical Association
CCG	Clinical Commissioning Group
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CSU	Commissioning Support Unit
DES	Directed Enhanced Service
DH	Department of Health
EU	European Union
FT	Foundation Trust
GMS	General Medical services
GP	General Practitioner
GPFH	General Practice Fundholding
HWB	Health and Wellbeing board
HSCA12	Health and Social Care Act 2012
LAT	Local Area Team (NHS England)
LES	Locally Enhanced Service
LINK	Local Involvement Network
NHS	National Health Service
NICE	National Institute for Clinical Excellence (subsequently: National Institute for Health and Clinical Excellence)
PbC	Practice-based Commissioning
PCG	Primary Care Group
PCT	Primary Care Trust
PEC	Professional Executive Committee (Primary Care Trust)
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
SHA	Strategic Health Authority
TP	Total Purchasing

Chapter 1: Introduction

On the 11th May 2010, five days after a UK general election resulting in the first hung parliament since 1974, the Conservative Party and Liberal Democrats signed an agreement forming a coalition government. That July, Andrew Lansley, the then Health Secretary and Conservative Member of Parliament, announced the Coalition's plans for reform of the National Health Service (NHS) in England in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010). This laid the ground for the Health and Social Care Bill (Department of Health 2011), which proposed major structural changes to the NHS. This came as a surprise to many given the commitment in the previously published coalition agreement to '...stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government 2010, p.24). According to Delamothe and Godlee (2011, p.237), the reforms represented the '...the biggest upheaval of the NHS in its 63 year history.'

The focal point of the Health and Social Care Bill was the creation of what became known as Clinical Commissioning Groups (CCGs; originally called General Practice Consortia). These General Practitioner (GP) led organisations were to take responsibility for approximately 60% of the NHS commissioning budget to purchase the majority of healthcare services for their local populations (The King's Fund 2011). All 152 Primary Care Trusts (PCTs), and the 10 Strategic Health Authorities (SHAs) that oversaw them, were to be abolished in the new system. A new organisation would be created to take on various duties that had previously been the purview of the Department of Health (DH): NHS England (originally known as the NHS Commissioning Board) would operate at arm's length from ministers and would be responsible for authorising CCGs and assessing their performance on an on-going basis.

The Bill attracted considerable criticism on the grounds that it would open up the NHS to a greater degree of privatisation than ever before (Campbell 2011a), and that it represented an attempt to remove the Secretary of State's duty to provide a comprehensive health service free at the point of delivery, thereby reducing ministerial accountability (Pollock and Price 2011). The extent of negativity towards the plans from

professional associations (such as the British Medical Association (BMA) who called for the Bill to be withdrawn (British Medical Association 2012)), led Prime Minister David Cameron to announce that the Bill would be subject to a “pause” in order to address concerns. A group called the NHS Future Forum was assembled in April 2011 to review and make recommendations on alterations to the Bill (NHS Future Forum 2011). These recommendations were tendered in June 2011 and adopted (Chapter 2, Section 2.1.3). Despite considerable resistance, the Health and Social Care Bill completed its journey through Parliament and became an Act in March 2012. All 211 CCGs were authorised by NHS England in April 2013. This process, and the story of the policy, is explored in more detail in the following chapter.

The NHS is an institution of great symbolic and practical significance to the population of the UK, the government, and political parties in opposition. A cycle of policy-driven change to the service has become the norm, to the degree that it exists in a near constant state of ‘redisorganisation’ (Smith et al. 2001, p.1262). The Health and Social Care Act (2012; henceforth HSCA12) represents the latest phase in this process, but it is of particular significance because of the extent to which it reconfigured elements within the system and the speed at which this occurred. The figurehead of the HSCA12 was the introduction of CCGs, the latest in a long line of initiatives to involve primary care clinicians in the commissioning process. However, by making CCG membership compulsory by law for all GP practices, CCGs are the most extensive initiative of this type to date.

There is a tendency for NHS policies to present policy-making as an exercise in identifying a particular issue or problem, and then unproblematically deciding on the best course of action in order to solve it based on available evidence (Russell et al. 2008). This evidence-based understanding of policy-making is reflected in the dominant approach to analysing healthcare policies (Greenhalgh and Russell 2009), where there is also a general tendency to frame policies as rational, unambiguous, and unfolding in a linear fashion from problem identification to implemented solution (Shore and Wright 2011). The study of policy enactment is often divorced from social and historical contextual detail (Pettigrew et al. 1988). This has particularly been the case in healthcare where the dominant

biomedical model of medicine and evidence-based practice valorise knowledge that is de-contextual and generalisable.

This thesis presents a case study of an English¹ commissioning organisation—Notchcroft CCG (a pseudonym; see Chapter 6, Section 6.7)—and the policy from which it emerged—the HSCA12 (Chapter 2). It aims to address the deficiencies in studies of policy analysis identified above by attending to both policy content and policy enactment (Gordon et al. 1977), and to demonstrate the value of engaging with contextual detail at both the local organisational level and national policy level. The analysis of policy content focuses particularly on one of the core ideational elements of the HSCA12: CCGs and their status as *membership organisations*. This presentation of CCGs was subjected to *problematization* (Chapter 3), and the understanding from this process informed the data collection and analysis.

The analysis of policy enactment focused on Notchcroft CCG and the experiences of those within the organisation. Thirteen months of fieldwork (from October 2012 to December 2013) were carried out employing ethnographic methods, namely: observation of CCG meetings and events, semi-structured interviews with those working in the CCG, and local documentary analysis (see Chapter 6, Section 6.4). The problematised understanding of the policy was developed prior to fieldwork and used to inform the study of the organisation. The institutional logics theoretical framework (Thornton et al. 2012) was employed as a sensitising device or analytical lens (Chapter 5, Sections 5.3—5.5) and I consider its value in enhancing analytical understanding of multiple elements of the study (Chapter 12, Section 12.4).

This study can be conceptualised as a series of concentric circles, as in Figure 1 below. Briefly, this illustrates how Notchcroft CCG is the primary ‘site of governance’ (Laffan 2001, p.710) under investigation and the main empirical focus, but it is situated in a broader organisational and policy context that is recognised as important. Analytical attention shifts between circles through the thesis and each circle provides important contextual background for the circles within it. The ideas and arguments

¹ Control over the NHS was devolved to Scotland, Wales, and Northern Ireland in 1999. Therefore, the HSCA12 was only relevant to the reform of the English health service.

developed within one circle may call on those from other circles. This is discussed in more detail in Chapter 6 (Section 6.3).

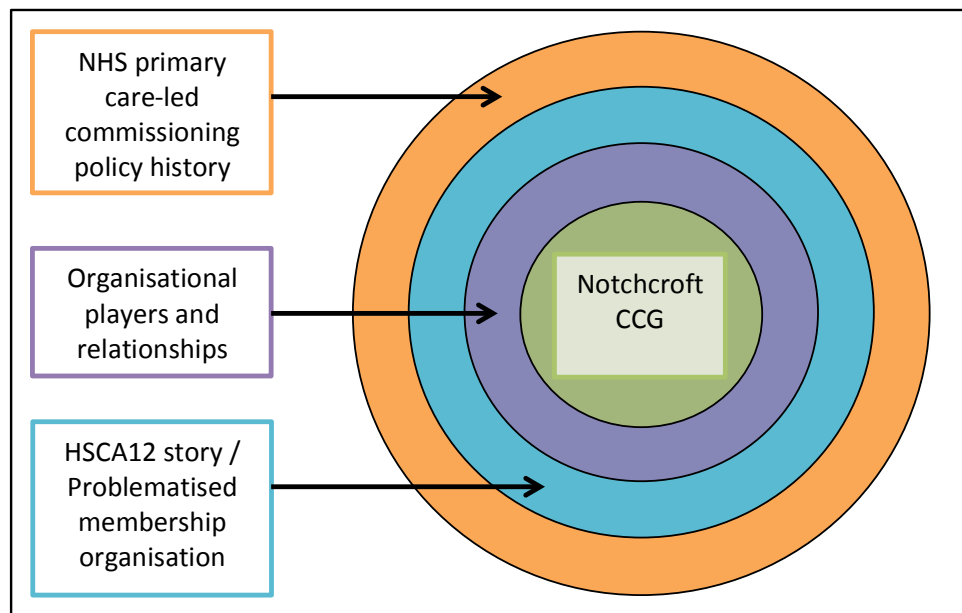


Figure 1: Conceptualisation of the study as four concentric circles

The rest of the thesis is structured as follows:

- Chapter 2, Sections 2.1 and 2.2 provide a detailed account of the instantiation of the HSCA12 and the structural and organisational changes within the English NHS resulting from it;
- Chapter 2, Section 2.3 focuses on the history of primary care-led commissioning initiatives in the NHS and reviews literature that has studied them;
- Chapter 3 presents a problematised account of the HSCA12 and associated policy documents;
- Chapter 4 provides an account of the small body of NHS policy analysis literature employing methods consonant with this study, and to which it will contribute;
- Chapter 5 considers the theoretical landscape of new institutionalism, identifies the institutional logics approach or meta-theory as being of potential utility to this study, specifies how it will be applied, and considers the NHS and HSCA12 from an institutional logics perspective;
- Chapter 6, the methodology, specifies the aim, objective, and research questions and explains how their selection was based on engagement with the policy and existing

scholarship. It also explains the research methods and process, and provides an introduction to Notchcroft CCG;

- Chapter 7 introduces the governing core concept, which was created as a means of describing those people, including but not limited to the governing body, involved in CCG governance processes above the GP practice level;
- Chapters 8—12 contain the main substantive findings of the study, a discussion of how these address the research questions, consideration of the contribution that this study makes to an understanding of the topic and institutional theory, reflections on the research process, and suggestions for future research.

At the end of each chapter is a concise summary section containing the key points from the preceding discussion.

Chapter 2: Situating the Health and Social Care Act 2012 and the introduction of Clinical Commissioning Groups

The aim of this chapter is to explain the HSCA12, the changes to the English healthcare system resulting from it, and to situate these changes—particularly in relation to primary care led commissioning—within a broader socio-historical context. To this end, the story of the HSCA12, including its creation, parliamentary journey, and the reactions it elicited, will be told below (Section 2.1). This will be followed by an account of the organisations that emerged or were reformulated as a result of the policy and an overview of their roles (Section 2.2). The final sections will provide a historical synopsis of policy-driven primary care-led commissioning initiatives in the NHS (Section 2.3).

2.1: The story of the Health and Social Care Act 2012

In 2008 the great recession took hold as a result of the global credit crunch (Jenkins et al. 2012). The reliance of the UK economy on the financial sector meant that it was particularly exposed to negative economic impacts. The Labour government instigated a rescue package for banks, such as Lloyds and RBS, which were in danger of organisational collapse. The Bank of England cut interest rates drastically and the UK's budget deficit increased dramatically. The scale of the economic difficulties faced by the UK provided the impetus for NHS Chief Executive, Sir David Nicholson (in post 2006-2012), to announce that the NHS would be required to make £20 billion of efficiency savings between 2011 and 2015 (Ball and Sawyer 2009).

The recession and the economy were central issues in the 2010 UK general election campaign. The election on 6th May 2010 resulted in a hung parliament meaning that no party had the requisite number of seats for a majority in the House of Commons. The Conservative party received the highest number of votes but was 20 seats short of an overall majority. Five days of talks between the Conservatives and Liberal Democrats resulted in an agreement by the parties to form a coalition. As the new Government became established the economy continued to be the central issue of attention. A broad swathe of spending cuts were announced (BBC News 2010a) and the Government stated

that ‘...deficit reduction, and continuing to ensure economic recovery, is the most urgent issue facing Britain’ (HM Government 2010, p.15).

2.1.1: Equity and excellence: liberating the NHS – White Paper

In July 2010, Andrew Lansley, the then Health Secretary and Conservative MP, announced the coalition’s plans for reform of the NHS in England in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010). The White Paper emphasised three key aspirations of the reforms: ‘putting patients and the public first, improving healthcare outcomes, and empowering health professionals’ (Department of Health 2010, p.2). Of particular note is the lack of attention to the broader context of recession and the programme of major public service cuts getting underway at that time. These factors were clearly of prime relevance to the Government’s approach to NHS reform (as demonstrated in the above paragraph). Furthermore, these aims are remarkably similar to those presented as underpinning numerous previous, successive NHS reforms (discussed in Section 2.3.8). These issues aside, the White Paper announced some significant changes to the structure and dynamics of the NHS in pursuit of these aims. All 152 PCTs (NHS trusts introduced by Labour that held responsibility for commissioning primary, secondary, and community healthcare services) and the 10 SHAs that oversaw them would be abolished in the new structure. Clinical Commissioning Groups (CCGs)—GP led, geographically localised organisations—would be given responsibility for purchasing the majority of healthcare services for their local populations with approximately 60% of the NHS commissioning budget (The King’s Fund 2011). They were described as *membership organisations*, and every general practice in England was legally obligated to join one.

A new organisation, an executive non-departmental public body, called NHS England (originally known as NHS Commissioning Board; NHS England is used throughout here) would be given responsibility for authorising and overseeing CCGs. It would be a body at arm’s length from the DH, composed of four regional offices subdivided into 27 area teams, each of which would work with a group of local CCGs. It would also commission certain specialised services, such as paediatric cardiac services and adult congenital heart disease services, as well as commissioning GPs themselves to provide primary care

services. NHS England would take control of the budget and management of the NHS at large, and consequently the DH would be reduced considerably in size and remit (Greer et al. 2014).

The White Paper proposed more sweeping changes. Directors of public health and their departments would move from PCTs to top tier and single-tier local authorities². Health and Wellbeing boards (HWBs), statutory sub-committees of top tier and single-tier local authorities, would be established as a forum for setting the strategic direction of health and social care, and responding to the public health needs of their respective areas. Another new organisation, Public Health England, would be created as an executive agency of the DH and take on responsibility for advising local public health departments. Monitor, the NHS regulatory organisation, would have its role extended to include the promotion of competition within the market of NHS service provision. The cap limiting the amount of income that NHS provider trusts could receive from treating private patients was to be removed.

A number of think tanks and professional groups endorsed the broad aspirations of the reforms but emphasised concerns about their pace and scale, particularly given a seeming lack of supportive evidence of efficacy, or detail about their implications and functionality (Dixon and Ham 2010; RCGP 2010; RCN 2010). The White Paper also prompted concerns about a conflict of interest for GPs on two related fronts. Firstly, caring for the needs of individual patients at the same time as making decisions about spending on services for a whole population, and the inevitable rationing of care that this would involve, were seen as objectives with the potential for tension. Care rationing has been a concern associated with every form of primary care-led commissioning but was particularly pronounced in relation to CCGs because of the austere economic context. Secondly, CCGs would be in a position where they could potentially commission care from their own membership; although primary care would be commissioned by NHS England, GPs could still carry out

² In England, single-tier local authorities are responsible for the provision of all local government services in their particular area. They are distinct from two tier local authorities; these have a county council top tier (responsible for services such as social care, education and transport across the whole local authority area) and a district or borough lower tier (concerned with activities such as planning, housing, environmental health and refuse collection) of which there can be multiple within one county area.

some work beyond the traditional remit of primary care, for example: joint injections, and anticoagulant monitoring.

2.1.2: The Health and Social Care Bill

The Health and Social Care Bill (Department of Health 2011) was introduced to Parliament in January 2011. It developed the content of the *Equity and Excellence...* White Paper (Department of Health 2010) and contained details of major structural changes to the NHS. It was vast: roughly three times bigger than the Act that founded the NHS in 1946 (Timmins 2012). Its size was primarily a result of the numerous detailed clauses that articulated how the new collection of organisational bodies would interact. The then NHS Chief Executive Sir David Nicholson commented that it was the only change management programme so big that it was visible from space (Delamothe and Godlee 2011).

During the election the Conservatives had offered little indication that such a significant upheaval of the NHS was planned. They had emphasised their commitment to increasing real terms spending on the NHS each year that they were in Parliament; they talked broadly of their intentions to make the NHS more patient-centred, increasing patient choice, and shifting more power to clinicians to enable them to shape the care of their patients (Lansley 2010). These objectives were not revolutionary and seemed to suggest a continuation of the approach to the NHS taken by New Labour; however, in the run up to the election, in the context of recession and significant economic uncertainty, the minutiae of the plans for meeting them were never spelled out. The common expectation was that Lansley would make various tweaks to the NHS inherited from Labour, not pursue a major structural reorganisation through legislation. Indeed, the freshly drafted coalition agreement contained a commitment to ‘...stop the top-down reorganisations of the NHS that have got in the way of patient care’ (HM Government 2010, p.24), which was echoed in the sentiments of various Conservative politicians, including David Cameron, throughout the election campaign.³ The proposals were particularly ambitious

³ When challenged on this point, Lansley would later argue that the reforms were in fact “bottom up” rather than “top down” for two reasons: they involved putting more power in the hands of general practice to shape services, and they would prevent “top down” reorganisations in the future because such changes would require further legislation (Timmins 2012).

because of the time scale sketched out for their implementation: all GP practices to be part of fully functioning CCGs by April 2013. Furthermore, the government was also intent on simultaneously pursuing £15-20 billion of “efficiency savings” from NHS trusts over a three year period as part of their real terms spending increase commitment (Helm and Campbell 2012).

The Bill was opposed by various Royal Colleges and professional groups (Rogers 2012). It was criticised on the grounds that it would open up the NHS to a greater degree of privatisation than ever before through the extension of *any willing provider* (subsequently revised to *any qualified provider*—AQP): an initiative intended to increase competition for certain healthcare services, whereby a range of different providers (that meet baseline standards) offer a particular service and patients then choose among them, most commonly at the point of referral from their GP. Critics argued that an increase in the pursuit of profit as a bottom line was at odds with the founding equitable principles of the NHS and would lead to a “race to the bottom” in terms of care quality (Leys and Player 2011). A number of anti-privatisation campaigns became established, for example: 38Degrees launched a “Protect our NHS petition,” which opposed the fragmentation of the NHS to serve the interests of private profit makers, and collected over 600,000 signatures (38Degrees 2012). A number of public protests focused on the perceived privatisation agenda of the Bill took place, including the occupation of Westminster Bridge in October 2011 (Wintour and Taylor 2011).

Another aspect of the Bill to receive criticism was the replacement of the Secretary of State’s duty to “provide” a comprehensive health service free at the point of delivery with a ‘duty to “act with a view to securing” comprehensive services’ (Pollock and Price 2011, p.n/a). Critics identified this as a step towards removing ministerial accountability from a health system particularly at risk of falling into chaos as a result of the reforms (Pollock and Price 2011). Further concerns related to uncertainty about whether the changes to commissioning would open up the NHS to EU competition law, making it more vulnerable to the interests of private healthcare organisations and speculative capital (Campbell 2011b).

Sections of the Liberal Democrat party also spoke out against the plans. During the party's Spring conference in March 2011, the Bill was resoundingly rejected because it was perceived to be a 'damaging and unjustified market-based approach' (Stratton and Wintour 2011, p.n/a). Pressure mounted on Nick Clegg—Deputy Prime Minister and leader of the Liberal Democrats—to exert some influence to change aspects of the plans that he had been publicly backing. In May 2011, in a referendum that was one of the Liberal Democrat's coalition conditions, voters resoundingly rejected the prospect of introducing the Alternative Vote system, which the Liberal Democrats supported. The party also suffered badly in the local elections, losing numerous seats to Labour. Following these events, Nick Clegg adopted a new tougher stance on some of the proposals, claiming that there would be '...substantial, significant changes...' to the Bill (Barker and Timmins 2011, p.n/a). Labour leader, Ed Miliband, became increasingly vocal in his attacks of the Bill and called for its complete withdrawal (Syal 2012). He pointed to the financial costs of such a reorganisation and the nursing jobs that were already being lost from the NHS because of cuts. Scrapping the Bill entirely, he argued, could protect the jobs of front line staff (Syal 2012).

Even prior to the Bill being published, however, aspects of the reforms were already being realised. The Government was eager to begin the restructuring process wherever possible. Many PCTs and SHAs began to shed staff through redundancies, and uncertainty about job security meant that many employees chose to leave on their own terms and seek work elsewhere. Concerns were raised that this process created a considerable skills deficit in the NHS workforce (Caldwell 2011). A "pathfinder" programme was established in late 2010, which encouraged CCGs to begin the process of becoming operational. The aim of this was to try out different CCG formats, spread best practice, and '...empower pioneering groups of GP practices' (Harkin 2010, p.1).

2.1.3: The "pause"

In April 2011, an announcement was made that there would be a "pause" in proceedings so that a "listening exercise" could take place (Triggle 2011). Reports from those working inside Downing Street suggested that the decision was one imposed on Lansley by Cameron and Clegg because of the extent of negativity towards the Bill (Timmins 2012).

They were concerned that the pressure of dissatisfaction had mounted against Lansley's plans to such an extent that such measures were necessary to protect the Bill's progress. It was Cameron and Clegg who took responsibility for explaining the need for, and form of, the pause to the House of Commons and the electorate. The NHS Future Forum, a group headed by Professor Steve Field (former Chair of the Royal College of General Practitioners (RCGP)) and composed of health professionals, representatives from the voluntary sector and patient groups, was established to gather and assimilate opinion on aspects of the Bill and present recommendations for amendments to the Government (NHS Future Forum 2011). In June 2011, the Government accepted all the group's recommendations, which are summarised below:

- GP Commissioning Consortia were rebranded CCGs and their membership was extended to include lay members and health professionals' representatives from secondary care.
- Monitor's role in promoting competition was de-emphasised (addressing "anti-competitive practices" instead) and a focus on fostering co-operation and collaboration between organisations was added.
- Enhanced measures to ensure transparency and accountability of organisations in charge of spending NHS funds were introduced.
- The role of HWBs was enhanced in relation to the better integration of health and social care.
- Health scrutiny processes were to be kept the responsibility of local authorities and not HWBs.

Cameron, Lansley, and Clegg all claimed that the pause had served their individual aims in an attempt to increase their individual political capital. However, overall it did not increase general acceptance of the policy significantly. More Royal Colleges and professional organisations—a list that now included the RCGP, the Royal College of Nursing (RCN), and the BMA—called for the Bill to be dropped (Adams 2012). For much of the time throughout the policy realisation process, Lansley proved fiercely partisan and took every opportunity to differentiate the reforms from the approach taken by Labour, emphasising how revolutionary the plans were compared to the NHS he had inherited. However, during questioning by the Health Select Committee in November 2011 he

changed tack and presented the reforms as an evolution on the design of Labour (Timmins 2012). Indeed, an argument can be made that the reforms represent a logical progression of Labour health policy, which itself can be considered to be on the same trajectory of reforms started with the purchaser/provider split in the early 1990s; this will be elaborated on in Section 2.3.

2.1.4: The realisation of the Act

After a 14-month journey through Parliament, the Health and Social Care Bill received Royal Assent on 27th March 2012, despite the concerted efforts of various campaign groups, professional organisations, MPs and Lords. It was subject to over 2000 amendments in the process (Local Government Association 2012). In the details, the HSCA12 underwent extensive tweaking but its main features remained largely intact: CCGs were created nationwide in order to take on commissioning work that had previously been the purview of the PCTs that were abolished; public health teams were relocated to, and HWBs were established in, top tier and single-tier local authorities; NHS England was established and took on responsibility for authorising and performance managing CCGs as well as commissioning primary care and certain specialised services; and competition in the market of service provision was increased due to the extension of the AQP (Any Qualified Provider) initiative and changes to Monitor's role.

The Government's approach in pursuing a legislative path to reform is of interest. During questioning in the House of Commons on 4th April 2011, Lansley remarked that legislation was not really necessary for many aspects of the reforms, but that he was seeking to enshrine these structural changes in legislation to create more robust and enduring accountability structures (House of Commons Hansard 2011). However, it is precisely this approach to reform through legislation that was taken by some as evidence that the Government's central agenda was to further privatise the NHS (Timmins 2012). Other events fed into this sense of conspiratorial obfuscation: in November 2010, Labour issued a freedom of information request for the publication of a register drawn up by the DH detailing the risks associated with the reforms. This resulted in a protracted conflict culminating 19 months later with the Government taking the unusual step of formally vetoing its publication (Campbell 2012).

One likely reason that a legislative route was pursued was the fact that the Coalition Government enjoyed a majority in the House of Commons and the House of Lords. Perhaps it was the confidence from this that influenced Lansley's decision to make CCG membership compulsory for all GP practices, as this significant decision was made after the general election (Timmins 2012). However, Timmins (2012) claims that Lansley's driving aspiration was to realise a health service that was, because of its structural components and their relationships, capable of being reactive and improving itself. Services would be offered by AQP, CCGs would make decisions about the most appropriate mix of services for the patients in their area, patients would choose the treatment option they preferred, and Monitor would regulate the market. The role of Government would be more "hands off" because the system would be better equipped to regulate itself: it would run as if it were a 'clockwork universe' (Timmins 2012, p.34). Reorganising the NHS in this way, through legislation, would provide greater stability to the structural form of the NHS because it would require further legislation to change. The frequency of future NHS reorganisations would be slowed. This was one retrospective justification for the claim that the Government would '...stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government 2010, p.24).

It has been argued that the Government failed to construct a compelling narrative for the need for NHS reform, and this is one of the factors that made realising the HSCA12 so challenging and costly (Timmins 2012). A story that convincingly explained what the problems with the NHS were, what the reforms were about, why they would solve these problems, and why they were needed now, particularly in a time of economic difficulty, was lacking (Timmins 2012). Furthermore, the *Equity and Excellence* White Paper was published at a time when the NHS was experiencing high levels of patient satisfaction. The newly elected Government emphasised how poor the NHS was compared to the health systems in other countries. For instance, they argued that, despite spending the same amount on healthcare, mortality rates from heart attacks in Britain were double that in France. Appleby (2011) illustrated how these claims were based on an isolated statistical measure from 2006. Considered with a minor amount of additional context,

trends showed that NHS heart attack treatment was improving rapidly and on course to overtake France by 2012.

The Coalition majority in both Houses was an important factor in the ultimate success of the Bill, but there were others; for example, the passage of the Fixed-term Parliaments Act (2011), which ensured that the Coalition would have a period of five years in government. This meant that the parliamentary session was two years, which was longer than usual, and this worked to the Government's advantage. Lansley also spent a considerable length of time as Shadow Health Secretary, which allowed him to develop his plans extensively. Consequently, he published the White Paper at a very early stage, while the dust was still settling after the formation of the Coalition and dealing with the recession was the most pressing concern for Government. Timmins (2012) suggests that claims of support from Cameron and others were perhaps issued prematurely in this context, and once they had publicly backed the plans they could not be seen to brand them as fundamentally flawed. Furthermore, there was no one in the cabinet other than Lansley that had much experience in health. Finally, the sheer scale of the Bill itself meant that there were multiple aspects attracting criticism and this reduced the coherence of the debate about it as a whole.

An overview of significant events in the realisation of the HSCA12 between 2010 and 2013 is shown below in Figure 2.

2010

May Conservative - Liberal Democrat Coalition Government formed

May Coalition's 'programme for government' published – it promises to '...stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government 2010, p.24)

July *Equity and Excellence: Liberating the NHS* White Paper (HMSO 2010) published

December General Practice Consortia pathfinder programme launched

2011

January The Health and Social Care Bill introduced to the House of Commons

January The Nicholson Challenge, for the NHS to make £20billion of efficiency savings by 2015, begins

March Liberal Democrats call for significant changes to the Bill during their spring conference

March British Medical Association calls for the Bill to be withdrawn

April RCN passes a vote of no confidence in Andrew Lansley

April Due to mounting public dissent, Prime Minister Cameron announces a "pause" in the passage of the Bill in order to "listen, reflect, and improve" (Mulholland 2011). The Future Forum was established to provide recommendations on changes to the Bill

June Primary Care Trusts arranged into regional "clusters" with a single management board

July Future Forum renders their recommendations and the government accept the majority (NHS Future Forum 2011): General Practice Consortia are renamed Clinical Commissioning Groups (CCGs) and their membership extended to include lay members and secondary care health professionals; some elements of the Bill relating to competition are relaxed and Monitor's duties amended to 'protect and promote patients' interests' (Williams 2011)

September The Bill clears the House of Commons and moves to the House of Lords

October London's Westminster Bridge is occupied in a public protest against the reforms (Wintour & Taylor 2011)

2012

March The Bill receives royal assent and becomes an Act of Parliament

September Jeremy Hunt replaces Andrew Lansley as Secretary of State for Health

October NHS Commissioning Board is launched

2013

April All CCGs authorised by NHS England (prior to this point they had operated in shadow form, as committee/sub-committees of PCT clusters); PCTs and SHAs abolished; NHS England takes on full statutory responsibilities; HWBs take on statutory status; public health responsibility moves to top tier and single-tier local authorities

Figure 2: Significant events in the realisation of the HSCA12 from 2010-2013 (adapted from The King's Fund 2012)

2.2: Structural and functional changes within the English healthcare system

The HSCA12 instigated some significant changes to the structure of, and accountabilities and funding relationships within, the healthcare system in England. Figures 3 and 4 below demonstrate approaches to visualising these changes. Figure 3 shows the post-HSCA12 system structure including funding and accountability relationships. Figure 4 shows the newly reformed NHS' organisational cast, as well as the primary purpose of each organisation and their level of operation. The organisations featured in these diagrams are briefly explored in turn in the remainder of this section.

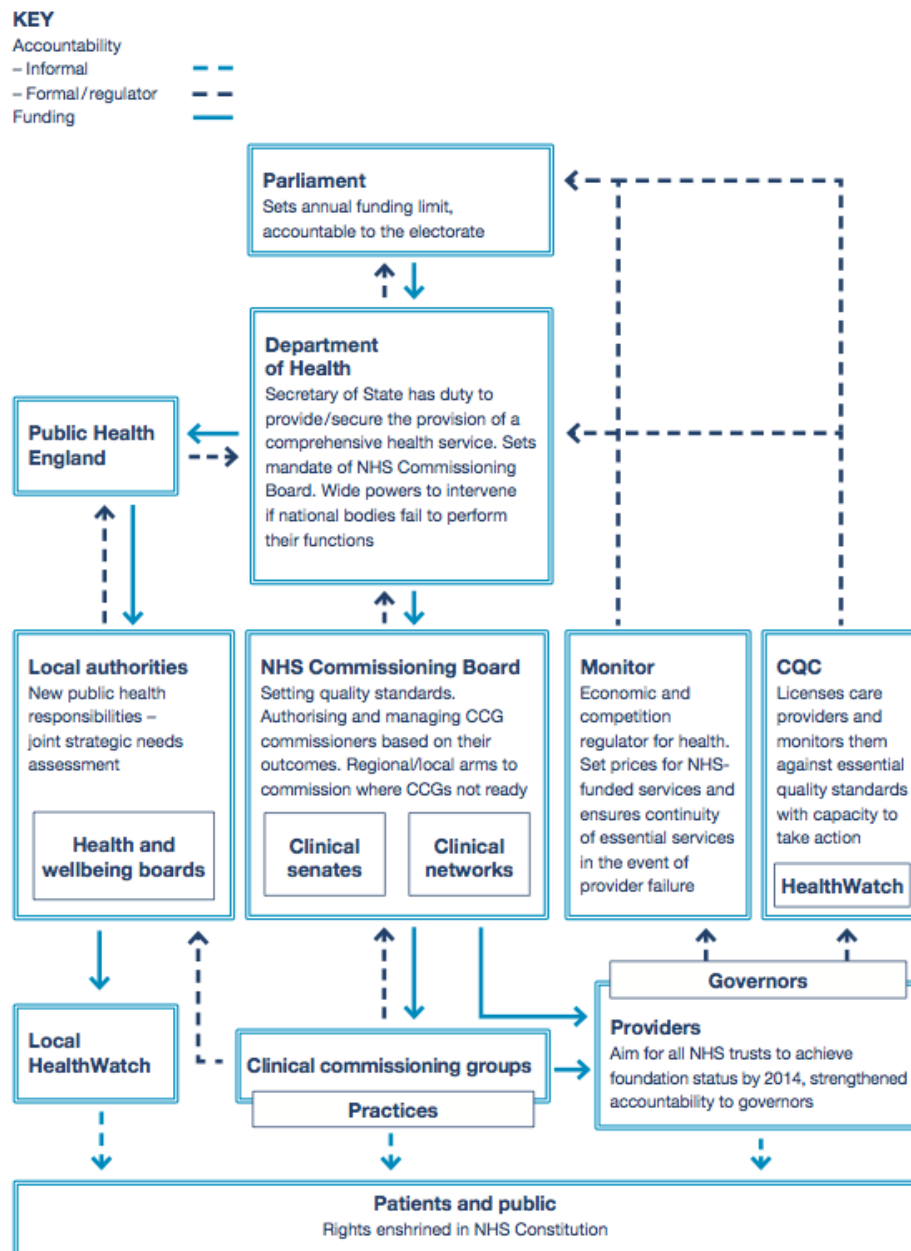


Figure 3: Accountability and funding dynamics in the post HSCA12 English NHS (The King's Fund 2011)

The diagram illustrates the governance and delivery of the NHS, centered around 'PEOPLE & COMMUNITIES'. It shows the flow from central services through various departments and boards to government oversight.

- Central Core:** PEOPLE & COMMUNITIES (represented by a family icon).
- Inner Ring (Services):** Ambulances, GP surgeries, Hospitals, Health centres, Pharmacies, Dentists, Opticians, Home care homes, Personal helpers, Community groups.
- Middle Ring (Regulatory & Support Bodies):**
 - Care Quality Commission**
 - Healthwatch England**
 - Local Healthwatch**
 - NHS Blood & Transplant**
 - NHS Clinical Research Networks**
 - NHS Litigation Authority**
 - Human Fertilisation and Embology Authority**
 - NHS Commissioning Board**
 - NHS Trust Development Authority**
 - NHS Business Services Authority**
 - Public Health England**
 - Local Government**
 - Medicines & Healthcare Products Regulatory Agency**
- Outer Ring (Government Departments):**
 - DEPARTMENT OF HEALTH**
 - HEALTH & WELLBEING BOARDS**
 - LOCAL ORGANISATIONS**
 - NATIONAL ORGANISATIONS**
 - REGULATION & SAFEGUARDING**
 - SECRETARY OF STATE**
 - OTHER GOVERNMENT DEPARTMENTS**

31

2.2.1: Clinical Commissioning Groups

As noted in Section 2.1.1, CCGs are geographically demarcated, GP led organisations. There are now 211 CCGs, each with an average patient population of 226,000, responsible for around 60% (or £65 billion) of the NHS budget in 2013/14 (The King's Fund 2014). Every GP practice in England is now a member of a CCG as a result of changes to the General Medical Services (GMS) contract⁴. CCGs are responsible for commissioning the majority of health services in their specific geographical area, including: acute or hospital care, community services, and most mental health services. The commissioning process involves assessing local need relevant to particular services, establishing contracts with providers to meet that need, and assessing the performance of providers to deliver what was agreed. CCGs can commission services from any provider that meets requisite standards and obtains a license from Monitor and the CQC (Section 2.2.6). CCGs replaced PCTs, and the SHAs that oversaw them were also abolished. Prior to authorisation in April 2013, "pathfinder" and other emerging CCGs operated in shadow form (i.e. without statutory powers). They were committees or sub-committees of PCT or SHA clusters: regional groupings of PCTs/SHAs, each with a single board, formulated just prior to the abolishment of these organisations. Shadow CCGs operated with delegated powers from their relevant cluster and had to report to them.

The HSCA12 set out some specific requirements of CCGs in terms of their structure and governance. Every CCG required a governing body comprised of, at a minimum: Chair, Accountable Officer, Chief Finance Officer, representatives from some member GP practices, 'one registered nurse, one secondary care specialist doctor and at least two lay people (one with a lead role in championing patient and public empowerment, the other with a lead role in overseeing key elements of governance such as audit, remuneration, and managing conflicts of interest)' (NHS Commissioning Board 2012a, p.33). In addition to a governing body, CCGs were also legally obligated to have an audit committee and a remuneration committee, and were strongly encouraged to have some form of quality committee (NHS Commissioning Board 2012a). Every CCG was also required to produce and publish a constitution that explicitly set out how it would function and fulfil its legal

⁴ The GMS contract is negotiated between the BMA, on behalf of the GP profession, and the government every year and specifies how GPs are remunerated for their services. Since the HSCA12, NHS England has taken responsibility for its negotiation from the DH.

responsibilities (NHS Commissioning Board 2012a). All CCG members had to have an opportunity to comment on a draft of the constitution, and the governing body had to demonstrate to NHS England that the constitution had the support of the membership before it was approved. Aside from these stipulations, CCGs had some latitude in terms of how they were organised and how they operated.

CCGs are membership organisations composed of GP practice members to whom the governing body of each CCG must account. The governing body of each CCG is also held to account by NHS England, as are the member GP practices that NHS England commission to provide primary care medical services (discussed more in Section 2.2.2). This accountability dynamic is more complex than that which PCTs experienced. PCTs were primarily accountable to SHAs and, ultimately, the Secretary of State (Maybin et al. 2011). They were also duty bound ‘to account to patients and the public, consulting them and providing information about their decisions’ (Checkland et al. 2013, p.10) and required to hold some meetings in public. However, in practice, it was the ‘managerial accountability regime’ (Checkland et al. 2013, p.10)—where individual managers were at risk of losing their jobs if the SHA or DH deemed their performance inadequate—that was the primary driving force in PCT management, perhaps at the expense of being accountable to their local populations in a meaningful way (Checkland et al. 2013). Devolving commissioning responsibility to local clinical commissioning membership organisations was presented by Government as a means of addressing this accountability deficit.

2.2.2: NHS England

The structure of NHS England was discussed earlier in this chapter (Section 2.1.1). The introduction of NHS England is particularly significant because it ‘provides for the first time a statutory division between ministers and the Department of Health on the one hand, and the commissioning and provision side of the NHS on the other’ (Timmins 2013, p.3). This design decision was made with the aim of reducing ‘the ability of the Secretary of State to micromanage and intervene’ (Department of Health 2010, p.33) in the day-to-day operation of the NHS. However, it should be noted that the Secretary of State still retains control over the most significant appointments to its board. The extent to which

this separation has been respected in practice is debatable, particularly once Jeremy Hunt replaced Andrew Lansley as secretary of state (BBC News 2013).

One of the key responsibilities of NHS England was the authorisation of CCGs against six domains (Table 1). This occurred in four waves with the first wave being informed of the authorisation status in December 2012 (34 CCGs), the second in January 2013 (67 CCGs), the third in February 2013 (62 CCGs) and the fourth in March 2013 (48 CCGs). There were three possible outcomes from an authorisation assessment, a CCG could be fully authorised, authorised with conditions, or established but not authorised. All CCGs, unless classified as “established but not authorised”, took on their statutory responsibilities on 1st April 2013. At this point across all waves, 106 CCGs were fully authorised, 90 were established with conditions, and 15 were established but not authorised (NHS Commissioning Board 2013). NHS England remained statutorily responsible for those CCGs deemed established but not authorised until they could demonstrate improvements through assurance processes and their status changed. Those CCGs authorised with conditions could be subject to legal directions from NHS England if their support needs were judged particularly significant. (Notchcroft, the case study CCG, was authorised with a small number of conditions.)

The HSCA12 gave NHS England statutory responsibility for the on-going assessment of CCG performance. This involves the assessment of CCGs in relation to the six domains of the assurance framework (Table 2). Responsibility was devolved to NHS England area teams to carry out this process with their local CCGs. Quarterly meetings between the area team and governing body of the CCG take place, with the final one of the year being an annual review. After each quarterly meeting NHS England announces that they are either “assured” or “not assured” overall (NHS England 2014a). NHS England is also subject to an annual assessment by the DH.

Domain number	Domain title	Indicator criteria example
1	A strong clinical and multi-professional focus which brings real added value.	Engagement from constituent practices.
2	Meaningful engagement with patients, carers and their communities.	Ensure inclusion of patients, carers, public, communities of interest and geography, Health and Wellbeing Boards, local authorities and other stakeholders.
3	Clear and credible plans, which continue to deliver the QIPP challenge within financial resources in line with national requirements (including excellent outcomes) and local joint health and wellbeing strategies.	Track record of delivering service transformation to improve outcomes, quality and productivity, whilst reducing unwarranted variation and tackling inequalities, within the financial allocation.
4	Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commissioning all the services for which they are responsible.	Properly constituted with the appropriate governance arrangements.
5	Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.	Robust arrangements for working with other CCGs in order to commission key services across wider geographies and to play their part in major service reconfiguration where appropriate.
6	Great leaders who individually and collectively can make a real difference.	Distributed leadership throughout the culture of the CCG, and through the involvement of other clinicians via commissioning processes.

Table 1: CCG authorisation assessment domains and criteria examples (NHS Commissioning Board 2012b)

Domain number	Domain title	Indicator example
1	Are patients receiving clinically commissioned, high quality services?	Co-design a clear vision and priorities including aims for improving quality, agreed and shaped by member practices, which will be reflected in their operational and strategic plans.
2	Are patients and the public actively engaged and involved?	Have transparent arrangements in place to feed patient and public insights into CCG decision making, including evidence from local Healthwatch patient feedback, complaints and concerns.
3	Are CCG plans delivering better outcomes for patients?	Ensure contracts with main providers are agreed and signed off each year, including systems in place to track performance against contracts.
4	Does the CCG have robust governance arrangements?	Have well-developed governance arrangements, including a robust constitution that meets the requirement of legislation and standard financial management arrangements.
5	Are CCGs working in partnership with others?	Have collaboration arrangements in place with a range of NHS, local government, community and voluntary providers, with strong links with the Health and Wellbeing board, evidenced by the production of a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
6	Does the CCG have strong and robust leadership?	Involve clinicians in service redesign and improvement.

Table 2: CCG assurance framework (NHS England 2014a)

The HSCA12 gave NHS England responsibility for commissioning primary care (i.e. the services provided by all GP practices that make up CCGs), the majority of specialised services, offender healthcare, and certain services for the armed forces. A service was deemed specialised and appropriate for NHS England to commission when it was only relevant to a relatively small number of patients spread out over a large geographical area, the costs of providing that service were high, and it could be provided in only a small number of specialised centres. NHS England's "manual for prescribed specialised services" sets out the 143 services that NHS England was responsible for commissioning in 2013/14, such as: blood and marrow transplantation, cystic fibrosis, and paediatric cardiac services (NHS England 2014b).

NHS England also oversees Commissioning Support Units (CSUs), which were introduced as part of the HSCA12 in order to provide a menu of services that CCGs (and, less commonly, NHS England and provider trusts) could purchase in order to meet their commissioning obligations. These services include 'business intelligence, health and clinical procurement services, as well as back-office administrative functions, including contract management' (Thiel 2013, p.n/a). A large proportion of CSU staff previously worked for a PCT. There has been considerable variation across the country in the extent to which CCGs have utilised CSUs.⁵ In April 2013 there were 23 CSUs in operation across England (Thiel 2013). This number has now been reduced to 18 as a consequence of several mergers. NHS England intends for CSUs to become independent, commercial organisations by 2016 (NHS England 2014c).

2.2.3: Local authorities, public health, and health and wellbeing boards

As noted in Section 2.1.1, under the HSCA12 public health responsibility transferred to top tier and single-tier local authorities. Every such local authority—of which there are 152—was also required to establish a HWB as a statutory sub-committee. Every HWB must comprise a minimum membership of: the local authority director of adult social care, the local authority director of children's services, director of public health, an elected local member (at least one), a representative from every relevant CCG, and a representative from local Healthwatch (see Section 2.2.4) (The King's Fund 2013).

⁵ See Petsoulas et al. (2014) for insights into CCG opinions of commissioning support.

The HSCA12 (Sections 197-199) defined the purpose of each HWB as the improvement of the health and wellbeing of the people in their area, the reduction of health inequalities, and the promotion of the integration of services. HWBs were presented as having a vital role in linking up health and social care and influencing commissioning work so that it met the specific needs of the local population, i.e. a strategic overseer. Every HWB is obligated to produce a Joint Strategic Needs Assessment every three years. This document outlines the present and predicted future health and social care needs in a local area. Based on the document, the HWB is then required to produce a Joint Health and Wellbeing Strategy, containing plans for commissioning services in that local area. HWBs do not have any statutory responsibilities for commissioning, although CCGs may delegate such responsibilities to them if they choose. However, CCGs must ensure that commissioning decisions are consonant with the objectives set out in the Joint Health and Wellbeing Strategy. The role of HWBs has continued to evolve within the system; for instance, HWBs now have a responsibility to co-ordinate and approve Better Care Fund⁶ plans developed by top tier and single-tier local authorities and CCGs.

2.2.4: Healthwatch England and local Healthwatch

Healthwatch England is a new statutory organisation, and sub-committee of the Care Quality Commission (CQC; discussed in Section 2.2.6), established as part of the HSCA12. It is a patient representative body funded by and accountable to local authorities, and it describes itself as the 'consumer champion for health and social care in England' (Healthwatch England 2013, p.6). Healthwatch England oversees 152 local Healthwatch groups, one based in each top tier or single-tier local authority area, each of which aims to provide a means of representing the views of patients and public in their area. Healthwatch replaced Local Involvement Networks (LINKs): locally based patient watchdogs with some statutory powers commissioned by top tier and single-tier local authorities.

⁶ The Better Care Fund, formally the Integration Transformation Fund, is £3.8 billion (2015-2016) pooled budget for integrating health and social care service (Bennett and Humphries 2014).

2.2.5: NHS provider trusts

NHS trusts are public sector bodies that provide particular healthcare services. They represent a big proportion of the providers that CCGs commission services from.

With the abolishment of PCTs, there are now four types of NHS trust: acute (which manage secondary care), ambulance, mental health, and community. Any of these types of trust can apply to become a Foundation Trust (FT)—an invention of New Labour—a process overseen by the NHS Trust Development Authority. Becoming an FT means that trusts become legally independent from government and possess more control over their governance and financial activities. The Government set a target date for all trusts to become FTs by April 2014 (British Medical Association 2013), although 99 trusts were unsuccessful in obtaining foundation status by this time.

2.2.6: Monitor and the Care Quality Commission

Monitor and the CQC are NHS regulators. They are executive non-departmental bodies of the DH. Monitor was established in 2004 to licence, assess, and regulate FTs. The HSCA12 gave Monitor new duties, extending the remit of its regulation to the English healthcare sector at large (including non-profit and private providers), with particular attention to economic issues. Its revised responsibilities are to:

- 'Set prices for NHS-funded care in partnership with NHS England;
- Enable integrated care;
- Safeguard choice and prevents anti-competitive behaviour which is against the interests of patients;
- Support commissioners to protect essential healthcare services for patients if a provider gets into financial difficulties' (Foundation Trust Network 2014, p.n/a).

The CQC was formed in 2009 to conduct inspections of health and social care services in England and assess the quality of the care they deliver. It publishes the results of its inspections and rates the performance of providers. The HSCA12 extends the CQC's remit to the licensing of health and social care providers. The CQC is frequently referred to as

the “quality regulator” whereas Monitor is the “market regulator.” Together they have a joint statutory responsibility to licence all health and social care service providers.

2.3: A brief history of NHS primary care led commissioning initiatives

The aim of this section is to provide historical context for the HSCA12 and the introduction of CCGs by considering previous primary care led commissioning initiatives and the policy analysis literature associated with them. Table 3 shows the range of primary care led commissioning initiatives that have emerged since the first—GP Fundholding—was introduced in 1991. These are discussed in turn in the sub-sections below.

1991	<ul style="list-style-type: none"> • Introduction of purchaser-provider split (trusts and health authorities) • <i>GP Fundholding</i> (a parallel innovation) • <i>Locality commissioning</i> and <i>GP Commissioning</i> (Range of different approaches to commissioning with GPs at fulcrum of emerging relationships)
1995	<i>Total Purchasing</i> – and extension of Fundholding (3 year pilot)
1997	Change of government... Labour outlines plans to end Fundholding and move to <i>GP Commissioning</i> groups
1999	Fundholding officially abolished, 481 <i>Primary Care Groups</i> established with aim of progressing to <i>Primary Care Trusts</i>
2005	<i>Practice-based Commissioning</i> introduced
2010	Change of government. Conservative proposals include abolishing Primary Care Trusts and replacing with <i>GP Consortia</i>
2011	Pathfinder <i>Clinical Commissioning Groups</i> (the new name for GP Consortia)
2013	<i>Clinical Commissioning Groups</i> become statutory bodies

Table 3: Timeline of NHS clinical commissioning initiatives (Miller et al. 2012)

Relevant health policy analysis literature was identified by consulting textbooks that provided overviews of reforms and reviews of their analysis (Ham 2009; Klein 2010), and a more recent systematic review of primary care led commissioning (Miller et al. 2012). In addition, keyword searches were carried out in Google Scholar (Appendix 1) in order to identify any sources not contained in the textbooks and the systematic review. The reference lists in the most relevant papers were then explored in order to identify any gaps in the accumulated literature and ensure that as complete a picture as possible was obtained. This literature is explored in Section 2.3.7.

2.3.1: GP Fundholding

In 1989, the Conservative Government, led by Prime Minister Margaret Thatcher, produced the *Working for Patients* White Paper (HMSO 1989), which proposed the introduction of an internal quasi-market within the NHS and, for the first time, a separation between purchasers and providers of healthcare services. This vision was realised in 1991 as a result of the NHS and Community Care Act (1990) and commissioning as a distinct activity emerged. Hospitals, community health services and others became public sector trusts and service providers (Klein 1998). District Health Authorities, Family Health Service Authorities, and newly introduced GP Fundholders (GPFH) became the purchasers: free to buy services from those in the private and voluntary sectors as well as NHS trusts (Le Grand 1999).

Taking part in GPFH was voluntary for GP practices that met certain eligibility criteria that were gradually relaxed as the initiative matured. Three hundred GP practices joined the initiative in the first wave in 1991 and uptake increased dramatically in successive annual waves (Moon et al. 2002). By the conclusion of the seventh and final wave, despite opposition to the reforms from much of the medical profession including bodies such as the BMA (Coulter 1995), approximately 50% of all UK GP practices were registered as GPFHs (Moon et al. 2002). They were given control of approximately a quarter of the secondary and community care budget to buy certain services for their patients, including in-and outpatient services, and pharmaceutical prescriptions issued by GP practices (Glennister 1994). Any surpluses that they generated could be re-invested into services or facilities that were of benefit to patients. Some GP practices chose to form consortia, or 'multi-fund groups' (Miller et al. 2012, p.3).

The policy rhetoric around GPFH presented GPs as patient advocates in terms of healthcare service acquisition because of their proximity to those patients, but GPFH was also a reflection of the growing governmental interest in primary care as a domain of the health service with the potential to make the system more effective and cost efficient (Peckham and Exworthy 2002). GPs were recognised as responsible for the allocation of a considerable amount of healthcare resources, and GPFH was seen as a means of making GPs more aware of the economic impacts of their clinical behaviour and incentivising

economically prudent actions (Audit Commission 1996). The explicit assumption was that GPs exercising choice over which services to buy would drive up competition in the marketplace and improve quality and efficiency in the NHS. Sub-standard providers would lose out on future contracts through a process of market selection. It was hypothesised that money would “follow the patient”: rewarding high performing hospitals and providing the necessary incentive for underperformers to improve. The competitive checks and balances of the system would provide the conditions for self-regulation.

Over the course of GPFH’s lifespan, a number of other commissioning initiatives were developed in various local contexts. These most commonly formed through collaboration between a local grouping of GP practices and their health authority, and they built or developed certain elements of the GPFH model.

2.3.2: Total purchasing

In 1995, Total Purchasing (TP) was introduced as an extension to GPFH on a three-year pilot basis. Its creation was driven by a desire from some GPs to exercise commissioning control over a greater proportion of healthcare services (Miller et al. 2012). Under the initiative, GP practices could, in theory, purchase all hospital and community care services for their local population. Fifty-three pilots started in 1995 and a further 34 commenced in the following year (Miller et al. 2012). In practice, most TP pilots focused their commissioning activities on particular areas of local relevance and professional interest, and returned a proportion of funding to their health authority (which retained statutory commissioning responsibility) for it to allocate (Goodwin et al. 1998).

2.3.3: GP Commissioning

In 1997, the Labour party, led by Tony Blair, were elected to government in a landslide victory. During the campaign Labour had vowed to “save the NHS” and abolish the internal market, which they described as responsible for unnecessary and wasteful bureaucracy (Klein 2010). The Government quickly announced that they had done away with the internal market. However, they did not abolish the purchaser/provider split. Government communication began to feature the strategic substitution of the word

“purchasing” with “commissioning” in order to reduce market associations (Mays et al. 2011). At this time GPFH was brought to a close. This was allied to an announcement that 40 GP Commissioning pilots were to be created with the aim of testing out a variety of approaches to primary care led commissioning. The pilots took on responsibility for commissioning secondary and community services and were required to work in partnership with groups of local clinicians and public stakeholders.

However, later that year the Government produced *The new NHS: modern, dependable* White Paper (Department of Health 1997). It stressed an overarching pragmatism in the management of the NHS—the New Labour “third way” was portrayed as being about constructing policies from whatever worked and not clinging to partisan ideologies. An emphasis was placed on the assessment of healthcare services against national performance targets. The White Paper also announced the creation of Primary Care Groups (PCGs), discussed below. The GP Commissioning pilots were launched in April 1998 and ran for two years, overlapping with the introduction of PCGs (Miller et al. 2012).

2.3.4: Primary Care Groups

Although the Labour government wound down GPFH, they effectively extended the role of primary care in service commissioning with the creation of PCGs. GP practices were obligated to join a PCG, although they had some choice over their level of involvement. There were 481 PCGs created in April 1999, but PCGs could choose to begin operation at one of two levels: level one involved acting in an advisory capacity to the health authority; level two involved taking on responsibility for the commissioning budget, which was devolved from the health authority (of which the PCG was a sub-committee). The majority of PCGs began at level two (Audit Commission 2000).

PCGs were presented as a means to ‘promote the health of the local population; commission hospital and community based health services; and develop primary healthcare’ (Audit Commission 2000, p.3). They were composed of a ‘Chief Officer, support staff and a Board containing up to seven local GPs, two nurses, one lay member, one social services representative and a nonexecutive member of the health authority’ (Wilkin and Coleman 2001, p.216). As such, they were intended to extend clinical input

into commissioning by operating as a decision-making forum for local clinicians. PCGs were responsible for an average patient population of 100,000 (Wilkin and Coleman 2001).

2.3.5: Primary Care Trusts

The new NHS: modern, dependable White Paper (Department of Health 1997) also contained plans to allow PCGs that desired more autonomy and responsibility, and were suitably equipped for it, to transition into PCTs. Where PCGs were level one or two bodies, PCTs would be level three or four. Level four PCTs would be independent bodies composed of local clinicians commissioning care and providing community health services. PCTs were notable because they were responsible for ‘a single budget for healthcare provision, including general practitioner services, community health services and hospital services, with flexibility to shift resources between sectors and services’ (Wilkin and Coleman 2001, p.216), which amounted to approximately 80% of all NHS spending (Saltman et al. 2005, p.98). PCTs were presented as organisations that would be locally embedded and responsive to local needs—the Government would devolve ‘power and responsibility’ (Department of Health 2001, p.13) to PCTs so that they could address these needs. The White Paper suggested a gradual evolution, which would provide opportunities for ‘developmental learning’ (Wilkin and Coleman 2001, p.220).

However, just over 12 months later the transition plan was revised. The NHS Plan (Department of Health 2000), which announced a significant financial investment in the NHS over a five year period, contained a target for all PCGs to become PCTs by 2004. In a deviation from the original vision of PCTs as being managed primarily by clinicians, it was stated that each organisation would instead have a Professional Executive Committee (PEC), chaired by a local GP. The PEC chair would sit on the PCT board, which would also comprise a ‘lay chairman, non-executive director and a minority of executive directors, including the chief-executive, the finance director and the director of public health’ (Saltman et al. 2005, p.98).

This process of transition occurred rapidly. Thirty PCGs became PCTs in 2000, 124 in 2001, and the rest in 2002 (Dowling et al. 2008, p.87), two years earlier than the Government’s

original target. Many PCTs decided to become level four bodies straight away (Wilkin and Coleman 2001). PCTs were accountable to one of the 96 Health Authorities, which became 28 SHAs in 2002. Those 28 were then reduced to 9 via mergers in 2006, and the 303 PCTs were reduced to 152, which meant that they covered a larger patient population (an average of 330,000 (Naylor 2012)) and made the majority co-terminus with a local authority. However, clinical input in commissioning began to wane under PCGs as tensions between GP and non-GP board members emerged (Smith et al. 2000). When PCTs were introduced, the role of GPs in commissioning processes diminished further as the influence of managers increased (Bate et al. 2007). This led to disillusionment and withdrawal by some GPs, and GP involvement in commissioning reached a particularly low level as a result (Bate et al. 2007).

2.3.6: Practice-based Commissioning

From around 2002, a change in New Labour's approach to NHS policy was emerging. The emphasis on centrally set national standards and targets, through mechanisms such as National Service Frameworks (Department of Health 1998), began to be supplemented with market mechanisms. A full discussion of these changes is beyond the scope of this thesis; however, some of the most significant market based policy driven changes were: the increasing promotion of patient choice over provider, the introduction of Payment by Results (so that money could, once again, "follow the patient"), and the instantiation of FTs in 2003—'public benefit corporations' (Mays et al. 2011, p.8) with more autonomy, regulated by a newly created body: Monitor. For this thesis, the crucial thing to emphasise is that Labour's negative stance on the internal market when coming to power was seemingly eroded over a period of several years, to the extent that Mays et al. (2011, p.1) claim that Labour went 'further towards creating a market (rather than simply an internal market)' than the policies of the Conservative Government of the 1990s.

The final primary care led commissioning precursor to CCGs was Practice-based Commissioning (PbC), which began in 2005 (Coleman et al. 2009) and continued in some areas up until the abolishment of PCTs and authorisation of CCGs in April 2013. Under PbC, GP practices, usually as consortia but individually in some cases, could volunteer to take on certain local commissioning responsibilities (Coleman et al. 2009). They were

allocated an indicative budget (Coleman et al. 2009), devolved from their local PCT. This arrangement had parallels with GPFH except that GPFH were legally responsible for budgets themselves (Curry et al. 2008).

PbC was intended to redress the diminished levels of GP involvement in commissioning that had developed under PCGs and, in particular, PCTs (Miller et al. 2012). It was part of a 'package of policies ... intended to create a system that was patient-centred and 'self-improving'' (Mays et al. 2011, p.1). The Government presented PbC as a component of a healthcare system that emphasised 'patient choice of provider, payment by results of provider, and the roll-out of foundation trusts' (Coleman et al. 2009, p.4). PbC would allow GP practices to improve services for patients, because of their ground level knowledge of patient need, and save money in the process. PbC was presented as a beneficial initiative for patients because it would result in 'a greater variety of services, from a greater number of providers, and in settings that are closer to home and more convenient to patients', and beneficial to the NHS and public because 'front line doctors and nurses' would be more involved in commissioning decisions and the health service would be more efficient (Department of Health 2004, p.4). Money saved via PbC could be reinvested by consortia into services in their GP practices that would benefit patients. The Government presented PbC as a key part of their plan to redistribute healthcare from hospitals and nearer to patients' homes. This, it was argued, would increase efficiency and patient convenience and reduce costs (Department of Health 2006).

GP practice involvement in PbC was voluntary but PCTs were obligated to demonstrate to the DH that they were encouraging them to become involved. GP involvement was also financially incentivised with a Directed Enhanced Service (DES)⁷ introduced in 2006/2007 (Curry et al. 2008). Despite this, the uptake of the scheme was highly variable across the country, as was the parts of the budget that PCTs decided could be devolved to PbC consortia (e.g. some were given control over mental health but not prescribing).

⁷ DESs are one of three kinds of Enhanced Service (the others being Local and National) introduced as part of the 2004 GMS contract. DESs are nationally specified services that GPs can provide to a specific population (e.g. flu immunisations for over 65s and at risk groups) and receive additional income.

2.3.7: Primary care led commissioning analysis

In this section I will provide an overview of the findings of the evaluations and analysis of primary care-led commissioning initiatives. Miller et al. (2012) conducted a systematic review of this work and much of the discussion below relies on their report. Overall, they found very little consensus about the effect of these policies at a national level, which is perhaps indicative of the considerable variability between myriad local contexts and the pace at which successive reforms and restructures occur. Furthermore, trying to evaluate the impact of commissioning policies is particularly difficult because they are only one element of a broader policy set, the impacts of which are not straightforward to separate into constituent parts (Smith and Curry 2011).

Miller et al. (2012) found that the most evidence on the impacts of commissioning initiatives related to those things that were most straightforward to quantify. Primary care prescribing costs and their rate of growth was generally lower in GPFHs, PCGs, and PbC consortia. Waiting times for some secondary care services were shown to be lower for the patients of some GPFH practices (Le Grand et al. 1998) (although referral patterns were similar between GPFHs and non-GPFHs); and because approximately half of all GP practices were GPFHs at the height of the initiative, concerns were raised that a “two tier” NHS had developed.

There is minimal evidence about the impact of commissioning initiatives on patient satisfaction, quality of care, or the commissioning process itself (Miller et al. 2012). What does exist relates primarily to GPFH and is inconclusive (e.g. Howie et al. 1994; Dusheiko et al. 2007). Levels of patient and public involvement in the work of these commissioning organisations was shown to be low overall, with a suggestion that some GPs interpreted their own involvement as de facto patient representation (Miller et al. 2012). There is no evidence suggesting that these initiatives affected any significant change in secondary care services (Drummond et al. 2001; Craig et al. 2002). Evidence from TP pilot evaluations suggests that GPs tended to prioritise addressing issues that they perceived as specifically relevant to their patients rather than broader systemic ones (Dixon et al. 1998; Walsh et al. 1999).

Before CCGs were introduced, GPFHs were the only type of commissioning organisation that operated independently of a parent body. For example, health authorities oversaw TP pilots and PCGs, and later PCTs oversaw PbC consortia. There was considerable variety in the nature and perception of these relationships. Research suggests the behaviour of a particular parent body was significant in determining the degree of constraint that the commissioning organisations experienced (Miller et al. 2012, p.36). Curry (2008, p.58) highlighted power struggles occurring between PCTs and PbC consortia, which had a ‘paralysing’ effect. Unsurprisingly, “good” relationships—‘characterised by mutual trust, independence of the commissioning group and greater sharing of information’ (Miller et al. 2012, p.30)—were associated with a greater likelihood that commissioning organisations would meet their stated aims. Miller et al. (2012) concluded that there was evidence that under commissioning schemes where GPs perceived themselves as having sufficient influence, such as GPFH, they were likely to become engaged and do more than under initiatives where they felt they had less influence, like PCTs.

Another important factor influencing success, for every initiative apart from GPFH (where single GP practices were responsible for commissioning), was the acquiescence or support from local GP practices in order to legitimate the organisation (Coleman et al. 2009). In studies on GPFH, TP pilots and PbC there is evidence that the greater the level of engagement in commissioning from GPs the more likely the organisations were to realise their aspirations (Miller et al. 2012). However, this was associated with practical challenges including higher costs, particularly for larger organisations with a lot of GPs to engage. For TP pilots this amounted to a significant proportion of their overall spending (Place et al. 1998). There was also an indication that regular changes in clinical commissioning initiatives were a source of apathy for GPs. For example, some GPs explained a reluctance towards engaging with PbC because they were sceptical about its chances of lasting very long (Miller et al. 2012). Bravo Vergel and Ferguson (2006) found that PCTs faced challenges in making their care rationing policies successful without the “buy in” and involvement of GPs to lend the policies legitimacy amongst clinicians.

The particular form and dynamics of GPFHs and PCGs in local contexts have been shown to be relevant in shaping GPs’ perceptions of subsequent clinical commissioning initiatives and the ways that those initiatives manifest in such settings (Peretz and Bright

2007; Coleman et al. 2010). Additionally, Coleman et al. (2009) found that the development of PbC in a given area was influenced by the socio-cultural dynamics and healthcare service history in that area. They also found that ‘peer review and performance management of each others’ work’ (Coleman et al. 2009, p.6) had become more common for GPs. This was seen as having positive aspects but it was also recognised that it had the potential to diminish the legitimacy of PbC amongst stakeholders in a given area if handled insensitively. Miller et al. (2012) assert that GP peer review or intra-professional assessment was a feature of all clinical commissioning schemes, and there is some evidence that indicates that the idea has been normalised amongst GPs as a result.

2.3.8: Conclusions

Remarkably, eight major clinical commissioning initiatives have been instantiated since GPFH was introduced in 1991. Table 4 illustrates the range of characteristics that Miller et al. (2012) ascribed to these initiatives on the basis of their systematic review. What is notable about their development is that each was presented as a corrective to faults identified with its predecessors. By making it compulsory for GP practices to join a PCG, the Government attempted to avoid the inequity associated with the “two tier” health service resulting from GPFH. PCGs were intended to provide opportunities for a broader range of local clinicians to shape local services, and this was expected to develop further once they evolved into PCTs. However, the opposite occurred: GPs, in particular, disengaged from commissioning processes with PCTs. PbC was supposed to engender the involvement of GPs in commissioning once more. In the next chapter, I will explore the HSCA12 and associated documents, and consider how CCGs have been presented.

	GP Fundholding	Non-fundholding scheme (locality groups etc)	Total purchasing	GP Commissioning	Primary Care Groups	Primary Care Trusts	Practice-based-Commissioning	Clinical Commissioning Groups
Comprehensiveness of commissioning activity	Limited	Limited	Limited	Variable	Fully	Fully	Limited	Fully
Clinical leadership	High	Medium	High	High	High	Low	High	High
Clinical autonomy over commissioning decisions	High	Low	Medium	Medium	Medium	Low	Medium	Low-medium
Budgetary autonomy	Limited devolved budget	Shadow budget	Delegated budget	Shadow budget	Delegated budget	Full autonomy	Delegated budget	Devolved budget
Financial autonomy in commissioning	High	Low	Medium	Medium	Low	Low	Low	High
Strength of linkage/relationship with member GPs	High	Medium	Variable	Variable	High	Low	Variable	Variable depending size and governance arrangements
Strength of relationship with health authority/main commissioner	Variable	Low	Variable	Variable	Medium	N/A	Variable	New relationship with NHS Commissioning Board
Strength of relationship with other organisations	Variable	Low	Variable	Low	Medium	High	Low	Formal links via HWB

Table 4: Characteristics of primary care led commissioning initiatives (Miller et al. 2012)

It is notable just how similar the stated aims of many of these initiatives are to each other and the HSCA12, which will be explored more fully in the following chapter. The most common are: reducing bureaucracy and unnecessary management, improving efficiency through better-informed spending decisions, increasing clinician involvement, and making the health service more “patient-centred.” The policy presentation of PbC, specifically, is highly consonant with the HSCA12. As noted above, PbC was conceived of as one element of a health system that could, because of implemented checks and balances, effectively be ‘self-improving’ (Mays et al. 2011, p.1). This closely aligns with Lansley’s reported aspirations for the HSCA12 to establish a ‘clockwork universe’ (Timmins 2012, p.34), which illustrates a certain continuity between the Coalition’s flagship health policy and that of New Labour in the latter half of their incumbency.

Taken as a whole, the research on primary care led commissioning initiatives demonstrates the challenges associated with assessing the impacts of such schemes at the national level. Any such claims must be made with caution and multiple caveats precisely because of the huge variability that exists between local contexts and the way such initiatives are enacted. Studies adopting methodologies that allow for individual organisational contexts to be considered in analysis have shown just how crucial local social and historical context can be to the way commissioning initiatives are interpreted by stakeholders, as well as how they develop and operate (Peretz and Bright 2007; Coleman et al. 2010). Some of the key observations from the analysis of these initiatives relate to the increase in intra-professional performance management (Coleman et al. 2009; Miller et al. 2012), and the importance of legitimacy as a factor in the local development and operation of commissioning organisations (Bravo Vergel and Ferguson 2006; Coleman et al. 2009).

2.4: Chapter summary

The contentious HSCA12 has dramatically reshaped the NHS in England in terms of its structure, accountability dynamics, and funding relations. The centrepiece of the policy was the introduction of CCGs. Every GP practice was legally obligated to become a member of a CCG, and these organisations were given responsibility for commissioning the majority of healthcare services for the patients in their local areas. A new

organisation, NHS England was created and took on responsibility for authorising CCGs, overseeing their activities on an on-going basis, and commissioning certain specialised services at the national level.

CCGs represent the most comprehensive primary care led commissioning initiative in the history of the NHS, but they are also the latest in a line of commissioning initiatives stretching back to the instantiation of the purchaser/provider split and the introduction of GPFH in the early 1990s. Successive initiatives have been framed as responses to the perceived shortcomings of their predecessors, yet their stated aims have been remarkably similar.

There is little conclusive evidence about the impacts of each initiative at a national scale, and what evidence there is relates primarily to those phenomena that are straightforward to quantify. Research adopting an in-depth approach, where organisational level social practices are explored, has demonstrated how crucial local social and historical factors are to the interpretation and enactment of these policy initiatives. Such studies have identified and explored: how responses to previous primary care commissioning initiatives have shaped succeeding ones; how such initiatives have changed the intra-professional dynamics between groups of GPs as a result of performance management; and how local relationships, and the degree of legitimacy gained from the support of professional peers, effect the operation of commissioning organisations.

Chapter 3: Problematising the policy and the membership organisation concept

The aim of this chapter is to examine and critically engage with the HSCA12 and related documents in order to develop an understanding of the policy and the presentation of CCGs. One aspect of this is focused on in particular detail: CCGs' status as *membership organisations*. Three documents (listed below) have been selected for examination on the basis that, taken together, they span important periods in the life of the policy—from visionary statement of intent, through legislation, to implementation guidance. I will begin by explaining the analytical approach adopted in this chapter, before considering each of the three documents in turn, and finally focusing specifically on the nature and implications of CCGs as membership organisations.

- *Equity and Excellence: Liberating the NHS* White Paper (Department of Health 2010)
- The Health and Social Care Act (2012)
- Towards establishment: Creating responsive and accountable clinical commissioning groups (NHS Commissioning Board 2012a)

The analytical process that I undertake in this chapter is one of *problematisation*. This involves identifying and exploring the explicit policy problem presented in the HSCA12 and associated documents, and considering in detail one aspect of the proposed solution: CCG membership organisations. Conceived of in this way, problematisation can be understood as closely related to “theories of change”, such as theory-based evaluation (Worthen 1996) and programme theory (Weiss 1998). The introduction of CCG membership organisations can be seen as part of the HSCA12's programme theory for affecting change. There are other approaches to problematisation that have roots in Foucauldian discourse analysis (Foucault 2006), such as Bacchi's (2012, p.1) ‘what's the problem represented to be?’ or “WPR” method. Bacchi (2010, p.70) describes it as a ‘post-structural approach to policy analysis’ that aims to uncover the explicit and implicit ideological and normative content of policy. Bacchi's (2012) approach was considered for use in this study but ruled out on the basis that it focuses primarily on the implicit policy

problem(s) rather than the substance of the policy (i.e. the programme theory). Furthermore, utilising her approach would have necessitated an intensive historical tracing of the policy problem, the presentation of which would not have been feasible alongside the other elements of the thesis due to word length limitations.

3.1: Equity and Excellence: Liberating the NHS White Paper

The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic. The Government will liberate the NHS from excessive bureaucratic and political control, and make it easier for professionals to do the right things for and with patients, to innovate and improve outcomes. We will create an environment where staff and organisations enjoy greater freedom and clearer incentives to flourish, but also know the consequences of failing the patients they serve and the taxpayers who fund them (Department of Health 2010, p.9).

This was the Coalition Government's first significant statement of intent regarding NHS policy. Governmental White Papers are traditionally used to present the government's overarching policy message to gauge feedback before pursuing legislation. As such, they are an excellent resource for identifying the explicit presentation of issues that a policy is intending to address. The *Equity and Excellence* White Paper emphasises the NHS's skilled and committed staff, the successful organisational culture of research and evidence based medicine, and the value of the principles of equity of treatment. It is in relation to these points that the one aspect of the problem is set out:

Compared to other countries, however, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare, rates of mortality from some respiratory diseases and some cancers, and some measures of stroke have been amongst the worst in the developed world (Department of Health 2010, p.8).

In short, the NHS does not provide a standard of services that produces outcomes that compare favourably with other "developed" countries and it should. A contributory factor to this, and the core of the problem, is identified:

The current architecture of the health system has developed piecemeal, involves duplication, and is unwieldy. Liberating the NHS, and putting power in the hands of patients and clinicians, means we will be able to effect a radical simplification, and remove layers of management (Department of Health 2010, p.9).

This extract suggests that the NHS has been allowed, by the previous government, to develop without proper oversight and has become inefficient, overly bureaucratic, and “top heavy” with management. By redistributing power to clinicians and patients the NHS will be liberated from itself, from the management bloated and overly complex form it has evolved into as a result of neglect. The following extract expands on the solution (Department of Health 2010, p.1):

...we will empower health professionals. Doctors and nurses must to be able to use their professional judgement about what is right for patients. We will support this by giving front-line staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals...

Health professionals are presented as disempowered or in need of empowerment to some degree. They lack control because healthcare is currently run from the top down and this acts as a barrier to them exercising their expertise in the best interests of their patients. The implicit suggestion is that the healthcare system structure of PCTs and SHAs is characterised by multiple layers of management making decisions without sufficient knowledge of the needs of patients or what things are like “on the ground.” In other words, managers are getting in the way of clinicians utilising their expertise to make decisions about what is best for patients. The organisations envisaged to redress this are GP Consortia (which have since become known as CCGs):

The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia (Department of Health 2010, p.4).

The implicit assumption in the above extract, and elsewhere, is that the proximity of GPs to patients means that they are logically the best choice to make commissioning decisions about what healthcare services those patients need. The White Paper identifies another issue, which has already been touched on in the discussion above:

The NHS also scores relatively poorly on being responsive to the patients it serves. It lacks a genuinely patient-centred approach in which services are designed around individual needs, lifestyles and aspirations. Too often, patients are expected to fit around services, rather than services around patients (Department of Health 2010, p.8).

This problem—that the NHS is not sufficiently “patient-centred”—is presented as stemming from insufficient opportunities for patients to exercise *choice*. Offering patients more choice over their care is assumed to offer the benefit of giving patients what they want in terms of services. This will mean that service providers will have to adapt or, through the power of competitive forces, be replaced by ones more attuned to the wants of the patient population, which will drive up quality. However, this greater choice, and the control over the system that it is associated with, is linked to greater responsibility for patients:

In return for greater choice and control, patients should accept responsibility for the choices they make, concordance with treatment programmes and the implications for their lifestyle (Department of Health 2010, p.16).

There is a parallel with the way that GPs and patients are presented. Both groups will be given more choice and control over healthcare but it comes attached to greater responsibility in both cases. In the case of GPs, the vehicle for this qualified empowerment is the CCG.

3.2: The Health and Social Care Act 2012

The HSCA12 essentially codified the content set out in the White Paper, subject to the amendments that the Bill received during the process of gaining royal assent. Consequently, it is not subject to the same process of extract-based analysis as the other documents. The key significance of the HSCA12 to this policy examination is the way that

it institutes legal requirements upon CCGs in terms of their establishment and operation. Section 28 makes it a legal requirement for all providers of primary care medical services to be a member of a CCG. Schedule 2, one of the most crucial elements of the HSCA12 in terms of CCG governance, specifies that each CCG must have a constitution and this must be published. The constitution is a legally binding document that specifies how the CCG will make decisions and how it will ensure effective participation of members. It must also specify the mechanisms by which member practices can hold the CCG governing body to account. By obligating CCGs to produce a constitution, which must include provisions for ensuring membership participation and accountability mechanisms, a governance framework that applies to all CCGs was established.

3.3: Towards establishment: creating responsive and accountable clinical commissioning groups

This was an important document for CCGs and GPs. It was produced by NHS England (NHS Commissioning Board 2012a) with the aim of helping CCGs understand how to govern themselves. It decodes and develops the legal requirements specified in the HSCA12. It contains chapters on developing a constitution, governance structures, the importance of good governance practices, transparency and accountability.

The Government's ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (NHS Commissioning Board 2012a, p.4).

"Empowerment" is a key term in the policy presentation, as demonstrated by its use in one of the three principles guiding NHS reform in the extract above. It is employed multiple times in this document, primarily in relation to health professionals but also in relation to patients and the public. Greater knowledge, choice, and control for patients and "frontline" health professionals imply greater autonomy for both groups in a health service with a more locally devolved power base. Of CCGs, the document states:

These new organisations will be vital to delivering the quality and productivity agenda which is so essential as we move into an era of increasing healthcare need and lower growth in NHS resources. They will need to deliver the highest quality and outcomes for patients within the resources available to them (NHS Commissioning Board 2012a, p.4).

Putting CCGs in charge of commissioning is framed as a necessary measure because of the broader socio-economic context that the NHS is operating within. The professional expertise they contain and the efficiency gains that they will realise are essential in order to allow the NHS to operate successfully at a time when it must negotiate the dual challenge of rising treatment costs and relatively lower funding. The rest of the document focuses particularly on the structure and governance processes that CCGs will adopt—i.e. their qualities as membership organisations—which will be explored in the following section.

3.4: Problematising the membership organisation concept

As identified above, one of the key policy problems that the HSCA12 and associated documents explicitly presented was an excessive number of managers within NHS organisations. These managers were disconnected from the needs of patients and contributing to an inefficient health service. The solution was the abolishment of PCTs and the introduction of new, local GP led commissioning organisations: CCGs. The *Equity and Excellence* White Paper notes that:

A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality (Department of Health 2010, p.28).

The key point above is that all GP practices were required to become a member of a consortium of practices (which would later become known as a CCG) but would have latitude to influence their organisation in ways that they believed, based on their professional expertise, would be in the best interests of their local population. The structural changes to local NHS commissioning were enforced but GP practices would be empowered to exert influence over the form and functions of their CCG.

In the following extract CCGs are presented as different and valuable because they are *membership organisations*. This novelty stems from the idea that CCGs have a dual nature: they are statutory bodies that must fulfil certain responsibilities within a legislative environment, and they are internally accountable groups composed of, and shaped by, their constituents: GP practices. A connection is drawn between the responsibilities that GP practices have to ensure that they are governed appropriately by their CCG and their ability to fulfil their professional obligations effectively. Being a good doctor is bound up with being a good member.

CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. These member practices must decide, through developing their constitution, and within the framework of legislation, how the CCG will operate. They must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively (NHS Commissioning Board 2012a, p.4).

Connecting these explicit elements of the presentation of CCGs together: all *GP practices* must be a member of a CCG; being a membership organisation means having statutory duties and being accountable to members; GP practice members have a duty to engage with their CCG, shape its operation, and ensure that it demonstrates principles of good governance (e.g. transparency and democratic accountability). Failure to do this could have a negative impact on the care that GP practice patients, and the broader local population, receive.

The question that emerges from this understanding of the policy is: how does the membership organisation status of CCGs logically relate to the claimed problem of a healthcare system featuring a profusion of ineffective managers? As noted above, it is the

local knowledge that GPs have of their registered list of patients (and their professional expertise), as a result of their proximity to those patients, which is the basis of the justification that CCGs will shape better, more efficient, care provision than PCTs staffed by managers disconnected from patient need. However, in order for this to be meaningful in practice it requires more than just a small self-selected sub-set of GPs making decisions that affect the care of *all* patients in a CCG's area. This is particularly the case for CCGs covering a large patient population, as the likelihood of variation in need between different geographically based patient groups is higher and a single GP will not have first-hand professional knowledge of the needs of all of those groups. In order for a CCG to better represent the interests of *all* local patients there must be some means by which all GPs have the ability, however nominal, to influence that organisation. Making CCG membership compulsory for GP practices, and instituting legal requirements for CCGs to demonstrate the existence of opportunities for members to contribute to the operation of the organisation, realises this.

The need for GP practice members to hold "the CCG" to account establishes a sub-division or distinction within the organisation: "the membership" as opposed to "those that govern." The details of this distinction were developed in the HSCA12 and supporting regulations, which specified that every CCG must have a *governing body*, which would comprise a minimum of particular roles (see Chapter 2, Section 2.2.1). The Towards Establishment (NHS Commissioning Board 2012a) document proposes that member GP practices must agree on the process for identifying and appointing suitable candidates to the governing body, and ensure that the process is 'democratic, inclusive, fair, open and transparent, and avoids conflicts of interest' (NHS Commissioning Board 2012a, p.9). However, it also notes that 'whatever process is adopted, it should have widespread support within and across all member practices especially clinical support including sessional and locum GPs' (NHS Commissioning Board 2012a, p.9). The mention of locum GPs is particularly interesting because they, by definition, do not belong to a particular GP practice. The document suggests that their opinion is valuable but they are not, according to the policy, part of the CCG membership. This elision between GP practices and GPs as CCG members was a recurring feature of the policy presentation, but it also indicates part of a broader confusion around membership. For instance, each governing body must legally include two lay people, a chief finance officer, and a secondary care doctor. It is

not possible that all of the people in these roles would also be employed by a member GP practice, therefore, they are not technically CCG members. The same applies to any CCG employed managers or analysts. One must also recognise that many GPs affiliated with particular practices are salaried and/or part time—this may well have implications for the extent of their involvement and influence within a GP practice and, consequently, their capacity to affect the CCG as a member.

This guidance from NHS England on how to be a *good* membership organisation by following principles of sound democratic governance must be recognised as a feature of on-going assessment processes that CCGs must engage in. Through the initial authorisation process and then recurring cycles of assurance (see Chapter 2, Section 2.2.2), CCGs must demonstrate to NHS England—a managerial appendage of the state (albeit operating at a greater “distance” than the DH)—that they are operating in a manner consonant with the ideological and logistical organisational requirements set out in the policy. Failure to do so would lead to them being deemed illegitimate and the removal of their statutory status as commissioning organisations. By making CCG membership a legal obligation for all GP practices, requiring CCGs to demonstrate governance practices that provide opportunities for all members to engage in its work, and by emphasising the need for all GPs to have input into the CCG for the benefit of patients, the membership organisation model can also be understood as a conceptual policy tool used to reconfigure the relationship between the state and GPs as a professional group.

This necessitates a broader consideration of the historical development of the relationship between GPs as a professional group and the state. A detailed exposition goes far beyond the limits of this thesis, however, I will briefly consider the broader dynamic of the medical profession and the state, before attending more specifically to the GP profession. It is widely recognised that the professional dominance and autonomy that the medical profession enjoyed in the first decades of the NHS has declined (Harrison and Ahmad 2000). The causes of this decline are the subject of debate but a number of relevant factors can be identified. In the 1980s, there was recognition in Conservative Governments that rising healthcare expenditure needed to be brought under control through increasing the efficiency of provision (note the parallel with the justification for

creating CCGs discussed in Section 3.3). Historically, the dynamic between the state and the medical profession had been that the former had determined the budget and the latter then spent this in a way that they deemed most appropriate, but this began to change. A shift occurred towards greater managerial control of NHS organisations, including the introduction of general managers who were ‘increasingly compelled to respond to governmental agendas and were consequently less able to respond to internal professional agendas’ (Harrison and Ahmad 2000, p.133). This coincided with a number of other legislative measures from government that represented a ‘downgrading (though by no means abandonment) of the corporatist relationship with the medical profession’ (Harrison and Ahmad 2000, p.137). Other more recent changes have contributed to a decline in medical professional autonomy, two such examples are: Prime Minister Tony Blair’s Labour Government’s introduction of “clinical governance”, which set standards against which NHS organisations could be held to account for the quality of their services, essentially collectivising responsibility for clinical practice quality (Baeza 2005); and the creation of the National Institute for Clinical Excellence (NICE), which sets clinical treatment guidelines and has a role in determining the content of clinical audits for hospital doctors.

For GPs, these changes had different implications because of the professional group’s historically liminal relationship with the state. At the creation of the NHS, GPs negotiated to maintain their independence and, consequently, became established as independent contractors providing NHS services.⁸ This meant that GPs were not amenable to governmental control in the same way as other clinicians employed directly by the NHS. With the introduction of the quasi-market and the first primary care led commissioning initiative—GPFH—groups of GPs gained access to clinical secondary data, and a role in assessing the performance of and controlling other clinicians, primarily hospital consultants. This HSCA12 has only extended this with CCGs having statutory powers and direct responsibility for a larger proportion of the commissioning budget. On one hand, these initiatives can be understood as a force increasing the autonomy of GPs; on the other, they have aligned the cost management interests of managers (and ultimately, the state) with groups of GPs, and represent an attempt by the state to co-opt one part of the

⁸ This is still the case although there are now a significant proportion of GPs that practice under Personal Medical Service (PMS) contracts, which make them salaried employees of a local commissioning organisation.

medical profession (i.e. GPs) to shape the behaviour of another in order to realise financial benefits for government—to divide and rule (Allsop 2005). Crucially, all of these initiatives are associated with tighter managerial control for GPs both from governmental organisations (such as NHS England) and from other GPs (Baeza 2005). As such, they can also be understood as part of a process to render GPs more governable.⁹ By making CCG membership compulsory for all GP practices, the HSCA12 marks a new phase in this relationship between GPs and the state. It goes further than any previous primary care commissioning initiative in providing powers and responsibility to primary care organisations, and GPs in particular, but also goes further in subjecting GPs and these new commissioning organisations to managerial control and accountability processes. How this plays out in practice in Notchcroft CCG will be explored in the results chapters (8—11) and discussion (Chapter 12).

3.5: Conclusion

In this chapter, a thread has been drawn through the *Equity and Excellence* White Paper, the HSCA12, and a governance guidance document written by NHS England to explore the presentation of the HSCA12, broadly conceived, and CCGs. This process identified the problem-to-be-solved as non-clinical NHS managers and their prevalence in PCTs, which was associated with service inefficiency and a lack of patient focus. The solution was a new kind of commissioning organisation: the CCG, which would be composed primarily of locally attuned GPs embodying particularly valuable professional knowledge and abilities. At the heart of the presentation of CCGs was their status as membership organisations. Being a commissioning membership organisation was strongly associated with notions of power devolution and empowerment (of both clinicians and patients/public), citizenship and professional responsibilities, representative democracy, and new governance mechanisms with greater accountability. All of these resonate strongly with the

⁹ Other policies have also had an important impact on this and, therefore, GPs' professional autonomy. For example, the GMS contract agreed in 2004 went further than any previous contract in linking GPs' pay to performance. Huby et al. (2008, p.64) comment on the extent to which GPs 'laid themselves open to external scrutiny and control through the way they are being measured against centrally defined targets' through the contract. The contract represented a notable step in the process of 'the increasing definition, measurement and regulation of professional work and the use of financial incentives as a mechanism for change' (Huby et al. 2008, p.63).

ideological principles David Cameron emphasised (whilst in opposition in 2009) would guide a Conservative Government: power would be relocated from the centre to the local level, and democracy would replace bureaucracy (Cameron 2009).

Through this process, I have highlighted some of the ambiguities and uncertainties of the policy in relation to CCG membership. I have also considered how the policy solution of CCG membership organisations might be assumed to address the policy problem of managerial domination in commissioning organisations, noting how the policy norms and requirements around membership reflect an effort to incorporate some engagement and influence from all local GPs, thereby avoiding the criticism that only a small self-selected group of GPs are responsible for making decisions about a larger population that they cannot have first-hand professional experience of. I have also identified that the introduction of CCGs, and compulsory CCG membership for GP practices, marks a new phase in the relationship between GPs as a professional group and the state. This understanding of the policy, developed through a process of problematisation, forms the analytical foundation that will be built upon in Chapter 5: *Institutionalism*, in the section on *The NHS and Health and Social Care Act 2012 from an institutional logics perspective* (Section 5.5). The resulting understanding of the policy will be considered in relation to events observed within Notchcroft CCG in the results chapters (8–11) and discussion (Chapter 12).

3.6: Chapter summary

In this chapter, I problematised the presentation of CCGs in the HSCA12 and two related documents to reveal how the organisations were framed as the antidote to an NHS afflicted with a preponderance of managers, disconnected from the needs of patients. GPs, in particular, would be given greater autonomy to use their professional expertise and local knowledge to make better decisions about care provision to meet patients' needs and improve the efficiency of the NHS. This would be coupled with a broad range of responsibilities and accountabilities to various groups, both locally and nationally, NHS England in particular.

The credibility of this vision is predicated on some degree of CCG involvement from all GPs in a local area. The membership organisation status of CCGs places various legal requirements and normative conditions on individual professionals and the CCG as an organisation to facilitate this. However, there is unresolved ambiguity in the policy about exactly who or what constitutes a member. What is clear is that the membership organisation model represents a development in the relationship between GP professionals and the state. GPs have been given more autonomy to shape local healthcare provision, but this is associated with greater exposure to managerial control from government and other GPs.

Chapter 4: NHS policy analysis literature review

In Chapter 2 (Section 2.3.7) I explored the literature on NHS policies relevant to primary care led commissioning initiatives over the last 30 years. The purpose of this chapter is to sketch out the body of existing general NHS policy analysis literature that employs methods consonant with this study, to which it will contribute. Throughout this process, I have sought to identify studies that exhibit some or all of the following qualities: an in-depth case study approach to the study of policy enactment; critical consideration of what and *how* policies mean (Yanow 1997); and consideration of policy “between levels” (i.e. how policy is presented at the level it is set and how it is enacted locally). I found that only a small number of studies fulfilled these criteria. These, and others that fulfil most of the criteria, will be discussed below. I also found that there is a general tendency for NHS policy analysis studies to privilege the quantifiable (Le Grand et al. 1998) and avoid critical engagement with aspects of policy itself (Bacchi 2012).

NHS policy analysis can be understood as a sub-field of public policy analysis, and my initial focus was on this broader level of literature. However, the inter-disciplinary nature of this field (e.g. social policy, sociology, political science, public administration), its considerable size, and the variations in terminology employed posed challenges when attempting to integrate understanding about methods and findings (Shore and Wright 1997; Yanow 2000; Wedel and Feldman 2005; Dubois 2009). Furthermore, literature in this field, unlike that in medicine and allied disciplines, is rarely well indexed, and does not use keywords in a systematic way. It therefore does not easily lend itself to a conventional systematic review. Instead I began by consulting key texts in public policy analysis—such as Parsons (1995) and Moran et al. (2008), which chart the methodological and theoretical landscape of public policy analysis in detail—and employed these to shape successive reading. I then conducted keyword searches (Appendix 1) using Google Scholar (<http://scholar.google.co.uk/>). Through this process it became increasingly clear that, while there are considerably more studies that fulfil the criteria of interest identified above in this field than in the sub-field of NHS policy analysis, such a large and disparate body of work would prove too challenging to present in a sufficiently coherent and concise way within the constraints of this thesis. After deliberation, I decided that I would focus my attention primarily on a review of NHS policy analysis studies. However, before

this, there is one particular strand of theory and work in public policy analysis that is highly relevant and merits some attention: the study of policy implementation.

Policy implementation emerged as a prominent focus of public policy research in the early 1970s and in the context of Pressman and Wildavsky's (1992) study of the US Economic Development Agency's central government funded projects in Oakland California. It signalled a shift in scholarly attention from planning to action. Much of the resulting body of work centres on a debate between the appropriateness of "top-down" versus "bottom-up" approaches to analysis: the former, which sees implementation as an '...administrative and hierarchical follow on process...' (Barrett 2004, p.252), is concerned with compliance; the latter seeks to uncover the complexity of actual practices at the local level and open space for critical engagement with the policy itself (Lipsky 1980; Matland 1995; Hill and Hupe 2002). This debate represents, in part, a struggle over the definition of a boundary between formulation and implementation—"top downers" insist that formulation and implementation are distinct and "bottom uppers" claim that any such boundary is blurred, if existent at all (Barrett and Fudge 1981).

Policy implementation literature and the top-down/bottom-up debate are particularly relevant to this study given that CCGs are both an expression of the HSCA12 as well as organisations tasked with its implementation. This study has been shaped by certain tenets of bottom-up approaches: the problematising of a policy element (CCGs as membership organisations), and working closely with CCG members at the local level. However, it also seeks to explore local conceptualisations of the CCG with constructions of the policy at broader institutional and political levels. As such, the term *enactment* is employed in favour of implementation throughout this thesis. Enactment 'refers to an understanding that policies are interpreted and 'translated' by diverse policy actors... rather than simply implemented' (Braun et al. 2010, p.547). Before moving on to addressing NHS policy analysis studies specifically, I will discuss two exemplar public policy analysis studies, selected on the basis that they fulfil the criteria specified at the start of the section and are relevant to the field of policy implementation/enactment.

Dubois (2009) undertook fieldwork with welfare officers in France. He studied the policy guidance for dealing with certain applicants and compared it with the actual social practices of their work. He found that officers had a variety of ways of classifying potential welfare recipients in order to make judgements about the legitimacy of their claims. As such, in the messy and situated reality of actual practices, he observed and identified the application of schema for making judgements about the poor, which were quite removed from the policy level guidance on what basis such decisions should be made. He refers to his approach as policy ethnography, which he defines as the generation of qualitative data through fieldwork in order to give a ‘...more nuanced and realistic ground-level view of policies too often analysed abstractly from the top’ (Dubois 2009, p.221).

Brady (2011) carried out a study of a welfare policy in Australia that required those receiving income support as the low income primary carer of a child to seek work in order to remain eligible. He supplemented a theoretical orientation to governmentality (Foucault et al. 1991) with ethnographic field work “on the ground,” and discovered that local discourses and social practices of policy implementation differed significantly from each other and the policy guidance. The top-down (policy representation) perspective treated paid work for single mothers as an unqualified positive; whereas from the bottom-up (social practices) perspective, some of the agencies tasked with implementing these policies acted in a way that belied different judgements about the value of certain parenting practices. This disjuncture of reality between top-down and bottom-up perspectives is particularly interesting because its existence was only accessible through engagement with meanings and social practices across levels. Both Dubois’ (2009) and Brady’s (2011) studies employed ethnographic methods and sensibilities, engaged with policy presentation, and explored the role of street-level bureaucrats in shaping policy locally (Lipsky 1980; Hammond et al. 2013).

I will now discuss a number of NHS policy analysis studies that fulfil some or all of the criteria established at the beginning of the section. Literature was identified through the use of keyword searches (Appendix 1) using Google Scholar (<http://scholar.google.co.uk/>) and the Scopus database (<http://www.scopus.com/>). Studies were also identified “by hand”, reading through the reference lists of chapters in relevant books, such as Exworthy

et al. (2011), and each relevant paper as and when it was identified. This approach allowed for a thorough overview of NHS policy analysis literature to be developed.

Checkland et al. (2009) studied five PbC consortia and explored the “barriers” that participants identified to implementing PbC more fully. They employed the same three methods as my study: meeting observations, interviews, and document analysis. However, they conducted interviews with a broad range of people from organisations in the local organisational field and not just those from the PbC consortia. They employed Weick’s (1995) concept of “organisational sensemaking” as a theoretical tool and came to understand “barriers” identified by the PbC consortia as ‘windows into the underlying sensemaking’ (Checkland et al. 2009, p.21) within the organisations. They found that the same “barrier” descriptor could mean quite different things to different PbC consortia, which highlighted the importance of understanding local context in any centralised policy implementation process.

As part of the same overarching study, Coleman et al. (2010) explored the implementation of PbC by focusing on how sensemaking (Weick 1995) processes shaped local variations in the development of PbC consortia. They found that the ways different PbC consortia made sense of, and enacted, the reforms was related to their ‘...historical legacies’ (Coleman et al. 2010, p.294). Individual and organisational identities were partly bound up with feelings towards past GPFH status and the on-going associations with this. Coleman et al.’s (2010) work illustrates how an awareness of historical context aids understanding of how policy is enacted on the ground, and why it is enacted in a particular way. It demonstrates how local development occurs iteratively: the translation and enactment of policy is built upon the past experiences of those involved. In terms of methods and the focus on NHS commissioning organisations, the study from which Checkland et al. (2009) and Coleman et al. (2010) emerged matches up closely with this study. The major point of distinction is that, while Checkland et al. (2009) and Coleman et al. (2010) provide a brief account of the policy itself, there is no overt focus on policy meaning or attention to how the policy is transferred or translated between levels.

Huby et al. (2008) studied the observable impacts of the 2004 GMS contract (see Chapter 2, Section 2.2.1) on GP practices across four case sites, as well as the impacts that GPs in

those sites perceived as a result of the contract. They also employed Weick's (1995) "organisational sensemaking" in the development of (what they explicitly present as) "stories" that each GP practice constructed about themselves and the changes they experienced. They found that these stories failed to reflect common changes resulting from the contract, namely that: 'decision-making became concentrated in fewer hands. Formally or informally constituted "elite" multidisciplinary groups monitored and controlled colleagues' behaviour for maximum performance and remuneration' (Huby et al. 2008, p.63). Huby et al.'s (2008) study is consonant with my study in that it focuses on the constructions of policy meaning amongst those involved in local enactment, and in terms of the methods employed. However, there is little critical engagement with the national level policy presentation.

Singleton (2006, p.112) studied a community public health initiative called 'The Heart of the Shire', the objective of which was to train every member of the community in a rural British area in cardio pulmonary resuscitation (CPR). Her approach was to combine analysis of the policy itself with observations of social practices of enactment. This involved observing training sessions, analysing promotional materials, and talking to various members of the community. Singleton (2006) demonstrated how the enactment of the policy created new (and shaped existing) norms, negativities and categories of actors. She found that the scheme lent a legitimacy and objectivity to certain perspectives about how people should live and die, and created the conditions for normative judgements about people that were or were not involved in the scheme and trained in delivering CPR.

Pope et al. (2006) studied the introduction of NHS Treatment Centres, which were first developed as ambulatory care centres in the 1990s and became established through *The NHS Plan* (Department of Health 2000). These centres were intended to reduce waiting lists for elective surgical operations by increasing capacity and efficiency through new and redeveloped premises and redesigning service processes. Pope et al. (2006, p.62) used a combination of interviews, observations, and document analysis in order to explore how policy meaning around Treatment Centres was constructed by different groups. Their interest was '...not with a single organization or echelon of the NHS, but rather with the interconnections and interdependencies of meanings operating at different levels...'. They

looked at the ways the policy was framed at different organisational levels: government (macro), modernisation (meso), and Treatment Centre (micro). The policy was presented by government in association with aspirations to enhance patient choice, both generally and in terms of selecting a particular hospital for surgery. They found that the variation in development of Treatment Centres reflected differences in interpretation of the policy—“headroom” that allowed for local improvisation, which, in some cases, was transported “upstream” and came to be reflected in governmental narratives about the form and purpose of the reforms. There are a number of similarities between Pope et al.’s (2006) work and my study: primarily, the focus on policy meanings and related social practices at multiple levels, and the combination of methods employed. The main difference between Pope et al.’s (2006) work and this research, aside from the policy under consideration, is that they carried out fieldwork in multiple local sites and compared across them, whereas this study focuses on one organisation, albeit with consideration of the broader organisational field.

Waring and Bishop (2011) also studied Treatment Centres but they focused specifically on Independent Sector Treatment Centres, which involve partnerships between public and private providers. Of particular relevance to my study is that Waring and Bishop (2011) explored changes in the identities of clinicians who were, in some cases, obligated to transfer their work to the private sector. They conducted interviews and identified three particular identities from the narratives that clinicians presented about themselves and the changes to their working practices: the “pioneer” saw the changes as an opportunity to improve treatments and forge new relationships; the “guardian” perceived the need to maintain or rebuild previous social structures and dynamics within the new context; and the “marooned” were highly uncertain about their place in the new system and felt isolated (Waring and Bishop 2011, p.673). The study is particularly relevant because of its focus on policy driven change and the experiences and identities of those at the local organisational level. However, it does not engage with the content of the policy itself in the way that Pope et al. (2006) did, and data was gathered solely via interviews.

In conclusion, there are few studies of NHS policy enactment that fulfil the criteria set out at the start of this section: an in-depth case study approach, a critical consideration of what and *how* policies mean, and a consideration of policy “between levels”. I have

identified and discussed a number of studies that fulfil some of these criteria, and two that meet all of them and are, therefore, most congruent with this study: Singleton (2006), and Pope et al. (2006). Of these two, Pope et al.'s (2006) focus on NHS organisations makes it the most direct relative. These studies illustrate that engaging with local and historical context can offer valuable insights when studying NHS policy and its enactment in local organisational settings. The aim, objective and research questions of this study, specified in Chapter 6 (Section 6.1), are intended to foster a study that adds to this small but important pool of research.

4.1: Chapter summary

This chapter situates my study within the NHS policy analysis literature, which is itself framed in relation to the literature on public policy analysis more broadly and its sub-field of policy implementation. I identify certain defining characteristics of my study—an in-depth case study devoting attention to the meanings of a policy and experiences associated with its enactment at the local level—and consider other studies of NHS policy adopting a consonant approach. Six studies exhibiting these qualities to differing degrees are identified; two of these match particularly closely with my study: Singleton's (2006) exploration of the enactment of a policy to train a rural community in the administration of CPR, and Pope et al.'s (2006) study of the introduction of NHS Treatment Centres, which examined policy meanings and related social practices at multiple organisational levels. This study intends to contribute to this small cross section of NHS policy research—the aim, objective and research questions have been created with this in mind.

Chapter 5: Institutionalism

5.1: Introduction

In this chapter I will introduce and discuss the theoretical approach that I will employ as part of the analysis process: institutional logics. I will describe how and why I selected this approach, how I will employ it, and on what grounds I will consider its utility. As part of this process I will provide an account of some of the (copious and much debated) institutional theory literature where it is necessary to contextualise the approach, its features and potential benefits.

This study is concerned with the ideational content of policy, as presented at the governmental level, in relation to social practices in a specific local, organisational context. To be more specific, this study identifies the ideas implicit and explicit in the presentation of the HSCA12 by Government and considers them in relation to a particular CCG and the broader context it resides in. When I began fieldwork in Notchcroft CCG I was struck by the structural complexity of the organisation (the governing body, various committees, working groups, geographically and historically arranged clusters of general practices, various professional groups, GPs as independent businesses etc.) and the changing environment within which it operated, which involved interplay between a host of organisations including: NHS England area team, HWB, the local authority, other CCGs, primary and secondary care providers, professional bodies, CSUs etc. What I was exposed to was the intra- and inter-organisational dynamics of the system, albeit largely from the perspective of the governance¹⁰ of the CCG (primarily through meetings and events), which were incredibly rich and nuanced. It became apparent that a useful theoretical approach would be one that helped me to think about the ideational and symbolic

¹⁰ Governance is a somewhat general term that has taken on a number of meanings: it is used simply to refer to government; it is used in contrast to government to describe a process of governing through 'self-organizing, interorganizational networks' (Rhodes 1996, p.652); it is often used in the NHS context as a shorthand for hierarchical, "top down" control. The term governance is used throughout this thesis to simply refer to the running of an organisation.

content of the policy in relation to the social practices¹¹ that I was observing, and the reported beliefs and perceptions of those in that setting; it also needed to help me understand and organise the intra- and inter-organisational practices that I was observing and hearing about. Finally, the approach needed to have the potential to assist me in moving between analytical levels—from micro level interactions, to inter-organisational environments, to the macro level of the state—and to think about these in relation to each other, not individually. As I will illustrate, the institutional logics perspective offers the prospect of all of this.

The institutional logics perspective has developed from a body of work referred to as new institutionalism, which is cast in contrast to what has come to be called old institutionalism and certain theoretical trends in twentieth century social science. In the following section I will briefly consider some of the ideas and literature relevant to a thorough understanding of institutional logics. I will then discuss an alternative institutionalist meta-theory—Scott’s (2013) three pillars—before focusing in on the institutional logics approach and explain why I have chosen to employ it in this study.

5.2: Institutions and institutional theory: a brief survey

Institution is a commonly used term. The Oxford English Dictionary defines an institution as ‘an organization founded for a religious, educational, professional, or social purpose’ and ‘an established law or practice’ (Oxford English Dictionary 2014). This illustrates that an institution can be understood as a thing—in this specification, a particular kind of organisation—and/or an embedded practice or process.

5.2.1: New institutionalism

The phrase “new institutionalism” was coined by March and Olsen (1984). The approach it described was delineated in contrast to two broad bodies of work: the formal-legal,

¹¹ A social practice can be understood as ‘a routinized type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, “things” and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge’ (Reckwitz 2002, p.249).

largely atheoretical and normative, approach to institutional study prevalent in the late 19th and early 20th centuries, which subsequently became known as “old institutionalism” (Bell 2002; Peters 2005);¹² and behaviouralist approaches, such as systems theory and structural functionalism, which were prominent in the social sciences in the 1950s (Hall and Taylor 1996). It is now commonly understood that there are not one but multiple new institutionalisms. The most established typology identifies three: rational-choice, historical, and sociological (Hall and Taylor 1996). Each is founded on a different disciplinary base and they vary in terms of how they define an institution, how institutional emergence and change is understood, what effects institutions exert, and how structure and agency are perceived. They are, however, united by an appreciation that institutions are important in aiding understanding of socio-political processes.

The prevailing narrative of the development of new institutionalism is that the three ‘species within the genus’ (Peters 2005, p.2)—rational-choice, historical, and sociological—formed almost simultaneously in the late 1970s (Hall and Taylor 1996). Although this version of events broadly reflects historical developments, it has been subject to contestation. Bevir and Rhodes (2010, p.26) refer to it as the ‘authorised biography’ of new institutionalism because of the way that it legitimises the existence and independence of these new institutional brands—reifying them and investing them with an undue degree of internal coherence. However, bearing these caveats in mind, Hall and Taylor’s (1996) delineation remains a useful classifying device, which helps impose a little order on a somewhat confused and confusing field. Rational choice, historical, and sociological institutionalism (the order reflects their chronological emergence (Adcock et al. 2009)) are briefly discussed in turn below.

Rational choice institutionalism borrows theory and concepts from economics and tries to explain how institutions are created, the behaviour of political actors within them, and the outcomes of strategic interactions between people. Its key assumption is that people and organisations are rational entities that make calculated decisions in order to realise their particular set of interests. However, they are not assumed to possess flawless decision-making abilities or have access to perfect information; therefore, they operate

¹² Although DiMaggio and Powell (1991) associate the term more specifically with the work of Philip Selznick (1948; 1949; 1957).

with “bounded rationality” (Simon 1957; Lindblom 1959). Institutions are defined as constraints upon individual decision-making: they are ‘the rules of the game in a society, or, more formally, are the humanly devised constraints that shape human interaction’ (North 1990, p.3).¹³ The approach can be criticised on the grounds that it focuses on agency at the expense of structure, does not offer an explanation for how preferences are initially formed or change over time, and ultimately oversimplifies human motivation and interaction.

Historical institutionalism emerged in explicit contrast to rational choice. It emphasises the importance of institutions in explaining the developments and organisational configurations in different settings over time (Steinmo et al. 1992). Institutions are defined as ‘the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy’ (Hall and Taylor 1996, p.938). One of the key concepts of historical institutionalism is “path dependence” (Pierson 2000), which refers to the idea that past events are important in shaping current events in a given context because socio-political processes can create the circumstances for “increasing returns”. This makes change less likely because investment in these institutions, in particular forms, accumulates over time creating a kind of inertia. This is used to explain why institutions are relatively stable or “sticky” (Pierson 2000). However, dramatic institutional change can occur at moments of “punctuated equilibrium” (Pierson 2011), typically moments of external crisis (Collier and Collier 1991; Thelen 1999)–“exogenous shocks”, such as wars (Thelen and Steinmo 1992). Historical institutionalism takes a more macro, structural approach than rational choice and has some difficulty in addressing micro processes and accounting for individual agency (Bevir and Rhodes 2010; Schmidt 2010). In analysis, institutions and forces precipitating institutional change are treated as separate from the people and organisations effected.

Sociological institutionalism is based on an assumption that culture and identity are relevant factors in understanding institutions (Katzstein 1996), which are defined as the ‘shared rules and typifications that identify categories of social actors and their appropriate activities or relationships’ (Barley and Tolbert 1997, p.96). In contrast to the

¹³ Shepsle (2008) argues that there exists another school of thought within rational choice that sees institutions as equilibria conditions rather than constraints.

other two new institutionalisms, sociological institutionalism understands peoples' beliefs and interests to be bound up with institutions because those people are embedded within them. Early sociological institutionalists sought to understand why organisations within certain groups became more similar over time ("isomorphism") (Meyer and Rowan 1977; DiMaggio and Powell 1983). Engaging with Weber's (2002) ideas about the "iron cage" of bureaucracy, DiMaggio and Powell (1983) argue that this occurs because organisations adopt particular practices that confer legitimacy in their "organisational field."¹⁴ In contrast to rational choice's "logic of calculation", this process is based on a 'logic of *social appropriateness*' (Campbell 1997, p.26) and can lead to organisations developing practices counter to the realisation of their formal aims, making them dysfunctional. Like historical institutionalism, sociological institutionalism adopts a macro analytical focus—the organisational field is highlighted as a particularly appropriate level (DiMaggio 1991)—and has been criticised on the same grounds, i.e. that it lacks sufficient attention to the role of agents and micro-politics (Hall and Taylor 1996).

As noted above, the three species of new institutionalism differ on a number of bases, including how they define the institution itself. Attempts have been made to adapt and combine them to address perceived shortcomings. For example, a cross pollination has occurred between rational choice and historical institutionalism in an attempt to supplement the structural and contextual focus of the latter with the micro decision making explanatory power of the former (Thelen 1999). Of the three new institutionalisms, sociological institutionalism is most congruent with the methodological approach of this study (see Chapter 6), including the problematisation approach presented in Chapter 3, because of its explicit recognition of the relevance of symbols and ideas. However, sociological institutionalism lacks attention to the micro level social processes within organisations or a perspective on how these have the potential to shape these settings and relevant institutions. Sociological institutionalism in its most established form, like rational choice and historical, emphasises institutional stasis rather than change; and when change does occur it is explained as being imposed from "outside" (Schmidt 2010). These issues led me to rule out sociological institutionalism as a

¹⁴ '...those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products' (DiMaggio and Powell 1983, p.183).

theoretical approach on the basis that an appropriate approach would: a) offer the ability to engage analytically with micro level inter-personal processes and ideas and link these with events and ideas associated with broader levels, such as the organisational field and state; and b) facilitate understanding of institutional dynamism as well as resilience, as this may be relevant to the diverse and evolving context of the NHS.

5.2.2: Three pillars institutionalism

Three pillars institutionalism is a meta-theoretical framework and “‘omnibus” conception’ (Scott 2003, p.880) developed by Scott (1995; 2008; 2013) that incorporates the three major species of new institutional literature. Scott (2008, p.42) defines institutions as ‘social structures that have attained a high degree of resilience [and are] composed of cultural-cognitive, normative, and regulative elements that, together with associated activities and resources, provide stability and meaning to social life.’ The three elements are the pillars in Scott’s framework—they constitute *and* support institutions by providing a degree of stability. The regulative pillar refers to the force of rules, regulations, and formal assessment processes; the normative pillar relates to the values and norms that are the basis of socially expected behaviours and shape roles; the cultural-cognitive pillar is composed of the shared perspectives that comprise reality, particularly deeply embedded conceptions that are taken for granted and largely unquestioned. The pillars vary across a number of dimensions, such as their bases for compliance, logic, and how they confer legitimacy (Scott 2008, p.51). Each of Scott’s three pillars is primarily associated with one of the three new institutionalisms discussed above (note how the description of each pillar resonates with one of the new institutional species’ definition of institution). He argues that most of the studies located within each of these bodies of literature actually acknowledges the existence of every pillar but emphasise one as primary (Scott 2013).

Checkland et al. (2012a) postulate that the NHS can be understood as an institution, although not in any exclusive sense, using Scott’s (2013) model. It possesses a regulatory pillar in the form of legislation and national guidance documents, as well as a normative pillar that is explicated in, for example, the NHS constitution and broad organisational “values”. They state that the existence of a cultural-cognitive pillar is a question that

merits empirical attention but highlight the vigorous challenges to various health service reforms on the grounds of protecting the “NHS way” as a potential indicator of its presence.

For Scott (2013), these pillars exist in some evolving, interactive combination of relative strength or prominence in every organisational context. He suggests that the most enduring institutions are those where the pillars are relatively balanced. If the pillars in a given context are particularly asymmetrical—and a shift in one can have knock on effects on the others—then institutional change is more likely. He employs the idea of “institutional carriers”¹⁵ as the mechanism for institutional change. Carriers come in a variety of forms (symbolic systems, relational systems, routines, and artefacts (Scott 2003)) and transport institutional ideas across space and time and between contexts. They might contain ideas associated specifically with one of the pillars or a combination of them. For example, a law is considered a symbolic systems carrier, yet the application of that law in a given context necessitates interpretation, a process influenced by a range of actors and organisations (Scott 2003). Carriers can operate between societal levels creating ‘opportunities for institutions to come into conflict and into complementarity, creating prospects for organizational change and stability’ (Thornton 2002, p.83) in a given context. Importantly, the form of the carrier affects how its ideas are received by recipients, which creates greater scope for institutional change to occur in complex, unpredictable and contextually specific ways. The institutional carriers idea resonates with Giddens’ (1984) theory of structuration, which Scott (2008) cites as influential. This is the idea that micro level social interactions take place within macro societal structures, which both constrain and provide opportunities for action, yet macro societal structures are also being changed by micro level social actions. In other words, structure and agency are mutually constitutive—a duality engaged in an ever evolving dynamic.

Scott’s (2013) approach is potentially well suited to pursuing the aims established at the beginning of this chapter. He advocates an inductive approach, harmonious with the methodological orientation of this study, to studying an organisational context by considering what aspects of the pillars are present, how they interact, and what the effects are. The normative and cultural-cognitive pillars, in particular, provide a base from

¹⁵ The concept can be traced back to Di Maggio’s (1991) study of art museums in the USA.

which to engage with the ideational and symbolic content of the HSCA12 as it relates to the case study CCG. Calling on Giddens' (1984) structuration theory, Scott (2013) develops the institutional carriers concept so that it offers a useful device for explaining institutional change, which transcends the static tendencies of the new institutionalisms. Scott (2013) also divorces his approach from the assumption, prevalent in much new institutional scholarship, that institutional forces are making organisations more similar. He advocates empirically investigating how they may also be making organisations more diverse (Scott 2010, p.12).

There are, however, two issues with Scott's (2013) approach that have influenced my decision not to employ it in this study. First, at times Scott neglects to go beyond the description and categorisation of institutionalism research for his three pillars model. This creates uncertainty as to how his theoretical approach develops them further and can be observed, for example, in his discussion of institutional creation (Scott 2013, Ch.5). The consequence of this is that the three pillars approach offers little more in this regard than a survey of the prominent new institutional scholarship, which is of limited use, particularly given Scott's (2008, p.70) admission that some of these approaches are of questionable compatibility (Thornton et al. 2012). Second, Scott's understanding of the interplay between agency and structure and his use of the institutional carriers concept provide a basis for grappling with institutional change, however, he does not devote attention to the mechanisms by which micro-level interpersonal and intra-organisational processes shape, and are shaped by, institutions as they relate to the three pillars. Although Scott (2008) recognises that institutional analysis can be focused on any level from the individual to the global, he advocates adopting broader levels of analysis (in preference to more localised levels) and identifies the organisational field¹⁶ as a particularly relevant focus. Although the organisational field and broader analytical levels will be considered in this study, the primary focus is the organisational level of the CCG. Consequently, I decided not to employ Scott (1995; 2008; 2013) three pillars approach in favour of a framework that could offer theoretical tools for micro-level analysis.

¹⁶ Defined by Scott (2004, p.9) as 'a collection of both similar and dissimilar interdependent organizations operating in a functionally specific arena together with their exchange partners, funding sources, and regulators.'

5.3: Institutional logics

The institutional logics perspective is a meta-theoretical framework most closely associated with Patricia Thornton and William Ocasio (Thornton et al. 2012; Thornton and Ocasio 1999; Thornton and Ocasio 2008) but building on an approach developed by Friedland and Alford (1991). In brief, it advances that there are a number of major institutions in a society and each is associated with particular logics, which are defined as ‘the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality’ (Thornton and Ocasio 1999, p.804). These logics are partly constituted through ‘vocabularies of practice’ (Thornton et al. 2012, p.94)—‘systems of labelled categories used by members of a social collective to make sense of and construct organizing practices’ (Thornton et al. 2012, p.159)—which serve to explicitly articulate, or implicitly suggest, norms and values. The institutional logics framework has grown from new institutional scholarship but Thornton et al. (2012) stress that it represents a significant departure because it treats material practices and cultural symbols as profoundly integrated and endeavours to understand the dynamics between them. This will be discussed in more detail below.

The fundamental assumption at the core of institutional logics is that ‘to understand individual and organizational behaviour, it must be located in a social and institutional context, and this institutional context both regularizes behaviour and provides opportunity for agency and change’ (Thornton and Ocasio 2008, pp.101–02). This is associated with a set of further assumptions, which are described in Table 5.

Assumption	Description
Embedded agency	The beliefs, preferences, and social practices of individuals and organisations are embedded within institutional logics, and ‘decisions and outcomes are a result of the interplay between individual agency and institutional structure’ (Thornton and Ocasio 2008, p.103)
Society as an inter-institutional system	Society is composed of multiple institutional orders (Table 6) each of which is associated with a set of ‘expectations for social relations and human and organizational behaviour’ (Thornton and Ocasio 2008, p.104)
Material and cultural foundations of institutions	The institutional orders of a society contain both material and cultural elements, which interact and, through this process, have the potential to shape institutional change
Institutions at multiple levels	Institutional logics manifest at multiple levels, which makes the theory flexible but requires the level(s) under consideration in a given study to be clearly articulated
Historical contingency	Historically situated social, economic, and political conditions are assumed to be relevant in shaping the beliefs and behaviours of individuals and organisations

Table 5: Assumptions of the institutional logics approach

Considering these assumptions, the framework can be understood as one that treats engaging with social, historical, and institutional context as essential in institutional research. From the institutional logics perspective, individuals are nested within “higher” levels—organisation, organisational field, society etc.—and the institutions that make up society operate across all of these levels. These inter-related institutions vie for dominance, for cultural control, and exist in a shifting state of conflict or co-operation *at a given level of analysis, in a given context*. Individuals and organisations call on multiple institutional logics in their practices, which provide limitations and possibilities, and, crucially, form the agential basis from which institutional change can occur. The idea that agency and structure exist in a recursive relationship is at the heart of the institutional logics perspective. This, as with Scott’s (2013) three pillars, resonates with Giddens’ (1984) structuration. However, Thornton et al. (2012) argue that Giddens’ (1984) theory lacks a conception of society and focuses primarily on how actors build or protect their social power. The institutional logics perspective develops a model of society—the inter-institutional system—and argues that to understand how and why actors exercise power it is necessary to understand the context of their position within it and, therefore, what logics they may be employing.

Thornton et al.'s (2012) conception of society as an inter-institutional system is key to the approach. Developing Friedland and Alford's (1991) typology of institutions within Western societies, they specify a set of seven Weberian ideal types (Thornton and Ocasio 2008), displayed in Table 6: institutional orders populate the columns, and the categories that make up the rows are the material practices, cultural symbols and norms associated with each of these. Taken together they make up institutional logics. Thornton et al. (2012) argue that the strength of this model is that it allows for analytical attention to be applied across multiple levels, from individual to societal, and for the material and the symbolic to be considered in an integrated manner. The elements composing each logic are understood as having a certain independent existence and can be reduced into smaller elemental systems in a fractal-like way. This is referred to as "decomposability." However, these elements are also understood as inter-related and even transposable (i.e. elements can move from one order or category to another), the result of which is institutional change. This is discussed in more detail below.

Categories	Institutional orders						
	Family	Community	Religion	State	Market	Profession	Corporation
Root metaphor	Family as firm	Common boundary	Temple as bank	State as redistribution mechanism	Transaction	Profession as relational network	Corporation as hierarchy
Sources of legitimacy	Unconditional loyalty	Unity of will Belief in trust and reciprocity	Importance of faith & sacredness in economy & society	Democratic participation	Share price	Personal expertise	Market position of firm
Sources of authority	Patriarchal domination	Commitment to community values & ideology	Priesthood charisma	Bureaucratic domination	Shareholder activism	Professional association	Board of directors Top management
Sources of identity	Family reputation	Emotional connection Ego satisfaction & reputation	Association with deities	Social & economic class	Faceless	Association with quality of craft Personal reputation	Bureaucratic roles
Basis of norms	Membership in household	Group membership	Membership in congregation	Citizenship in nation	Self-interest	Membership in guild & association	Employment in firm
Basis of attention	Status in household	Personal investment in group	Relation to supernatural	Status of interest group	Status in market	Status in profession	Status in hierarchy
Basis of strategy	Increase family honour	Increase status & honour of members & practices	Increase religious symbolism of natural events	Increase community good	Increase efficiency profit	Increase personal reputation	Increase size and diversification of firm
Informal control mechanisms	Family politics	Visibility of actions	Worship of calling	Backroom politics	Industry analysts	Celebrity professionals	Organisation culture
Economic system	Family capitalism	Cooperative capitalism	Occidental capitalism	Welfare capitalism	Market capitalism	Personal capitalism	Managerial capitalism

Table 6: Inter-institutional system ideal types (Thornton et al. 2012)

One of the charges against all of the new institutionalisms, to differing degrees, is that they are more suited to explaining institutional stasis than change (Gorges 2001). As noted above, Scott's (2008) three pillars meta-theory addresses this with the concept of institutional carriers. Thornton et al. (2012) equate the category elements in the rows of Table 6 with carriers, but they argue that the key distinction between the concepts is that material practices, cultural symbols, and norms are fundamental parts (in some form) of every institutional order, whereas with Scott's (2013) conceptualisation these can be treated as distinct.

The institutional logics framework assumes that individuals—their beliefs, preferences, and practices—are embedded within institutions, yet it is these same actors that shape the change of these institutions (N.B. this is the principle of embedded agency discussed above). This initially appears contradictory but the process is made possible by the institutional orders within the system existing in an evolving state of inter-dependency and conflict. Multiple logics are available to individuals and organisations in a given context, creating scope for a degree of agential autonomy. Change within the inter-institutional system is possible because it is essentially modular, meaning that category elements (Table 6, rows) can relocate. Thornton et al. (2012) refer to this understanding of the dynamics of the relationship between individuals and their institutional environment as the “micro-foundations” of the approach. It provides an explanation for how institutional change occurs across analytical levels—from the micro-interpersonal, to the meso-organisational, to the macro-societal. Thornton et al. (2012, pp.84–85) explain this process:

Institutional logics focus the attention of individual actors through cultural embeddedness, activating a social actor's situated identities, goals, and action schemas. The activated social identities, goals, and schemas and the shared focus of attention shape social interaction. Social interactions generate communication and resource flows, and interdependencies, resulting in social practices and structures, including organizations and institutional work. Situated practices are selected and retained through processes of cultural evolution; from these evolutionary processes, institutional logics emerge at the levels of society, institutional field, and organization.

Thornton et al. (2012) develop an extensive model for conceptualising this process of institutional change across analytical levels, which they refer to as the “cross-level” model. They suggest a number of theories from various disciplines, including psychology

and sociology, which can be employed to explain sub-processes within it. A full explanation of this model extends far beyond the scope of this work. However, there are aspects of it that are potentially useful in conceptualising the particular kind of “cross level” dynamics that are a key focus of exploration in this study—namely, intra-organisational social practices *in relation to* national policy ideas and presentation. An institutional logics perspective can be applied to this process by a) considering what institutional logics are relevant to the HSCA12 and CCGs, and b) exploring how people within the case study CCG relate to such forces and conceive of themselves and the work they are engaged in. On this basis, the most useful element of Thornton et al.’s (2012) cross level model to incorporate into analysis is identity. I will briefly explore Thornton et al.’s (2012) treatment of identity in their cross-level model before demarcating the boundaries of relevant identity theory and explaining how it will be applied in this study.

As Table 6 illustrates, different institutional logics are associated with different sources of identity. An individual has multiple identities, embedded in institutional logics, which co-exist and potentially conflict. These include category identities, such as profession or ethnicity, and role identities, which are defined in relation to others, such as manager or parent (Thornton et al. 2012, pp.85–86). Thornton et al. (2012) argue that the way that individuals and organisations cope with conflicting institutional logics is to ‘loosely couple or decouple who they are from how they act’ (p.58), which holds the potential for cognitive dissonance. However, certain identities come to the fore in particular contexts or circumstances. Thornton et al. (2012) employ the concept of situationism to explain that the qualities of a given situation shape how particular identities manifest through behaviour (Ross and Nisbett 2011). Certain identities become more frequently used and readily available when they are reinforced and legitimised in particular settings, which in turn solidifies dominant configurations of institutional logics in those settings. As Meyer and Hammerschmid (2006, p.1001) note, ‘identity work, thus, is the micro-level enactment of social structure.’ In the cross level model, individual identities shape social interactions, which in turn shape organisational practices and identities.

Identity has long been a central element in institutional theory (Glynn 2008). Selznick (1957, p.40) equates the process of institutionalisation itself with the creation of ‘a distinct identity for the organization’ and the endurance of this identity is a key factor in

the endurance of the organization. From an institutional logics perspective, however, it is institutions that supply 'cognitive templates for both the form (grammar) and content (meanings; symbols) of organisational identities' (Glynn 2008, p.426). Both perspectives are relevant and harmonious: organisations become so well established that their identity becomes enduring and socially embedded, and institutions themselves provide the materials from which such identities can be created.

Identity theory is a broad church covering large bodies of literature across multiple disciplines. Thornton et al. (2012) confine their engagement with this voluminous literature to organisational identity. Glynn (2008) provides a comprehensive review of this work and identifies two particularly well-established approaches within it. One, which can be traced back to the work of Albert and Whetten (1985), treats identity 'in terms of essential central, distinctive, and enduring attributes' (Glynn 2008, p.420); it reflects the actually existing character of an organisation. This approach can be understood as emerging from an individualist or personal conceptualisation of identity dominant in psychology (Glynn 2008). The other approach conceptualises identity as a 'strategic resource, being deployed to competitive advantage and functioning as a guide to decision making and strategic choice' (Glynn 2008, p.416). Crucially, these two approaches are not mutually exclusive and some studies employ both (e.g. Dutton and Dukerich 1991; Corley and Gioia 2004).

However, Glynn (2008) also identifies a number of studies that adopt an institutional approach to organisational identity, sometimes in concert with the two approaches above, by calling on 'institutional elements or explanations' (Glynn 2008, p.416) (e.g. Rao et al. 2000; Lounsbury and Glynn 2001; Whetten and Mackey 2002). Work in this vein emphasises organisational identity as a set of 'claims to a social category' (Glynn 2008, p.419) relative to other organisations within an organisational field. This approach has a more contextual and sociological emphasis than the two discussed above, and it is often used to explore identity similarities between particular groups of organisation. This study will employ a broad conceptualisation of organisational identity, with the potential to call on any of the three approaches identified above as appropriate: identity as organisational qualities and character, identity as a strategic resource, and identity as a product and process of the institutional context.

Before addressing how I will apply the institutional logics perspective to this study, I will consider the growing body of research employing the institutional logics perspective, or ideas consonant with the approach (for an overview see Thornton and Ocasio 2008), and focus particularly on studies that have considered identity or healthcare issues and contexts. Thornton and Ocasio (2008, p.109) perceive the essence of institutional logics research as the study of ‘the effects of content, meaning, and change in institutions.’ Temporality is at least acknowledged as an important consideration in these studies, and many focus specifically on how dominant logics in a given context change over time. To this end, all manner of methods have been employed but the most common are interviews and document analysis, sometimes combining qualitative and quantitative analysis approaches.

I have identified two studies that have specifically explored institutional logics and identity. These are Townley’s (1997) investigation of how university academics’ professional identities shaped the imposition of a newly dominant institutional logic in the form of a performance appraisal regime; and Meyer and Hammerschmid’s (2006) exploration of changing institutional logics and identities in the Austrian public sector. They found that actors in local organisations would utilise elements of multiple institutional logics and combine them in unique ways. The accounts that actors provided of their work, and the specific vocabularies employed, represented acts of identity construction related to bespoke, localised institutional environments.

A number of studies have applied institutional logics to healthcare issues and contexts (Scott et al. 2000; Reay and Hinings 2005; Currie and Guah 2007; Harris and Holt 2013; McDonald et al. 2013; Allen 2014; van den Broek et al. 2014). I will discuss the most relevant of these here and in a further section on *The NHS and Health and Social Care Act 2012 from an institutional logics perspective* (Section 5.5). Despite Scott’s (2013) three pillars theory of institutionalism being identified as an alternative to the institutional logics approach, aspects of that theory and some of Scott’s previous work are highly consonant with institutional logics. Scott et al. (2000) employed content analysis of journal articles in their longitudinal study of the healthcare system in the San Francisco Bay Area, USA, to track changes in configurations of institutional logics over time. They

found that the dominance of a societal level medical professionalism logic came to be diminished as the logics of management and market grew in prominence. This resulted in a greater distribution of influence between these three logics.

Reay and Hinnings (2005) focused on the organisational field of healthcare in Alberta, Canada. They analysed a range of written materials, including newspaper articles and transcriptions of governmental meetings, to explore a shift away from a dominant medical professionalism logic and a rise to prominence of market and managerial logics. They found that the shift in logics was associated with structural changes in the health system itself, but the medical-professional logic still played an important part in the reformulated system and its presence counterbalanced the influence of market and managerial logics in decision-making processes.

Where Scott et al. (2000) and Reay and Hinnings (2005) defined their focus of an organisational field geographically, van den Broek et al. (2014) focused on the enactment of a healthcare policy programme in a single hospital in the Netherlands, and considered how the plural institutional logics of the policy were negotiated in practice. They employed a combination of methods: observations, interviews, document analysis, and focus groups. The content of the policy programme, called “Productive Ward: Releasing Time to Care”, was assessed and identified as containing elements associated with two prominent institutional logics: quality improvement, which was associated with a nursing professional logic; and efficiency, associated with a ‘business like logic’ (van den Broek et al. 2014, p.16). They found that in the implementation of this ‘hybrid innovative practice’ (van den Broek et al. 2014, p.18), nurses’ initial enthusiasm about the prospect of professional empowerment gave way to feeling jaded as the perception grew that its primary aim was to cut costs. Consequently, the social practices that the programme aimed to embed amongst nurses were never ‘internalized’ (van den Broek et al. 2014, p.18) or institutionalised.

Of all institutional logics studies on healthcare, van den Broek et al.’s (2014) work is the most closely related to my study. A number of commonalities can be identified: both studies employ observations, interviews, and document analysis; and both are concerned with identifying institutional logics embedded in policy, exploring how these relate to

social practices in the context of the enactment of the policy at an organisational level, and considering how health professionals feel about the policy work they are engaged in.

5.4: Utilising and assessing the institutional logics perspective

The institutional logics perspective will be employed as an interpretive aid for engaging with the data rather than an undergirding empirical framework. It can also be thought of as a sensitising device to assist thinking about the different institutional forces at play in the local fieldwork context and the broader health policy context. The approach will be considered valuable if it aids the process of making sense of the data—i.e. has “narrative value” (Spence 1984)—and contributes towards the generation of insights that would not, on the basis of reasonable assumption, have arisen otherwise. I will reflect on the utilisation of the approach in this fashion in the discussion (Chapter 12).

Thornton et al. (2012) note that despite the applicability of institutional logics to a range of analytical levels, the overwhelming tendency is for research to focus at the organisational field level. They specifically highlight the need for studies that apply an institutional logics perspective to the ‘intraorganizational dynamics of practices and identities’ (Thornton et al. 2012, p.134) because of the potential value in this currently under-explored vein of institutional research. Similarly, Greenwood et al. (2011, p.357) note that the major focus of literature using the approach has been on ‘how shifts in logics or the existence of plural (usually two) logics affect organizations across a field’, and identify a deficit of research that explores intra-organisational experiences of institutional forces. This study aims to make a modest contribution to redressing these deficiencies.

In the next section, an understanding of the NHS from an institutional logics perspective is established, with particular attention to the development of the health service over time; the critical understanding of the HSCA12 and problematised membership organisation concept from Chapter 3 is then called on and considered from an institutional logics perspective. I will argue that institutional logics have proliferated in the NHS over time, that a combination of these logics is prominent in the presentation of the HSCA12, and that the CCG represents a convergence point of multiple logics that

individuals and groups can potentially draw on in their social practices. This exercise will serve as the foundation for the consideration of institutional logics in the four results chapters (8–11) and the discussion (Chapter 12).

5.5: The NHS and Health and Social Care Act 2012 from an institutional logics perspective

From an institutional perspective, there are multiple ways that the English NHS can be conceptualised. Certainly the NHS is an organisation (of remarkable size and complexity) but it can also be thought of as an organisational field (Checkland et al. 2012a): ‘a collection of both similar and dissimilar interdependent organizations operating in a functionally specific arena together with their exchange partners, funding sources, and regulators’ (Scott 2004, p.9). An argument can also be made that the English NHS is an institutional order: a “domain of institutions” organised around a “cornerstone” institution that embodies norms about healthcare provision being available to all without being based on the ability to pay (Thornton et al. 2012, p.53). These are not mutually exclusive and are both valid perspectives; for the purposes of this study, however, the English NHS is conceptualised as an organisational field, as is consistent with other relevant literature (Scott et al. 2000; Reay and Hinings 2005; Currie and Guah 2007).

Currie and Guah (2007, p.244) divide the history of the NHS into three eras: professional dominance (1948-1971), managerialism (1972-1997), and market mechanisms (1998-onwards); each of which is associated with a number of dominant institutional logics. These are set out in Table 7 below, and correspond to macro shifts in the dominant combinations of institutional logics in public policy and administration more broadly (Meyer et al. 2013). New logics have not replaced old: instead they have clashed and combined within the organisational field at a variety of levels. For instance, Currie and Guah (2007, p.245) argue that ‘the concept of the internal market has been externalised and now encompasses a new vision for ‘patient choice’ to enhance the ‘public value’ of government controlled services.’ Note the parallels between Currie and Guah’s (2007) characterisation of the evolving configuration of prominent institutional logics in relation to the NHS and both Scott et al.’s (2000) and Reay and Hinings’ (2005) characterisations

of changes in logics in health systems in the USA and Canada respectively. This typology of logics forms the basis for a typology of HSCA12 logics developed later in the section.¹⁷

	Era		
	Professional dominance (1948-1971)	Managerialism (1972-1997)	Market mechanisms (1998-)
	Public sector ethos	Private sector ethos	Patient-centred ethos
Institutional logics	Professionalism	Performance	Patient choice
	Self-regulation	Government regulation	Public value

Table 7: Prominent institutional logics in the history of the NHS (Currie and Guah 2007)

In the Coalition Government’s policy narrative around the HSCA12, three principles are identified as guiding the reforms of the NHS: ‘...giving patients more information and choice; focusing on healthcare outcomes and quality standards; and empowering frontline professionals with a strong leadership role’ (NHS Commissioning Board 2012a, p.4). At this macro analytical level, these principles can be understood as corresponding to multiple institutional logics that co-exist and interact within the contemporary NHS: *“Patient information and choice”* speaks to the logics of the market mechanisms era (Table 7), which became particularly prominent in the late 1990s (Currie and Guah 2007). These logics are based on assumptions that individuals pursuing their preferences will drive competition in the market place, which will increase efficiency of service provision and provide better value for money for publicly funded services; *“Healthcare outcomes and quality standards”* is associated with the logics of the managerialism era in Currie and Guah’s (2007) typology. These logics emphasise performance measurement and managerial oversight as effective and appropriate mechanisms of organisational control (Meyer et al. 2013); *“Empowering frontline professionals with a strong leadership roll”* calls on the logics of the professional dominance era—it is the stock of legitimacy that healthcare professionals possess that justifies their empowerment, and the focus of *“leadership”*, which has become a prominent theme in NHS policy (Checkland 2014).

¹⁷ A typology of this kind inevitably involves a process of simplification and generalisation. There is no assumption here that the logics of these eras will map neatly on to the empirical observations of local contexts during these periods. Instead these logics reflect prominent forces contained within the presentation and mechanisms of policies during these times.

Table 8 takes Currie and Guah's (2007) delineation of the prominent organisation field level logics of the NHS and develops them in relation to the content of the HSCA12 presentation. Currie and Guah's (2007, p.245) assertion that 'patient choice' and 'public value' have become intimately bound up with assumptions about the efficiency of the competitive market is a feature of the institutional logics present in the HSCA12 and represented in the patient-centred choice logic in the table below.

Institutional logic	Presence in HSCA12 presentation
Medical professionalism "Autonomy, deference to expertise, decision making power"	GPs' professional and local expertise mean they should have more control and power over healthcare
Performance management "Managerial oversight, regulation, assessment"	CCGs will be monitored and assessed—their greater freedom is associated with responsibility to improve performance and efficiency
Patient-centred choice "Individual responsibility, self-management, citizen-consumer, benefits of market competition, increase public value"	Patients should have more information and should choose between competing services in order to drive up quality and efficiency. CCGs should be able to create more public value than PCTs could because they are better placed to make healthcare service decisions in patients' interests

Table 8: Prominent institutional logics of the HSCA12

CCGs are explicitly identified as a key vehicle for pursuing the Government's three principles of NHS reform (NHS Commissioning Board 2012a). Both their presentation and organisational duties call on the combination of institutional logics identified in Table 8. However, these are supplanted with others logics and norms that relate specifically to CCGs as an organisational project. The membership organisation status of CCGs is at the core of their presentation in the HSCA12 and a point of differentiation from the hierarchical management structure of PCTs. Emphasis was placed on CCGs as locally based and knowledgeable organisations, working in collaboration with other local services in order to serve patients in a specific place. This speaks to a community logic (see Table 6, p.83) that derives its authority from shared values amongst members jointly committed to a cause, but the HSCA12 attempts to engineer the necessary "buy-in" for this through regulation and norms. Crucially, CCG membership is a legal obligation for every English GP practice.

Every CCG was legally required to submit a constitution to NHS England that set out how it would ensure that its members would participate in the running of the organisation. The constitution had also to articulate the governance processes of the organisation, including the process for electing members to the governing body, their responsibilities, and how they could be held to account. This established the governance of the organisation according to the logic of the democratic state (see Table 6, p.83), which is predicated on notions of democratic participation and citizenship. In terms of appealing to norms, the policy rhetoric attempted to encourage a sense of investment amongst GPs in their CCG by suggesting that their engagement with their organisation was bound up with their ability to be good doctors (see Chapter 3).

Government policy makers have called on, and carefully arranged, a remarkable variety of institutional logics in their presentation and formulation of the HSCA12, and CCGs in particular. In so doing they have, for instance, co-opted the legitimacy of health professionals in a bid to engender the acquiescence of those professionals and the public to their plans. Consequently, these policy makers can be understood as “institutional entrepreneurs” (Battilana et al. 2009) or institutional engineers as they attempt to further reconfigure the organisational field of the English NHS (Currie and Guah 2007). This process has rendered CCGs a convergence point for multiple logics, or as an organisational environment of diverse institutional logics—a “hybrid organisation” (Battilana and Dorado 2010). Consequently, individuals and groups within the CCG potentially have a broad range of logics to call on in their social practices. As noted earlier in the chapter, identities are embedded within institutional logics; therefore, a variety of logics provides a range of materials from which identities can be constructed and adapted.

In conclusion, in this study the English NHS is conceptualised as an organisational field that has, since its inception, become characterised by an increasingly diverse combination of institutional logics. I have highlighted the most prominent of these by presenting Currie and Guah’s (2007) typology (Table 7). I have discussed the central principles in the presentation of the HSCA12 and identified three dominant logics manifested in the policy: *Medical professionalism*, *Performance management*, and *Patient-centred choice*. I have also identified CCGs as a key convergence point for these (and other) logics, making them

particularly institutionally diverse hybrid organisations. The expression and employment of institutional logics and identities in the context of the case study CCG will be explored in the results (Chapters 8—11) and discussion (Chapter 12).

5.6: Chapter summary

In this chapter, I describe various strands of institutionalist theory and identify institutional logics as the most appropriate approach to employ in the analysis of this study. The institutional logics approach views society as an evolving inter-institutional system. Different institutions are associated with different logics or systems of meaning, and logics are associated with different identities. People are both shaped by and shapers of this system. The basis of the application of the approach in this study is set out: as an interpretive aid, with sensitivity to issues of identity. The basis on which its utility will be assessed is established: the degree to which it enhances understanding of my observations in Notchcroft CCG in relation to engagement with the HSCA12.

Literature employing the institutional logics approach in the study of healthcare and, more specifically, the NHS is discussed, and it is established that the NHS will be understood as an organisational field. A typology of prominent NHS institutional logics is presented and used to inform the three main logics identified in the presentation of the HSCA12: *Medical professionalism*, *Performance management*, and *Patient-centred choice*.

5.7: The thesis so far

At this point, it is useful to pause and take stock of what has been covered in the thesis so far and explain how this will shape what is to come in the remaining chapters. In Chapter 2, a story of the emergence and realisation of the HSCA12 was presented. This was followed by a discussion of the organisations that were created and altered through the HSCA12, with a particular focus on CCGs. The organisational relationships within the NHS made explicit in the policy were considered. In the final section of Chapter 2, a concise history of every major primary care led commissioning initiative since the first, GPFH, was introduced in 1991 was developed in order to set the creation of CCGs into context. In terms of the governmental presentation of these policies, it was highlighted just how

similar their stated aims were to each other and how each was portrayed as a corrective to faults with previous policies. The literature analysing and evaluating these policies was considered, which revealed the limited number of broad conclusions that could be drawn about the qualities and impacts of such policies because of the local variability in how they manifested. The importance of considering local social and historical context to the study of commissioning policy enactment was stressed.

In Chapter 3, the HSCA12 and associated policy documents were subjected to problematisation, with a particular focus on CCGs' officially intended status as membership organisations. This demonstrated how CCGs were represented as a logical devolution of power away from unnecessary tiers of management, disconnected from the health needs of real people, to GPs who possessed professional expertise and local knowledge. How the policy presentation of CCGs as membership organisations related to the policy problem of an excess of managers disconnected from patient need was explained, and the ambiguity in the policy about exactly who, or what, constituted a CCG member was highlighted. Attention to these issues invited consideration of the historical relationship between GPs as a professional group and the state, which was briefly addressed at the end of the chapter.

Chapter 4 delineated and discussed a body of NHS policy literature employing methods congruent with this study. The basis of this was studies of the NHS that involved: an in-depth case study approach to the study of policy enactment; critical consideration of what and *how* policies mean (Yanow 1997); and consideration of policy "between levels" (i.e. how policy is presented at the level it is set and how it is enacted locally). Six studies fulfilling these criteria were identified but two matched particularly closely: Singleton (2006), and Pope et al. (2006). This exercise served to situate this study within a body of work to which it will contribute. The aim, objective, and research questions of the study were developed with this in mind.

In Chapter 5, the theoretical field of institutionalism was introduced and discussed. After some consideration, I determined that the institutional logics theoretical approach was of potential use in this study. I explained that I would employ it as a sensitising device and assess its utility on the extent to which it helped to enhance understanding of the

research questions and the broader policy context. Finally, I briefly explored the historical development of the NHS and the HSCA12 specifically using concepts from institutional logics. I established that the English NHS would be conceptualised as an organisational field that has grown in complexity since its inception and come to represent a diverse combination of institutional logics. I established that the presentation of the HSCA12 primarily called on three institutional logics—*Medical professionalism*, *Performance management*, and *Patient-centred choice*—and that CCGs were a convergence point for these (and other) logics, making them particularly institutionally diverse hybrid organisations.

Moving on the remainder of the thesis, the following chapter, Chapter 6, is the methodology. In it I will set out the aim, objective, and research questions of the study, discuss the methods employed, and the process of data collection and analysis. I will also outline ethical issues and how I have dealt with them, and provide an overview of the case study CCG: Notchcroft. In Chapter 7, I introduce a concept developed during analysis: the governing core. This concept was created as a result of the need for a way to talk about the broader cast of people, beyond (but including) the governing body, that were involved in CCG governance processes.

Chapters 8-11 are the results chapters. An explanation of how the four chapters relate to each other will be provided in Section 8.1. Each chapter will be composed of a number of themes that call on extracts from interviews and observational field notes in their explication. These chapters will implicitly address the research questions, making use of the governing core term and ideas from the institutional logics approach. The final chapter is Chapter 12: the discussion. In this chapter I will pull together data and insights from the four results chapters and directly address their relevance to answering the research questions. I will provide a reflective account of my application of the institutional logics approach, and discuss the governing core concept and its relevance to aiding understanding of the membership organisation status of the CCG. Finally, I will identify strengths and limitations of the study, highlight the policy implications of my findings, and suggest future research.

Chapter 6: Methodology

This chapter provides an account of the purpose and process of this research, including a discussion of the methodological tools employed. An overview of the case study CCG—Notchcroft—is also presented.

6.1: Aim, objective and research questions

Aim

The overarching aim of this research is to create and explore a contextualised account of the enactment of the Health and Social Care Act (2012; HSCA12). The experiences of a particular CCG will be considered in relation to the form and function of the policy as it is constructed at the governmental level.

Objective

To produce a detailed, contextualised account of the creation and early operation of a CCG, with special reference to its officially intended status as a “membership organisation”.

Research questions

With special reference to the policy that CCGs should be “membership organisations”—constituted by and accountable to their member GP practices:

1. How do those involved with the CCG conceptualise the organisation and enterprise in which they are expected to participate?
2. How do these conceptualisations shape action on the part of those involved with the CCG and manifest in the work of the CCG?
3. Is the institutional logics theoretical perspective useful in enhancing understanding of the organisational conceptualisations and actions of those involved with the CCG, and what critical reflections can be made about the approach and its application in this case?

The aim of this research, with its focus on creating a contextualised account of policy enactment and organisational practice, was developed as a result of engaging with health

policy analysis literature and finding a lack of studies in this vein (see Chapter 4). The focus on the membership organisation concept emerged from engagement with the HSCA12 policy and associated documentation, which is developed through problematisation in Chapter 3. It was the normative use of the concept, implicit assumptions about its value, and a lack of specificity about what it meant in practice in the presentation of the policy that earmarked it as an appropriate focus for critical investigation.

This study is intended to address the lack of research focused on policy and its consequences that critically examines policy content and communication itself (Bacchi 2012). My approach in this study is to explore the enactment of the HSCA12 policy focusing on meaning between the national and local organisational levels, which is an underexplored approach to health policy analysis (see Chapter 4 for further discussion and notable examples). The research questions have been formulated with this in mind. Question one is concerned with what people in the organisation think about the CCG and what it is they have to do. Question two is about how what they think relates to what they actually do. Question three is focused on whether the institutional logics approach is helpful in addressing questions one and two; this question was formulated to reflect the intention to assess the utility of the theory as a sensitising device. However, it also addresses a gap in the institutional logics literature, identified in the previous chapter (Section 5.4), by applying the theory to the study of 'intraorganizational dynamics of practices and identities' (Thornton et al. 2012, p.134) and exploring intra-organisational experiences of institutional forces (Greenwood et al. 2011).

6.2: Case studies and an ethnographic approach

The research strategy employed in this work is the case study. In this section, I will consider what defines a case study and discuss the particular variety of case study adopted in this study.

Case studies are employed in many different disciplinary traditions, undergirded by a range of epistemological positions. The term is used to refer to both process and product. Perhaps the most frequently cited definition is Yin's (2003, p.23): a case study is '...an

empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used.’ However, Stake (1995) argues that it is a focus on a particular case—some kind of “bounded system” (Smith 1978)—that is the defining feature of a case study and not the methods or evidence used to investigate it. Yin’s (2003) is an essentially positivist conceptualisation; he equates a good case study with one that provides maximal scope for “objectivity” and “replicability”, yet this emphasis is somewhat at odds with the indistinct boundaries of phenomena and context dependent qualities that he includes in his definition. For the purposes of this study, I define a case study as “the study of a case (a bounded system) that takes place in its natural context.”

Stake (1995) identifies three variants of case study, categorised on the basis of their objective: intrinsic, instrumental, and collective. An intrinsic case study is ‘the study of the particularity and complexity of a single case’ (Stake 1995, p.xi). An instrumental case study considers a specific case in order to enhance understanding of something else, such as a particular phenomenon. An instrumental case study implies that some form of generalisation is intended. A collective case study compares and contrasts between multiple instrumental cases. A case study can be, and frequently is, a container for a number of research methods and sources of evidence. Observations, interviews, and textual or documentary analysis are the most commonly used methods within qualitative case studies (Walsham 1995). Employing methods in combination offers the possibility of a greater depth of understanding of a context or issue. This process of methodological triangulation helps to ensure that the research process is rigorous (Stake 1995).

In any case study it is important to be clear about what the case is—i.e. what is under analysis (George and Bennett 2005). Case definition can be articulated at the start of the study or identified as part of the analysis process (Walt et al. 2008). What might constitute a case is broad: it might be an organisation or role; it might be a topic or social phenomena (Walt et al. 2008). This study differs slightly from the model of a conventional case study because *the* case comprises two inter-related loci of enquiry: the policy (i.e. the HSCA12), and a newly formed CCG created as a result of the policy and an entity tasked with enactment itself. It might appear odd to claim a focus on two phenomena

that are not of the same order but it is based on an understanding that they are mutually constitutive and are both employed to enable a better understanding of each individually. This approach is justifiable because the HSCA12 is not considered a singular entity that is knowable in its own right. This position stems from a rejection of assumptions inherent to some policy analysis that there is *an* implementation of *a* policy,¹⁸ consistent between local and national levels, to be studied. Instead, the HSCA12 is understood as creating conditions for change but the policy *as* case is understood as being contingent on local context, evolving over time, and most relevant when considered in relation to one of its features: in this study, that is the CCG, the people that shape its work, and (to a lesser extent, in this study) those that interact with it.

This study can be understood as a qualitative, intrinsic case study. Stake (1995) argues that conducting a case study of this type necessitates the researcher “being there”, i.e. some degree of contextual immersion. Researchers should observe and reflect, trying to make sense of what is happening and what it means to those people involved, in an iterative process. They must then decide what aspects of their observations are to be presented, apply one or more of a range of analytical approaches, and produce an account. This assessment shares much methodological ground with ethnography and I shall illustrate the considerable harmony between the general character of ethnography and the intrinsic case study. However, ethnographies and case studies are not mutually exclusive alternatives. It is possible to undertake a case study that employs an ethnographic method or an ethnography that features a case study or studies. I have decided that while the intrinsic case study best describes the research strategy, ethnographic fieldwork best describes the approach to data collection in this study. Consequently, I will provide a brief discussion of ethnography with a focus on methods and explain why this is the case.

Ethnography is fundamentally a study of people and culture defined by utilisation of the fieldwork method (Van Maanen 1988). It focuses particularly on norms, culture, and values and offers the potential to produce an account of a social setting rich in ‘texture,

¹⁸ That is not to say that there are no universalistic characteristics of the policy that are valid to consider in the same way across local contexts. However, contextual detail is important in establishing ‘whether processes are universalistic or contingent’ (Exworthy et al. 2011, p.7).

depth, and nuance' (Bevir and Rhodes 2006, p.101). Fieldwork involves being present in the setting of interest observing social practices, talking to locals, and creating some kind of record of the experience and the analytical insights developed. The most common medium for recording experiences is the diary: the ethnographer writes field notes and then develops these more fully to produce a "thick description" of the setting and a story from the fieldwork (Geertz 1994). Combining observations of social practices with interviews, a practice that has become common in ethnographic work, provides an opportunity for people to explain their understanding of their social world and the meanings it holds. Striving to gain insights into the *emic* perspective and tacit knowledge of "natives" is a key feature of ethnography. The degree of observer participation during ethnographic research can be understood as a continuum: at one end is the participant observer who becomes involved in many aspects of social life and activities; at the other is the passive observer who primarily watches and notes.

Although my study occupies a place at the *passive observation* end of the observation continuum, which is in contrast to "traditional" ethnographies involving deep cultural immersion, I do not believe that this is a deciding factor as to whether ethnographic methods were employed. In fact, I understand "ethnographic fieldwork" to be the most appropriate descriptor of the method employed in this study because of the primacy given to the social observations of a particular group of people in a single organisational context, the production of field notes as a basis for more developed "thick descriptions" (Geertz 1994), and the development of stories from fieldwork data.

In recent years, a body of work that has been ascribed the label "policy ethnography" has emerged (Walford 2003; Fforde 2009; Dubois 2009; Dubois 2010; Brady 2011; Stevens 2011), including a study focused on the NHS (Strong and Robinson 1990), which can be defined simply as ethnographies of public policy. This study could justifiably be described as a policy ethnography rather than a case study employing ethnographic methods. The distinction is largely semantic but I believe that the emphasis on the organisation—the CCG—in this study makes the case study using ethnographic methods descriptor the most appropriate.

6.3: Studying through

Wedel's (2004) concept of "studying through" has been employed in this study as a conceptual tool. She explains it as an approach to engaging with policy that involves tracking policy discourses, narratives, and/or ideas between levels or organisations, across space and over time. It involves trying to '...study through the policy chain...' (Wedel 2004, p.12)—following policy as it is constructed, interpreted, and adjusted at different levels. It was developed in response to perceived deficiencies with the dichotomous debate between whether policy enactment should be conceived of as "top-down" or "bottom-up" (see Chapter 4). This non-linear approach is based on assumptions about the non-linearity of the policy process itself.

In this study, it is the membership organisation concept that is being pursued or "studied through." Its presentation in the policy was subjected to problematisation in Chapter 3, and the understanding from this will be brought to bear on the fieldwork data from Notchcroft CCG. This process has the potential to help identify areas of disparity and harmony relating to the membership organisation concept, and provide broader insights into the policy enactment process.

Furthermore, I have been influenced by the principle of "studying through" in my conception of the different elements of this study and their relationships. I have found it useful to conceive of this study as a series of concentric circles, an idea that I introduced in Chapter 1 with Figure 1. In this metaphor, the outermost circle provides the contextual foundation for the circles it contains, as each successive circle does for those within it, and the ideas and arguments developed within each circle can interact with any of the others both inwards and outwards. The largest outer circle contains the socio-historical context of English healthcare policy with particular attention to primary care led commissioning reform (see Chapter 2, Section 2.3). Situated within that circle is the story of the HSCA12 and the problematised account of its presentation (see Chapter 3)—this circle is concerned with the symbolic and normative policy content, particularly as it relates to CCGs and their officially intended status as membership organisations (which is itself a nexus point for many of the ideological and normative elements of the policy). The next circle inwards contains an account of the structural changes and legislated

interactional practices of the new healthcare system—in other words, the new and reformulated organisational players and their specified inter-relationships (see Chapter 2, Section 2.2). Within that is the central circle and case study CCG—the primary empirical focus of the study (see Chapter 6, Section 6.7). Analytical engagement with Notchcroft CCG is shaped by the content of the surrounding circles. One “studies through” and between the circles in order to develop a clearer understanding of Notchcroft CCG and the HSCA12 policy. In this metaphor, the institutional logics theoretical framework (Chapter 5, Section 5.3) can be conceived of as a lens that is brought to bear on each circle individually, in combination, and in totality, but with a particular focus on Notchcroft CCG.

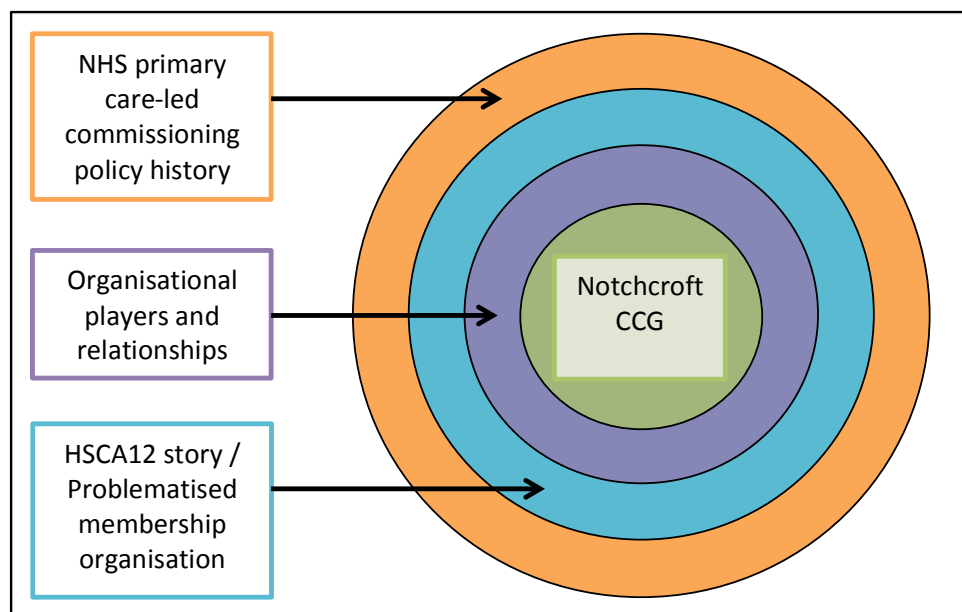


Figure 1: Conceptualisation of the study as four concentric circles

6.4: Fieldwork

Thirteen months of fieldwork were carried out with Notchcroft CCG from October 2012 to November 2013. A range of CCG meetings and events were observed (see Appendix 4). Semi-structured interviews were carried out with a range of interviewees (see Appendix 5). Both national level policy documents and local materials, including meeting agendas and minutes, relevant to the CCG and emergent issues from observations and interviews were collected. As I became a more familiar figure to CCG members, informal chats in

corridors and offices of the CCG HQ and at meeting venues also became a valuable source of information and contributed to my evolving understanding of CCG issues.

6.4.1: Recruitment and negotiating access

Identifying an appropriate CCG was relatively straightforward given that there was no expectancy that the case study CCG should possess any specific qualities. Therefore, selecting a CCG to approach was shaped largely by pragmatic factors, primarily the pre-existence of contacts that were able to provide initial introductions to those involved in some way with a CCG. It was on this basis that I decided to approach Notchcroft.

In June 2012 I arranged two meetings with Notchcroft GPs: one who had been involved with the management of the PCT and was highly knowledgeable about commissioning activities in Notchcroft, and another who had recently been elected to the CCG governing body. In both I explained my study and what I was hoping for in terms of CCG access (e.g. attending meetings, interviewing members) and asked their opinions on the most appropriate way of obtaining access to the organisation. They both suggested that I should contact the CCG Chair and Accountable Officer, present my study proposal, and seek permission from them. They both also offered to speak positively of me and my project the next time they spoke to them. I obtained the email addresses of the Chair and Accountable Officer and sent emails with an attached information sheet (Appendix 2), which contained details of the study, including its aim, and the implications of involvement. Initial responses from both the Chair and Accountable Officer were brief but favourable. However, arranging a meeting with either to seek permission to observe CCG meetings was a protracted process involving last minute cancellations. This period coincided with a busy phase in the CCG's authorisation process, which contributed to these difficulties. In October 2012, still not having met with the Chair or Accountable Officer, I decided to attend a public governing body meeting. I arrived early, identified the Chair and introduced myself. The Chair was apologetic for not finding a time for us to meet and afforded me a few moments to introduce myself and my study at the start of the meeting. I explained to attendees that I was hoping to research the work of the CCG and to interview some of them in the future. It was not until mid-November 2012, after that month's governing body meeting, that I was able to formally meet with the Chair. It was at this point that I was granted access on the condition that I contact the Chairs of

any meetings I wanted to attend beforehand to seek their permission. I was given the contact details of an administrator that could provide me with a list of meetings, Chairs, and email addresses and I began the process of contacting them.

6.4.2: Ethnographic observation

Thirty-eight meetings and events, ranging from 30 minutes to 3½ hours in duration, were observed. These included: public and private governing body meetings, various private sub-committees, district and locale meetings, urgent care meetings, a five-year plan development meeting, and a patient and public engagement event. A full list of all of the meetings and events attended, along with corresponding field note codes, dates, and durations can be found in Appendix 4.

Permission to attend each meeting was sought from the Chair of that meeting beforehand. Chairs were requested to introduce me to all attendees at the start of the meeting and ask if anyone had any objection to my presence. In practice, Chairs did not always do this. When they did no one raised an objection at any meeting I attended. At the start of each meeting I would sketch the table shape in my notebook and then fill in the seating plan with the initials of attendees as they introduced themselves during introductions. However, whilst this was a standing item on the agenda of every meeting, the Chair would sometimes skip it commenting that it was not necessary because everyone knew each other. This happened more frequently over time as most attendees at meetings became more familiar with each other, and me, but there were frequently people in attendance that I did not know and, presumably, did not know who I was and why I was there.

Field notes were hand written during meetings. In some fieldwork contexts active note taking can be interpreted as suspicious by actors and a source of friction (Campbell and Lassiter 2014). I found that I was able to write virtually continuously through meetings, producing detailed notes, without creating any visible signs of unease from attendees. However, I would refrain from taking notes temporarily if someone prefaced their comments with an instruction that they were not to be minuted. I believe that the

presence of a minute taker in each meeting, exhibiting similar writing behaviour to me, made my actions seem quite ordinary and unobjectionable.

After the first two meetings, when I realised that I was capturing some of the exchanges verbatim, I decided to develop a system within my notes that clarified the degree of accuracy attributable to a particular exchange or comment: single quotes denote something transcribed verbatim (e.g. GP: 'In my opinion, that's entirely appropriate. '), quotation marks are used when the speech captured was close to what was said but not necessarily exact (e.g. GP: "that's appropriate"), and comment summaries do not feature any kind of speech marks (e.g. GP said that he thought that was appropriate.) Field note extracts from meetings/events are denoted by the relevant code (see Appendix 4 for a complete list), followed by the number of that particular meeting type that I had attended (for recurring meetings/events; e.g. M1), and the month and year, all contained in square brackets, e.g.: [GB_M1_Oct12].

Notes were transcribed, usually within 24 hours after the meeting had taken place. This process involved adding additional detail and reflections to the original notes, creating a "thick description" (Geertz 1994). These document files were then transferred to a QSR NVivo 9 database.

6.4.3: Interviews

Sixteen semi-structured interviews, ranging from 30 minutes to 1¼ hours in duration, were carried out. Interviewees included: governing body members (GPs and non-GPs), CCG managers, and those in the CCG (predominantly but not exclusively GPs) that had very little involvement with the governing apparatus of the organisation. All interviews were conducted face to face in a variety of locations, including: CCG HQ offices, GP practices, and coffee shops. In some interviews, interviewees suggested documents that I might find useful, which they then emailed me afterwards. Before each interview, interviewees read the information sheet (Appendix 2) and completed a consent form (Appendix 3) in duplicate, with me taking one copy and the interviewee taking the other.

I employed an interview schedule containing some general questions as a starting point in interviews—I would ask interviewees about their job, their views on Notchcroft CCG, and what it meant to be a membership organisation—however, my approach was flexible as I wanted to ensure that each interview was able to develop on the basis of what issues interviewees covered. Some areas of questioning became a feature of later interviews as a result of early analysis of the data set as a whole. For example, as I became interested in the sub-structures of the CCG I began to question all interviewees about this.

Interview extracts are denoted by the Int prefix followed by the code for the interviewee and the month and year the interview took place, all in square brackets e.g.:

[Int_Mng3_Apr13]. In some cases, where I have assessed the subject matter to be of a level of specificity that risks revealing the identity of actors I have opted to omit the interviewee code and date identifier, e.g. [Int_Mng], or use the generic [Interview data] instead. More detail about steps taken to preserve the anonymity of individuals in Notchcroft CCG is presented in Section 6.6.

The audio of each interview was recorded with a digital audio recorder (Edirol R-09). Audio files were then transcribed and imported into the same QSR NVivo 9 database as the field notes. All of the interviews were transcribed professionally apart from the first two, which I transcribed myself. I checked all transcripts for accuracy upon receipt by listening to the original audio whilst reading through the transcript. Details of interviewees, including interviewee codes, the month each was conducted, and duration are presented in Appendix 5.

6.4.4: Documentary analysis

The HSCA12, and related documents, were subject to close analytical examination and problematisation in Chapter 3. Particular attention was paid to the membership organisation concept. The understanding of the policy gained from this process shaped the observational focus of fieldwork, the lines of questioning pursued during interviews, and the development of the analytical coding framework. However, local level documents, such as meeting minutes and agendas, also played an important role in the study. These documents were not subject to critical analysis in the same sense as the

HSCA12 but were employed in order to build knowledge of Notchcroft CCG, the key players within the organisation and their job roles, and identify significant issues that were the subject of discussion at meetings over time.

Once I had been granted access to attend a meeting (e.g. a particular committee, a district), I would ask the Chair of the meeting and administrator whether I could be added to the email list, which was agreed to in every case. Once included on such a list, I received paper packs (i.e. those documents tabled for discussion during the next meeting), agendas, and minutes. In the early stages of fieldwork it was particularly useful reading these documents in order to familiarise myself with attendees, commonly used acronyms, and on-going issues. Later on, I would compare the minutes of a meeting that I had attended with my own notes, which was useful in adding context to my own understanding of events, clarifying points about which I was uncertain, and identifying previously unknown attendees. It also meant that I did not have to request papers at each meeting and was, therefore, less burdensome to the CCG.

6.5: Analysis

The process of analysis began by reading a range of national level policy documents (including the *Equity and Excellence* White Paper (Department of Health 2010), the HSCA12 (2012), and the Towards Establishment document (NHS Commissioning Board 2012a) featured in Chapter 3), before a case study CCG had even been identified. During this process I familiarised myself with the emerging changes to the NHS and the key elements of the policy narrative, particularly relating to CCGs. Once I began fieldwork a new phase of analysis phase began. I created a QSR NVivo 9 database and imported field notes and interview transcripts into the database as they were produced, reading each one closely and creating descriptive codes. QSR NVivo 9 allows for memos to be written and linked to extracts from any source. These memos then become searchable data within the database. I made extensive use of this feature, writing memos when reading particular incidents or phrasings as thoughts occurred to me. This process of inductive coding and memo writing continued as further observations and interviews were conducted—creating a large number of descriptive codes, and a smaller number of more general container codes or themes—until I was satisfied that this code/theme structure

was sufficiently useful without further development. The collection of memos that I generated formed a valuable record of the analytical process and heavily informed the arguments and points that will be developed in the following chapters. An extract of codes from the database can be found in Appendix 6.

During the first few meetings that I attended I tried to capture as much of what was said as possible, which was particularly challenging because so much of the content was unfamiliar. Over time particular issues would surface repeatedly in meetings, they would often be discussed differently in terms of communication style and the meanings they held in different meetings. I came to think of these recurring issues as storylines, e.g. NHS 111 (Chapter 10), and I became more discerning in the meetings that I attended in pursuit of finding out more about them. These storylines shaped the selection of a schema for the presentation of my results: an overarching chapter composed of themes relevant to the membership organisation concept, followed by chapters delineated in a number of ways in order to provide a broad account of the CCG's work—i.e. an organisational relationship (with NHS England), a national service implementation programme (NHS 111), and a key activity domain (commissioning itself). The nature of these chapters and their inter-relationships are explained more fully in Chapter 8 (Section 8.1). Once I decided on this structure, I began to link codes within the NVivo database to one or more of these chapters, which enabled me to organise data relevant to each and identify some interconnections and areas of overlap.

Using a combination of observations and interviews (supplemented with information from local documents and framed in relation to national policy documents) provided opportunities to elaborate, interrogate, and contextualise understandings from one set of data using the other. On the application of the same methodological approach, Petsoulas et al. (2014, p.4) note that 'while this could legitimately be called 'triangulation', we regard it as an opportunity to develop and refine our findings rather than as a simplistic test of validity'. I share this perspective. For example, I found that analytical engagement with observation data led to questions that I pursued answers to during interviews, and interview data provided new perspectives on events I had observed during meetings.

It was fieldwork observations, and discussions with my supervisors, that reinforced my decision to focus particularly on CCGs' status as membership organisations. This led me to return to the national policy documents that I had initially engaged with in a more general way and subject them to problematisation with a particular focus on the membership organisation concept (Chapter 3). This ran concurrently to further data collection so that understanding gained from the policy analysis process informed the fieldwork process, shaping interview questions and the events during observations that were recorded in particular detail, for example. This parallel engagement with the local organisational context and national policy content and history is illustrated in the concentric circles of Figure 1 above. It is this traversal of "levels" that characterises my analytical approach in this study.

My application of institutional logics theory as a sensitising device meant that the theory was not a principle guiding force in the determination of what aspects of the data were selected and what themes were developed. Rather the institutional logics lens was brought to bear on the themes and analysis after they had been substantially developed.

6.6: Ethical issues

Conducting a case study with a single organisation makes preserving anonymity particularly challenging. As a consequence, I have been vague about, altered or omitted, various details regarding the organisation and its setting. This includes the omission of whole series of events from the results because I deemed the possibility that they would compromise anonymity unacceptably high. I have also taken a range of steps to protect the anonymity of individuals from others within the organisation, although this is inherently difficult to ensure. Generic job titles have been employed and participants organised into one of three categories: GPs, managers, or others. Individuals in each category were ascribed a number on the basis of the order of their appearance in a set of all field note and interview extracts selected for possible inclusion in the results. These numbers do not reflect perceived importance or value in any way. I am not particularly satisfied with the overarching category delineation because a broad range of roles are subsumed into "other", and using a generic category of this kind arguably connotes some kind of inferiority to GPs and/or managers. This is absolutely not the case. The decision to

do this was made because some categorisations of actors were small, therefore, describing them more specifically would narrow down the possible actors to an unacceptable level. I have also switched gender pronouns for some individuals.

In field note extracts where I perceived a particular risk to the anonymity of the individuals involved, I have omitted their descriptor and either used only the category to which they belong (e.g. Mng) or removed any identity descriptor completely. Where necessary to distinguish between two individuals of the same group in a particular extract, I have used sequential letters, e.g. "MngA talked to MngB". These are relevant descriptors within a specific extract only, i.e. MngA could refer to two different people in two separate extracts. In other cases, in a similar way, I have chosen to omit any kind of group identity descriptor and use "Person A, B" etc.

The measures identified above can be thought of as calculated trade offs. A study such as this, which valorises the provision of contextual detail in the story it tells, inevitably suffers when contextual detail is stripped away. This is a difficulty inherent to many intrinsic case studies and must be understood as a price to be paid for what has ultimately been produced. The study received ethical approval from the University of Manchester in July 2012, and research governance approval from the relevant PCT in August 2012.

6.7: Notchcroft CCG

In this section, as throughout the thesis, I have had to strike an appropriate balance between providing sufficient information about the CCG in order to provide a sense of depth and context and withholding information in order to protect its anonymity. Consequently, I have used generic names for certain things, such as committees, and altered or used approximate figures.

Notchcroft CCG is responsible for a largely urban area of England, serving a population of over 300,000 patients. It is in the upper third of CCGs in terms of population size (Naylor 2012). Life expectancy in Notchcroft is below the national average for men and women.

There are a relatively high number of FTs in the area compared to the national average, and multiple acute hospitals providers. There is one main community services provider.

Detail of the statutory requirements for CCG governing body membership can be found in Chapter 2 (Section 2.2.1). Notchcroft CCG has a governing body that meets monthly. This meeting is split into a public and a private session. There are approximately 15 full voting members on the governing body; approximately 10 of these are GPs, each of which represents one of the three districts (discussed below). The governing body Chair is a local GP with experience of previous clinical commissioning arrangements and work with the PCT. The rest of the governing body is mixed in terms of experience, with several members that have no previous experience of commissioning work.

Notchcroft CCG has a number of committees, which are governing body sub-committees, each of which oversees a specific aspect of the CCG's work, for example: human resources, or provider performance monitoring. The audit and remuneration committees are statutory requirements of every CCG. Notchcroft's governing body decided on the other committees, and the particular focus of each. The majority of committees had, or were soon to have, their first meeting at the time of the first governing body meeting I attended in October 2012. In addition to the committee structure, the CCG has a number of programmes or work streams, each with a lead who sits on the governing body.

The CCG is composed of over 75 member GP practices. These are organised into multiple small groups of GP practices known as "locales"; in turn, these comprise three "districts" (each a sub-committee of a governing body committee; referred to by numbers 1 to 3 in data extracts). Locales are approximate in size (i.e. the number of GP practices that belong to each). However, districts vary in size (i.e. the number of locales that they contain), and are not organised geographically (i.e. the locales that comprise them do not necessarily come from the same geographical area of Notchcroft). Every locale and every district have a monthly meeting attended by representatives from each GP practice and locale (respectively). Each district has at least one GP elected to the governing body of the CCG and a manager. A GP from every locale either sits on a district board or the governing body. Each GP practice in the CCG has a CCG lead who is intended to be the primary conduit between the practice and the other tiers of the CCG, although these are not

always the representatives that attend the locale meetings. The CCG holds bi-annual practice engagement events where representatives from every member practice are invited. Figure 5 shows the basic substructure of Notchcroft CCG.

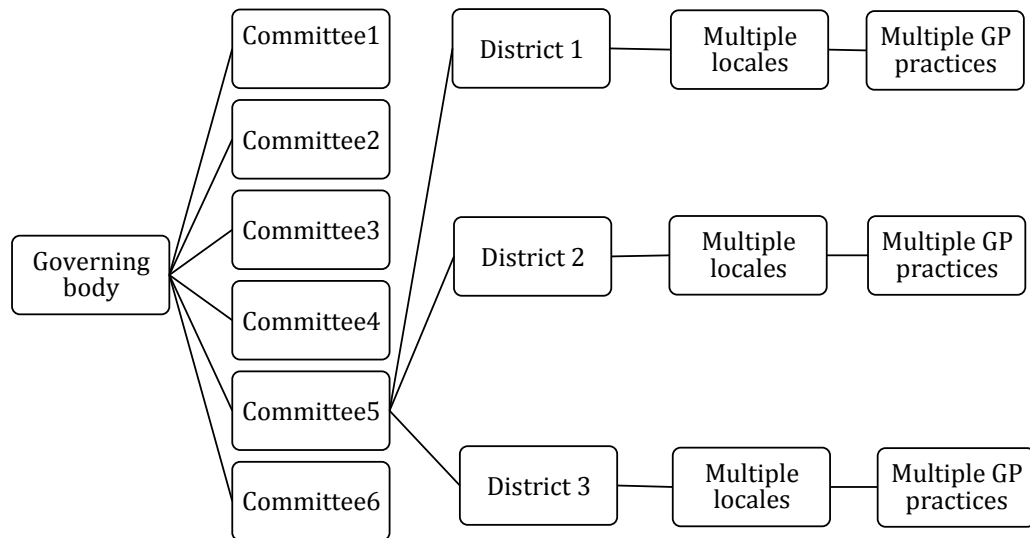


Figure 5: The structure of Notchcroft CCG

In common with many areas, Notchcroft has, in recent years, undertaken a process designed to even up funding per patient. The Locally Enhanced Service (LES)¹⁹ system has been used to support this, defining a set of services over and above core GP services that can be provided by every GP practice that signs up. I will refer to this initiative as the Primary Care LES. This had the effect of reducing variations in funding between GP practices in different parts of Notchcroft and between GP practices on GMS (see Chapter 2, Section 2.2.1) and Personal Medical Services (PMS) contracts (see Chapter 3, Section 3.4). The Primary Care LES predates the CCG but continues under it.

Notchcroft CCG's organisational vision, the production of which was part of the authorisation process, puts particular emphasis on reducing health inequalities. The CCG has also developed a strategic programme with a set of specific objectives, which it aims to meet in a matter of years. This programme is organised around a number of work

¹⁹ LESs are for services the GPs can provide that go beyond a baseline of primary care service provision. They are intended to address particular local needs and payments are negotiated locally between GPs and the body that commissions them.

streams that reflect particular health domains, such as mental health and cancer. In the early stage of its operation, Notchcroft CCG formed a network with other CCGs in the region in order to commission support services from a single provider, and to pool exposure to financial risk associated with significantly expensive treatment episodes.

6.8: Chapter summary

In this chapter I specify the study aim, objective, and research questions. I then explain that the research strategy adopted can be understood as an intrinsic case study of a CCG and the health policy that it is bound up with, conducted using ethnographic research methods: observations, interviews, and document analysis. I provide an account of the processes associated with employing these methods. I also highlight how the “membership organisation” concept is used to “study through” policy levels from the national policy narrative to enactment in the local organisation.

I provide an account of the analysis process itself, explaining how the data gathered from the different methods relates to each other and was combined into a single analytical database. Electing to study a single organisation presents particular ethical implications relating to the preservation of anonymity and I discuss these along with strategies that were employed to this end. Finally, I introduce the case study CCG—Notchcroft—and discuss some of its major characteristics. This includes aspects of the socio-demography of the local area, and the internal structure of the organisation, which featured two “levels” or sub-divisions below the governing body—districts and locales—rather than the single level more common amongst other CCGs.

Chapter 7: The governing core

When I began observing Notchcroft CCG meetings I was able to see how the CCG had turned guidance about the constitution of the governing body into practice. As stipulated in statute, the governing body included various individuals that were not health professionals (e.g. two lay people, a chief finance officer) and others that were but were not local to Notchcroft nor affiliated with CCG member GP practices (e.g. secondary care nurse). As I attended more meetings at a range of organisational levels it became clear that the governing body contained only a small but crucial section of those involved in the management and decision-making activities of the organisation. When trying to describe these processes I realised that I required an additional concept to refer to the broader group of people who had formal (or semi-formal) roles at various levels within the organisation (although not necessarily CCG employees) and who, by virtue of these roles, contributed significantly to the strategic and operational work of the CCG. I needed a term that would differentiate them from the general membership of Notchcroft who had little to no day-to-day involvement with the running of the CCG. I selected the term “governing core” for this. I will explicate this concept using examples from meeting observations in this chapter. I will then employ, develop, and analyse the concept through the results chapters (8—11) and discussion (Chapter 12) that follows.

The governing core was composed of all those people that played a part in the management and decision-making activities of Notchcroft CCG through the specified structure of the organisation above GP practice level. This means that all members of the governing body were part of the governing core, but not all members of the governing core were members of the governing body. For example, the governing core contained those that attended locale or district meetings, or committees, but never attended governing body meetings. This included GPs, nurses, other health professionals, managers, analysts; but also people from external organisations, such as public health professionals from the local authority, NHS England managers, patient representatives, and even service providers. If they had access to CCG decision-making forums then they had some potential influence in governance processes and were, therefore, part of the governing core. Some people featured consistently in the governing core (e.g. some CCG managers, or GPs that represented locales at district meetings) while others only

occasionally (e.g. CCG analysts, representatives from service providers), and had varying degrees of influence, depending on the forum being observed. A key point is that the composition of the governing core was not fixed, unlike the governing body; it varied over time and between contexts. I will illustrate the existence of the governing core in relation to governing body, committee, and district meetings below.

Committee meetings were attended by a variety of people from within the CCG and other organisations. The quorum of each committee was composed entirely of governing body members, but many non-governing body attendees enjoyed committee voting rights and were influential in shaping discussion and decision-making. In the following extract a CCG analyst explains to committee members that the data available about Walk-in Centre access was “flawed”. One of the districts had hoped to use that data as evidence to justify the high A&E use amongst their patients as part of the CCG’s internal primary care performance assessments. However, the contribution from the analyst led to an acknowledgment amongst meeting attendees that this was not possible:

GP7 asked OthA to talk about the WIC [Walk-in Centre] data.

OthA said that the data was ‘not very good’ and ‘unreliable.’ She said something about collecting the data not being worth the money [because it was insufficient?].

GP7 asked what conclusions she could draw.

OthA: None. [Com6_M2_Mar13]

Managers and analysts were regularly involved in governing body meetings. They would present and translate service provider performance data for attendees, often putting it in some kind of context that was more meaningful than the charts and coloured tables that contained it. These processes shaped dominant impressions amongst the governing body of the performance of commissioned services and whether any action should be undertaken:

MngA says that no a single contract (provider?) is hitting green on every single indicator (for the CCG).

OthA asks her for clarification (he sounds a little stunned): 'did you just say that not a single contract is hitting green?... ' ...

She says that it is to be expected, at this point, that none of the contracts will be hitting green on all indicators. [GB_M2_Nov12]

In a different committee meeting a senior member of the local authority public health team questioned the relevance of a presentation on aftercare for adults detained under the Mental Health Act. Her question put the onus on the committee Chair, a governing body member, to justify the inclusion of the presentation on the agenda. This then led to a broader discussion about the purpose of the committee itself and how members should perceive it:

Oth11 [from local authority]: 'Can I ask a really basic question: why has this come to this committee?'

GP6: 'that's what I was wondering'

Oth7 says that it is because it is a challenge... Need to go through the process. [Com5_M1_Dec12]

These extracts illustrate how processes of organisational governance at governing body and committee levels were influenced by those in non-governing body and non-CCG roles of the governing core. The membership of these committees was stated in their terms of reference and most included a combination of governing body and non-governing body roles from the CCG, but some also included roles from outside the CCG (e.g. a public health representative, patient representatives, or a commissioning support representative). As committee members, these people were eligible to cast a vote. However, the quorum of each committee was constituted entirely by governing body members (although usually not all of the governing body committee members for a given committee). In governing body meetings only full members were eligible to vote. However, I did not observe an issue being subject to vote in any of the meetings that I attended, which leads me to believe that such events were rare and not significant in determining decision-making and action. It was far more common for discussion to result in a consensus view being established.

A detailed terms of reference was only available for one of the districts and this was three years out of date. The board of this district was composed entirely of GPs, each of which represented a locale and had been elected by the GP practices within their locale. Every locale within the district was represented by at least one GP on the district board.

Quorum was dependent on at least four of the seven full members being present. None of the locales within the district had a terms of reference. Districts and locales were not (and, under the HSCA12, could not be) legal entities. They could not, for instance, allocate funds to providers or procure contracts themselves. However, their decisions and actions were consequential for the organisational layers below each: districts were of particular significance to locales and GP practices; locales were of particular significance to GP practices. In the following extract from a district meeting attendees discussed if and how they should, as a district, offer support to GP practices that had failed to successfully submit evidence to demonstrate that they had met Primary Care LES (Chapter 6, Section 6.7) targets and had, therefore, missed out on additional income. This demonstrates how those involved in district level discussions, most of whom were not also governing body members, contributed to decisions that had direct implications for the broader membership:

GP26 asked if they should send out a letter to those practices that had problems offering them help in the future. GP19 asked the opinions of the group. Mng1 said that she had verbally offered help to those practices.
[Dis2_M1_Dec12]

In another district meeting a public health representative from the local authority responded to a suggestion from a GP that some additional funding could be spent on installing a defibrillator in every CCG GP practice, which would provide a “good news story” for the CCG. Her remarks were influential in shaping a consensus opinion amongst the district board that it would not be a good idea because clinical evidence suggested that the money would be better spent on something else. She argued that it was important that the CCG established clear and consistent decision making processes for such issues [Dis1_M2_Jan13].

This chapter illustrates how a much broader cast than the governing body were involved in the governance processes of the CCG, which took place in various meetings. In the

results chapters (8—11) and discussion (Chapter 12) that follow I employ the governing core term to provide an additional degree of detail in describing the actions and interactions of individuals relevant to Notchcroft CCG. Through the themes explored it will become clear that many of those in the governing core are closely involved in issues of great significance to Notchcroft CCG and its status as a membership organisation.

7.1: Chapter summary

In this chapter I introduce the concept of the “governing core”, which will be an important feature of subsequent chapters. The HSCA12 suggested that CCGs would be composed of “the governing body” and “the membership.” My observations revealed that the governing body contained only a small but crucial section of those involved in the management and decision-making activities of the organisation—the cast involved in such activities was broad and included some people that were primarily affiliated with organisations other than the CCG. I developed the governing core concept to facilitate discussion of all those people involved in CCG governance processes including, but not limited to, the governing body above GP practice level.

Chapter 8: Membership organisation

8.1: Introduction to the results chapters

This is the first of four results chapters which focus on the events that occurred during fieldwork with Notchcroft CCG. Before I introduce this chapter specifically I will explain the organisation of, and relationship between, the four results chapters. This *membership organisation* chapter can be thought of as arching over and interacting with the three that follow it. As I highlighted in Chapter 3, the status of the CCG as a membership organisation is key to its presentation in policy documentation and rhetoric. It is a central focus of this study. The analytical exploration of Notchcroft CCG's status as a membership organisation spans the duration of the fieldwork period and relates to multiple domains of organisational activity. The subsequent three chapters focus on particular relationships, services, or activity domains: *NHS England: authorisation, assurance, and collaboration* focuses on the relationship between the CCG and the national oversight body established by the HSCA12; *NHS 111* considers the CCG's experiences of launching a new, nationally mandated service; and *Commissioning activities* explores the practicalities and implications of the CCG's core role.

In this chapter I explore the concept of the CCG as a *membership organisation*. As discussed in Chapter 3, the membership organisation status of CCGs is presented normatively in policy documents and identified as a key factor that should underpin their success. In this chapter I explore manifestations of this in Notchcroft CCG. During data collection, examples of attitudes, behaviour and actions relevant to the concept of membership were identified. This chapter presents this data in four, overlapping and interactive, themes: *Being a membership organisation*; *Notchcroft CCG history and structure*; *Legitimacy, credibility, and reputation*; and *Organisational identities and story telling*.

8.2: Being a membership organisation

This theme is about conceptions amongst CCG members relevant to the CCG's status as a membership organisation and the social practices associated with it. What being a membership organisation meant was discussed in meetings at multiple levels of the organisation. It was often associated with being a "*bottom up*" organisation or working in a "*bottom up*" way [Int_Mng4_Apr13; Int_Mng1_Apr13; Int_GP6_May13; Dis2_M2_Apr13; Dis1_M3_Mar13]. It was employed variously to describe the "*work in progress*" of GP practices being actively engaged with the CCG via locales [Int_Mng1_Apr13], the CCG seeking the opinions of GP practices to shape the development of specific plans [Dis1_M2_Jan13], and GP practices identifying their own performance targets in order to demonstrate their continuous improvement to the CCG [Int_Mng4_Apr13]. This was contrasted with the top down target imposition approach of the PCT:

...locales are built up of independent practices and so we can't, you know, there is no way that Notchcroft CCG was going to be a top down organisation, it always had to be a bottom up organisation and in order to do that you have to allow them to make those decisions, supported obviously, because it's new to them, it's new to us, but we have to make sure that we are not seen as an old style PCT that owned the targets and pushed those targets down - it has to come up from the bottom where they want to do continuous improvement and so they look for their own targets, they look for their own achievement.
[Int_Mng4_Apr13]

Being a membership organisation was highlighted as an argument in favour of canvassing the opinions of all practices on issues such as service re-commissioning, or (in the extract below) in the selection of CCG-wide performance indicators. The extract below is particularly interesting because in it an individual who is part of the governing core—yet external to the CCG—advocates the organisation take a particular course of action because it would be consonant with its status as a membership organisation:

GP1 asked whether it might be a good idea to consult the membership [about local quality premium outcome measures] GP1: “We could put the question to them: what are your practice priorities? What do you expect the CCG to be doing? If we came to the same conclusions then it would be a powerful process.”

...

The guy with glasses sitting to the right of GP2 [later identified as someone from the local authority] said the CCG should take the opportunity to demonstrate work as a membership organisation. [GB_M4_Jan13]

However, on the subject of asking member practices about how best to distribute resources across the CCG one district board member GP said [Dis3_M1_Jan13]:

“(laughing) The trouble is if you ask people if they want more jam they will say yes.” His comment suggests that the individual interests of GP practices would not necessarily be helpful in making higher-level strategic CCG decisions. There were instances where such interests clashed with the attempts of the CCG to involve members. For example, a story was relayed in a district meeting about some practice nurses having to use their annual leave in order to attend CCG-related events and activities because senior GPs would not allow them to be away from the practice during their contracted work hours [Dis1_M3_Mar13].

It was noted that engaging the membership was particularly difficult when some GPs did not attend any meetings or read CCG email communications. The following extract from a committee meeting illustrates how this governing core individual perceived “the CCG” to be “the membership at large.” He expressed frustration by what he perceived as a lack of recognition of this from some GPs who were, consequently, not fulfilling their membership obligations:

Oth1: “Can I just add a caveat? People have forgotten that this is a membership organisation. People say “what’s the CCG doing?” but it’s not that it’s “what are we doing?” It means you get ready by reading emails.” [Com6_M2_Mar13]

Interviewees were asked to explain how they perceived the role of the governing body in a membership organisation and the dynamic between the board and the members. One governing body member stated that the board was comparable to that of a charity in that

board members sat as trustees and operated with the delegated authority of the members, as opposed to a shareholding organisation where *“the shareholders in theory own the company and tell the board what to do”* [Int_Oth3_Nov13]:

...within that delegated authority from the total membership who signed up to the constitution, which is our governing document, then we have both the freedom and responsibility to enact the legislation and do the other things that we’re meant to do what it means is we’re accountable to several different groups... [Int_Oth3_Nov13]

He went on to specify the groups that the CCG was accountable to: members, patients, public (*“for the services we commission”*), Government and NHS England. One CCG manager likened the accountability of the organisation to that of local councillors who are accountable to the voting public:

So our accountability, the accountability of the organisation is... unusual I think... I suppose it’s like councillors. Local councillors. They’re accountable, they must be accountable to... the voting public...

...but then Notchcroft Local Authority would be accountable to the Government as well. So it’s kind of.. it’s a bit similar to that I suppose.. In some ways. [Int_Mng3_Jan13]

A district member GP perceived the job of “the CCG” to be balancing what the Government wanted with what the practices wanted. She explained that if *“they”* did not offer enough to the practices then they had no hope of members being engaged with the organisation. This extract is particularly interesting because it illustrates how, for this governing core GP, *“the CCG”* was an entity external to her, yet at other times she also contributed to discussions about how best to engage the membership and encourage them to recognise themselves as part of the organisation [Int_GP10_Aug13]:

it's ... almost like a symbiotic relationship the CCG feeds the practices resources the practices in return help the CCG meet its targets.
[Int_GP10_Aug13]

A CCG manager emphasised the rights and responsibilities of members:

...it's the practices who are responsible for agreeing the constitution, not the governing body... and it's the practices that are responsible for agreeing the vision and the values of the CCG ...but then the governing body can get on with... delivering those visions and values but testing it back all the time but the practices retain the responsibility for those... I think it's those three things: the constitution, the vision, and the values... and...who's on the governing body you know that's, they retain the right for that... [Int_Mng3_Jan13]

In mid-2012 Notchcroft held an election to determine the GP membership of the governing body. Any Notchcroft GP could nominate him or her self by filling out a form including a short statement on why he or she was a suitable candidate. Of interest, given the policy position that GP practices constituted the membership of the organisation, is that locum GPs were eligible to stand in the election if they had worked primarily in a Notchcroft practice over the previous twelve months. GPs were only entitled to vote on which GPs from their district would be elected to the governing body. In the extract from a governing body meeting below, a GP board member alludes to the democratic legitimacy that the board possessed to act in the name of the members and suggested that the majority of the membership would not actually desire much additional information about what they were doing:

GP3 thinks that most GPs won't be bothered with the details: "They will be happy to leave that to their colleagues that they have democratically elected to deal with." [GB_M1_Oct12]

One practice manager with no regular CCG involvement shared this view:

... the people that ... are on the board of the CCG we know ... and have been elected to that board by us so er we have a trust in those people that they are representing our values and our views really. [Int_Oth4_Nov13]

However, another interviewee, a GP partner with no regular CCG involvement, stated that she thought the election for the governing body was "*pseudo-democratic*" and "*not representative*" because a first past the post system was used [Int_GP12_Nov13]. The election method was decided locally with the assistance of the Local Medical Committee. There were opportunities for members to comment on what method would be used, but

the problems with the approach did not occur to her until after the election. She also believed that some GPs voted for candidates on the basis of a shared ethnic background above anything else [Int_GP12_Nov13]. Another interviewee, a part time GP outside of the governing core, said that he had recognized significant variety in how seriously candidates took the election [Int_Oth5_Dec13]: some canvased for votes using social media and text messages, others did little more than signing up as a candidate and were less successful. In some districts, the election was hotly contested with multiple candidates; in others there was more apathy. In one district the only two candidates that stood were elected [Int_GP6_May13]. This experience resonates with a survey of emerging CCGs, which found that many of them forewent a governing body election process because of a lack of interest and candidates, and one had an unfilled GP vacancy on the governing body for a period of several months (Checkland et al. 2012b).

It became clear during interviews that some GPs felt utterly disconnected from the CCG. One GP said that she did not perceive much of a difference between the CCG and the PCT: *'most of the names on the emails are the same'* [Int_GP11_Nov13]. She stated that: *'...the CCG feels like it's there to give us work to do as a salaried GP that's what it feels like, that's all I feel like I get back from the CCG'* [Int_GP11_Nov13]. This illustrates that for some Notchcroft GPs the notion of membership was largely meaningless, and the governing core's efforts to encourage "buy in" were not likely to make any impact.

8.3: Notchcroft history and CCG structure

The HSCA12 set out certain requirements of CCGs in terms of their structure, such as having a governing body and two statutory committees. However, beyond this CCGs had some latitude in how they organised themselves. In Notchcroft CCG there was clear continuity in terms of structure and purpose from previous clinical commissioning arrangements. The historical context of Notchcroft CCG and the nuances of its organisational form in relation to its functions were topics covered during interviews and arose occasionally during meetings. This section will focus on districts and locales (see Chapter 6, Section 6.7 and Figure 5)—elements of the CCG's structure—and issues that historically contextualise their development and operation.

What we've got in Notchcroft isn't something that developed overnight it actually has developed over something like 15 maybe almost you know 20 years. [Int_GP10_Aug13]

Districts can be traced back to the relationships formed between groups of practices for TP pilots in the 1990s (Goodwin et al. 1998) [Int_Mng4_Apr13]. When the Labour Government introduced PCGs in 1999, the district model was the basis for their organisation in Notchcroft. When Notchcroft PCT was introduced in the early 2000s, districts continued to exist as a less formalised sub-structure [Int_GP10_Aug13]. Districts were also the basis of PbC consortia established in 2005 (Coleman et al. 2009). When the plans for abolishing PCTs and creating CCGs were first announced there was debate in Notchcroft about whether there should be a single CCG or multiple CCGs that corresponded to the existing districts. Several practices migrated to different districts on the basis of their position on this issue [Int_Mng1_Apr13].

Members conceived of the nature and purpose of districts in a variety of ways. One manager referred to districts as the *"jam in the sandwich"* between the slices of locale and governing body bread [Dis1_M1_Dec12]. Districts were described by members as the *"engine rooms of the CCG"* [Int_Mng5_Aug13], *"a way to maintain localism"* [Int_GP6_May13], as well as *"engagement vehicles for the practices"* [Int_Mng1_Apr13]. There was also a sense that their existence was partly a trade off made between those that wanted a single CCG and those that wanted multiple separate CCGs based on the districts:

...in a way I suppose it was to placate those grass roots practices, GPs who wanted three CCGs, because their arguments were that the GPs would lose their say in a big CCG. [Int_GP6_May13]

There were several occasions in district meetings where the sentiment was expressed that it was important to ensure that the district's own interests and views were represented at the governing body level, as well as committees and working groups:

GP17: I think it's really important that we have some [District 3] representation at that meeting. [Dis3_M1_Jan13]

...

There are now two planned care leads for [District 1]: [GP names]. GP8 said that this was to be celebrated because it was important that [District 1] were represented. [Dis1_M3_Mar13]

Locales were developed in Notchcroft as forerunners to PbC groups [Int_Oth5_Dec13]. The first were associated with a number of new health centres, and they provided a forum for groups of local GP practices to meet regularly, share information, and create opportunities for joint working [Int_Mng5_Aug13]. Before then it was uncommon for GP practices, even those sharing the same premises, to have much contact [Int_Mng5_Aug13]. A CCG manager reported that there was some initial resistance to this idea, in part because of the nature of general practices as independent businesses [Int_Mng1_Apr13]. Locales in Notchcroft proliferated as a response to the changes embedded in the 2004 GMS contract (see Chapter 2, Section 2.2.1). In particular, the Primary Care LES was developed, which set minimum standards for primary care provision and offered payments for services beyond this (see Chapter 6, Section 6.7). The introduction of a performance management process of this sort was something that many PbC groups nationwide decided to do (Coleman et al. 2009). It was widely understood by GP practices as increasing funding to primary care and improving the equity of that funding [Int_GP6_May13], but it also embodied a performance regime based around the collection and analysis of local performance data. The Primary Care LES also specified that practices should work together in locales in order to improve performance, and when the CCG was created, locales were formalised as part of its structure and all practices were required to join one. One GP stated that, because of the developments associated particularly with PbC and the Primary Care LES, Notchcroft was already moving towards a primary care system model consistent with some of the requirements of the HSCA12 [Int_GP6_May13]. Another interviewee highlighted the systemic forces, pre-CCG, encouraging GP practices to join a locale:

Personally I think we were just getting there in Notchcroft because we had this locale approach and it seemed to me to be working and the PCT had introduced it as an incentive that you had to be an active part of a locale. [Int_Oth5_Dec13]

Locales were conceived of variously as “...*the way we communicate with our members...*” [Int_Mng4_Apr13], crucial to the delivery of healthcare, “*units of analysis*” that the governing core of the CCG needed to understand more comprehensively [Dis3_M1_Jan13], “*vehicles for change*” [Int_GP6_May13], and a means of ensuring a broad representation of opinions by providing a forum for even the smallest practices to voice their thoughts [Int_GP6_May13]. Locales contrasted with districts in that they were more geographically specific. One manager suggested that this made them more “*meaningful*” because they were focussed on the needs of particular patient demographics [Int_Mng1_Apr13].

Every CCG member practice was obligated under the HSCA12 to appoint a CCG GP practice lead to engage with the CCG, and this role was also a feature of Notchcroft’s constitution [Int_Mng5_Aug13]. In Notchcroft, it was decided that this role would be remunerated and an explicit responsibility for the lead to disseminate information from locale meetings to their GP practice would be attached to it. However, in November 2013 there were concerns raised at the district level about the efficacy of this given that knowledge amongst some practice staff about the CCG appeared to be low:

GP4: ‘Our receptionists thought the CCG was the CQC.’

MngA: ‘You get it a lot when you ring up receptionists because they know what the CQC is but not the CCG. Struck me that we’ve still got to work to do. When I asked you to find out about your practices and most of you came back and said that they don’t know.’

MngB: ‘[CCG GP practice lead payment figure times the number of general practices] goes out per month to practice leads and part of their role is about raising awareness of what the CCG is amongst the practice. I am concerned about that.’ [Dis1_M4_Nov13]

Districts and locales functioned as administrative units. Their delineation, however, did not necessarily match up with other existing units, such as council wards, and this had implications for successfully connecting them to existing schemes, such as public health initiatives [Int_Mng1_Apr13]. This contrasts with the CCG itself, which was co-terminus with the local authority [Int_Mng4_Apr13]. The piecemeal process of locale establishment meant that some had considerable expertise and experience whereas others were less mature [Com6_M1_Jan13]. As noted in Chapter 7, locales and districts

were not, and could not become, legal entities under the HSCA12. Consequently, they could not, for example, employ people directly, and this was identified as a barrier to realising some of the ideas for service provision that had emerged at the locale level [Int_Mng1_Apr13].

This degree of subdivision below governing body level was somewhat unusual in CCGs. Most of the larger CCGs had some sort of administrative unit at a local level (often called “localities”) (Checkland et al. 2012b). Notchcroft, by contrast, had two levels of subdivision. The short historical account given here highlights the reasons underlying this organisational structure, but in practice it presented problems. For example, there was clear overlap between the functions of districts and locales. Both were understood as platforms for enabling communication between the more local elements of the CCG and the broader governing elements, and as vehicles for action. One of the most significant differences between the two was that locales were said to be more sensitive to local population needs. The two were generally considered to be mutually constitutive by those in the governing core that I talked to. However, this was not a universal sentiment. One governing core individual expressed during an interview that he did not see the necessity in having both, and one manager said that he thought the district/locale model was still evolving and not a finished project. He suggested that in the future districts might become redundant but they were currently important to support the locales that were in very different states of capability:

...everything is coterminous and if you're bigger you have got clout. So obviously you lose, I don't know, the intimacy so you've got a functioning locale system. I never thought that it was really of any use at all to have a district and I'm not actually sure what the districts do. [Int_Oth5_Dec13]

...

[GP name] said we should have governing body then straight to locales erm that that might come in time I don't know it depends how those locales start to operate so they could become a federation GPs federating together so maybe we wouldn't need the district but I think in this moment in time we do need that district and I think that's because [the locales] are functioning very different. [Int_Mng5_Aug13]

Some of the locale meetings that I attended featured items where the locale would receive feedback from analysts on clinical performance relating to a specific area (e.g. cholesterol management); others were followed immediately by an integrated care meeting, in the locales that had begun the initiative, where various health and social care professionals discussed the needs of individual patients. However, in most cases the content covered between district and locale meetings was very similar, apart from the feedback from the relevant district or locale level. A typical agenda for a district/locale meeting looked something like:

- Issues from previous meeting
- Governing body meeting feedback
- Feedback from committees
- Feedback from locales/districts
- Lead area reports (e.g. mental health, prescribing, cancer)
- Any other business

Observing district and locale meetings revealed just how much repetition of verbal information was involved with this structure. For example, a message delivered by a committee member at a governing body meeting would be relayed by a governing body GP at their next district meeting, this message would then be relayed by a district level locale representative at their next locale meeting. Although this was not the only record of the message, there was ample opportunity for variations in tone, emphasis, and even content, when relayed verbally. One of the reasons behind such variations is discussed in the organisational identity section below. I also observed both district and locale meetings being used as a space to for attendees to vent and express frustration about issues within the organisation more broadly [Dis2_M2_Apr13; Dis3_M2_Apr13; LocA_M1_May13].

In conclusion, Notchcroft's district/locale structure was unusual, although not unique, amongst CCGs and rooted in the history of the area and the relational dynamics between groups of GP practices. The origin of districts can be traced back to the first primary care led commissioning structures of the early 1990s, whereas locales emerged more recently in relation to PbC. Pre-CCG, districts were concerned with service commissioning, and

locales were concerned with peer support and development between groups of local GP practices and information sharing.

In the process of establishing Notchcroft CCG, there was debate about whether there should be one CCG or multiple CCGs based on the existing districts. The decision to establish one CCG involved the placation of those that wanted three by maintaining the district model, and keeping districts and locales was seen as sensible because each fulfilled distinct functions pre-CCG. However, in the CCG these functions were not required in the same way. The commissioning work undertaken by districts was now the purview of the governing body and various committees. There was a lack of clarity from those in the governing core of the CCG about exactly what the distinct purposes of districts and locales were in the new organisation. However, districts were also containers for particular sets of interests and perspectives that members of each felt needed to be represented at the governing body and other levels of the CCG. Observations revealed considerable duplication of content between district and locale meetings, which suggests inefficiency, and created possibilities for breakdowns in communication between the different levels.

8.4: Legitimacy, credibility, and reputation

This theme is about attempts by the governing core to manage the reputation of the CCG by increasing, or protecting, the credibility and legitimacy of the organisation with the membership in particular, but also with providers, other organisations, patients and the public. The topic was discussed at governing body and district level. There were three main mechanisms identified as relevant to this: the CCG fulfilling actions that it had stated it would undertake; being responsive to issues identified by members and communicating efforts to address them; and differentiating the CCG from the PCT. I will highlight some examples relating to these below.

In a district meeting it was reported that an initiative to get midwives to vaccinate expectant mothers against flu was proving unsuccessful because midwives reported that they did not have the time to add the activity to their schedule [Dis1_M1_Dec12]. There

was a suggestion that the CCG membership had already been informed that this was going to be happening and the fact that it was not was a risk to the CCG's credibility:

GP5 – said that there might be a perception that if the CCG can't get midwives to vaccinate what can they do?

GP4 said something about the CCG losing credibility.

Mng4 said that the problem is that expectations have been raised that this will be happening and it's not. [Dis1_M1_Dec12]

A number of practices had expressed their desire to operate 24-hour blood pressure monitoring from their surgeries. A district member said that it was crucial for the CCG to act on this request in order to differentiate itself from the PCT by being responsive to practices:

'the CCG has "got to do something about it." In the past the PCT often heard things like this but didn't respond. The CCG is different and it has to. GP4 pointed out that in doing so the CCG would retain credibility, too.'

[Dis1_M2_Jan13]

In a committee meeting in April 2013, immediately post-authorisation, there was a discussion about an underperforming provider trust and how the CCG should respond. One member said that the CCG had *"a lot of credibility now"* and it was, therefore, a good time to *"put a marker down"* to show underperforming trusts what kind of response they could expect from the CCG [Com5_M3_Apr13]. I am not aware of any particular action taken towards trusts based on the opinions expressed in this conversation.

An event to enrol CCG GP practice leads (this role was discussed in Section 8.3 above) in May 2013 was cancelled due to a lack of interest. The possible reasons for this were discussed at a committee meeting later that month. One committee member believed that it was due to the CCG concentrating on strategy but failing to engage well with member GP practices [Com6_M3_May13]: *"We've got to problem solve to make noticeable differences to the day to day problems that practices experience."* There was some agreement with this view and a suggestion that the CCG should pursue some *"quick wins"* in order to better connect with practices. The 24-hour blood pressure monitoring

was identified as a possible quick win target. As one CCG manager put it: *“it’s about you said, we did”* [Com6_M3_May13]. This illustrates how the governing core, beyond the governing body, was involved in shaping the approach of dealing with the broader membership and strategising engagement.

In a further example, a discussion about how best to spend some non-recurrent funding took place at the district level and ran for several weeks. One GP suggested that the CCG might purchase defibrillators to install in every practice, as this would be *“defensible”* (on clinical grounds) and be *“good PR [public relations]”* (see also Chapter 7) [Dis1_M2_Jan13]. Others, particularly a public health professional from the local authority, expressed concern that there was not sufficient evidence to support the installation of defibrillators ahead of other public health orientated interventions. A district GP member added: *“my concern is that if we do this and public health consultants say the evidence suggests it doesn’t save lives.”*

GPA said something about getting defibs in all practices might be worth doing *“if you want to get a good news story.”*

OthA [public health]: the council does not support defibs because it is such a rarity that they’re used they are not thought to represent good value for money.

...

GPA: If we get to the end of March defibs might be a sensible use of funds if there is money left. We would be able to defend the position and it would be good PR.

OthA: The decision-making process that the CCG uses needs to be clear now so that further decisions made down the line are consistent. [Dis1_M2_Jan13]

This idea, and the discussion surrounding it, was then brought up at a committee meeting where the sentiment of concern about the paucity of clinical evidence for the effectiveness of such an initiative appeared dominant. I did not hear anything else about it in further meetings.

8.5: Organisational identities and story telling

This theme is about how the CCG governing core conceived of the organisation, and groups within the organisation, both explicitly and implicitly. It is also concerned with ideas amongst the governing core about the identity of the organisation and how it should be portrayed to local GPs, patients and public, and attempts to do so.

During the second governing body meeting that I attended, a discussion took place about breaches in targets for single sex wards in one hospital trust. One CCG manager framed Notchcroft as particularly conscientious compared to other local CCGs because the organisation was more concerned with understanding how and why problems happened rather than “*glossing over*” them [GB_M2_Nov12]. Notchcroft was conceived of as powerful because it was larger than most surrounding CCGs. This gave it “*clout*”: “...because of the resources that it's got actually that gives the CCG much more ability to control its own destiny” [Int_GP10_Aug13]. It was also portrayed as “*ambitious*” and having a “*positive culture*” [GB_M2_Nov12]. These identity affirmations speak to the first, and most major, body of organisational identity theory identified in Chapter 5 (Section 5.3): identity as particular organisational qualities or character.

At several different meetings (district, committee, and governing body) the point was made by several different people that the CCG needed to be prepared to “*take tough choices*” and not shy away from upsetting other local CCGs, NHS England or other organisations if doing so was a corollary of action that was in the best interest of Notchcroft patients. The following extract is one example of this:

GP3: It was noted at a previous governing body meeting that if a choice emerged between “*pressing ahead*” on a course of action or (waiting for agreement for all local CCGs?) then the CCG would do what was best for the people of Notchcroft. [Dis1_M2_Jan13]

The governing core often explicitly emphasised that the CCG was different from the PCT that had come before it, which other research identified as a common assertion amongst CCGs (Checkland et al. 2012b). The extract below suggests that Notchcroft's communications to GP practices would likely be received differently from those of the PCT:

In the past, a lot of these kind of letters have been "very high handed" and then I've scrolled down to see [head of PCT]'s name on it and it gets binned. "That goes to the core of makes us different from them." [Dis1_M2_Jan13]

However, a preoccupation of the governing core was how the existence of these characteristics could be effectively communicated to the broader membership and others. During the second governing body meeting that I attended, in November 2012, a general question was posed for attendees to reflect on about how the governing elements of the CCG could win "*the hearts and minds of members*":

'How do we share the vision of the CCG with all practices?'

He talks about the importance of winning the hearts and minds of the members. This is important to think about because the CCG is a membership organisation. All GPs are a part of it. 'How do we engage those that don't come to the meetings?', especially locums etc. [GB_M2_Nov12]

The extract above encapsulates two important points: that there was a perception at the governing body level that strategies needed to be developed in order to effectively communicate with the members of the CCG, and that there was some underlying vision of the CCG that needed to be communicated. In March 2013, the idea that the CCG should have a publicised launch to coincide with authorisation was mooted at a committee meeting [Com6_M2_Mar13]. The purpose of this event would be to promote the activities of the CCG and to establish its identity and the "*cultural change*" that it represented [Com6_M2_Mar13]. An event of this nature did not take place for reasons that remain unclear, although members of the governing body did feature on local radio [Com6_M2_Mar13]. By November 2013 there was a sense of frustration from some governing body members that the CCG had failed to present a narrative, particularly to the public, about its character and aims as an organisation, and district level patient representatives had identified this as an issue [Dis1_M4_Nov13]. One district member

suggested that the lack of a prominent “*little story*” about the organisation meant that it was vulnerable to developing an enduring association with a scandal or negative event, should one occur [Dis1_M4_Nov13]. A representative from one of the provider trusts at the meeting suggested that it would be helpful for his organisation to see such a short story in order to more clearly understand the CCG.

However, issues of identity were also relevant intra-organisationally. One CCG manager suggested that I would likely notice the different dynamics at each district meeting and these were reflective of the “*personalities*” of each: one of them was described as reflective—“*the CCG conscience*”—and pursued a shared position on an issue after democratic deliberation; another was more autocratic than democratic, somewhat masculine and keen to be at the forefront of any changes; the other was also quite reflective but also “*a little apathetic*” [Int_GP6_May13].

...there’s a real different culture, which is why I think districts are useful.
[Int_GP6_May13]

These “*personalities*” meant that each district responded differently to certain language. For one of the districts, managers avoided using the word “*target*” in written communication because the members were less comfortable with this than with terms such as “*achievement*.” The following extract explains this:

GP3: It might be better if comms come from the locality lead. A lot of people in the locality won’t know who [senior governing body GP] is, but I know if I see an email from [district lead] I’m much more likely to read it. “There is a certain way the [district 2] practices get engaged” and it’s different to the way [district 1] get engaged. “That’s why we need to have control over information flow.” [Dis1_M2_Jan13]

I am unable to pass sufficiently informed comment about the extent to which locales exhibited different personalities and how interests may or may not have varied between them. This is because I attended considerably fewer locale meetings than district meetings (Appendix 4) and, therefore, studied them in less depth. This was partly a consequence of having to make prioritisation decisions about which meetings to attend. I had to balance my interest in following particular issues or stories between different

committee meetings with arranging to attend locale meetings, which sometimes clashed. Moreover, it was through attending district meetings that I was able to speak to the Chairs of the various locales and request permission to attend their meetings. This process of approval became protracted because locale Chairs invariably stated that they would personally be happy for me to attend but would pose the question to all locale attendees at the next meeting and inform me of the decision at a subsequent district meeting.

Some of the GPs involved in the governing body expressed feelings of dissonance between their role as GPs and their role as part of the governing core of the CCG. In one locale meeting, a GP corrected his use of a pronoun when talking about *“the CCG”*:

GP6 said something about the CCG GP practice leads event [in] June. He referred to the CCG as “they” [as in external to him] and then corrected himself: “I can’t say they – I have to say ‘we’ and I hate that.” He smiled and the others laughed. [LocA_M1_May13]

8.6: Conclusion

In conclusion, those in the governing core understood that being a membership organisation meant operating in a *“bottom up”* way, in contrast to the out-dated, dictatorial and *“top down”* approach of the PCT. Being *“bottom up”* meant involving member GP practices in the work of the organisation, in ways such as seeking their opinions during decision-making processes. GP practices were seen as having a responsibility to engage in this process. It is important to note that the expectations of the governing core in this regard, and their broader ideas about what being a membership organisation meant in practice, closely mapped on to the normative presentation of CCGs as membership organisations in the national policy. However, there was a broad spectrum of involvement from member GP practices, and a lack of engagement from some GPs was a source of frustration for some in the governing core. There were also practical limits to seeking member input on organisational policy decisions because of the challenges inherent to reconciling a broad range of potentially competing interests of sub-groups within the CCG. This was allied to a recognition that

the governing body had to balance the interests of members with their legal duties towards government in the form of NHS England.

The governing body's remit, as expressed by governing body members, was to strive to realise the overarching vision and values of the organisation, which were agreed by the broader membership. The governing body had been legitimately "*entrusted*" with this "*delegated responsibility*" through the process of democratic election although, in practice, it was only the GPs that were elected and not, for example, the lay people or secondary care nurse. Governing body GP members were accountable to the broader membership and duty bound to inform them about their work and decisions. Some of those in the broader membership that I spoke to did not see things in the same way. They expressed feeling a lack of ownership of the CCG and its values and perceived it as an imposed extension of the PCT regime featuring some of the same people. This is perhaps unsurprising given the enforced nature of CCG membership. One individual questioned the democratic legitimacy of the election process and whether there was a lack of balance in the representation of GPs with particular interests on the governing body.

In their original—pre-CCG—incarnation, districts and locales can be understood as embodying different institutional logics. Districts were established as bodies for doing commissioning and their qualities reflected their purpose in terms of making and implementing commissioning decisions. As such, their role was essentially outward-looking and focused on what services needed to be bought for the population. Locales, by contrast, embodied an inward-facing logic based around the development of primary care. They were founded on the idea that local GP practices working closely together would enable mutual support and (most importantly) generate improvement through peer comparison. Both of these logics are defensible, and both were felt to have merit when the CCG was formed, so both were institutionalised into the CCG structure. However, strong *logic* does not necessarily provide clear *function*. Faced with a new structure, and with no clearly set out initial functions, new functions have been projected onto the two layers – hence the profusion of ideas as to what the different layers are *for* and the seeming overlap between the two. These functions now go beyond the original institutional logic for each: locales are not only about mutual self-improvement; they have been co-opted to enable communication with grassroots GPs and local population

intelligence gathering. The result of all this is duplication and potential confusion. This demonstrates how allowing an emergent organisational design, as the HSCA12 did, can result in a new organisation that allows the persistence of existing institutional logics, with the prospect that intra-organisational functions could become confused as a result.

The professional expertise of GPs in CCGs was the basis of the State's appeal to legitimacy in the policy. However, protecting and enhancing the legitimacy and credibility of Notchcroft CCG amongst its members, patients and public, and related organisations was an explicit concern of the governing core. The defibrillator debate illustrates how this concern was a factor under consideration in decisions about budget spending: reputational enhancement was weighed against evidence-based efficacy, a key element of the medical professionalism institutional logic, in the decision making process. This demonstrates how the demands of CCG management can have direct implications for the institutional logics of professional medical practice.

In their extensive study of PbC, Coleman et al. (2009) found that GPs' perceptions of the legitimacy of PbC was a key factor shaping the outcomes of the initiative in a given context. A number of factors encouraged greater sense of legitimacy, for example: 'formal sign up arrangements; a sense amongst "rank and file" GPs that they were being kept fully informed about PbC and its processes' (Coleman et al. 2009, p.54). Whereas others detracted from it, such as: 'perceived excessively tight control by PCTs, with overly bureaucratic processes or a failure to support innovation' (Coleman et al. 2009, p.54). My observations revealed that it was the broader governing core, and not just the governing body, of the CCG that were concerned with protecting and enhancing the legitimacy of "the CCG". The challenge that they face in this regard seems even greater than that of PbC because of the compulsory nature of membership and because CCGs have such a broad range of responsibilities, such as being involved in their local HWB board, and their statutory duty to assist NHS England in 'securing continuous improvement in the quality of primary medical services' (Department of Health 2012, p.6) (see Chapter 9, Section 9.2 for a discussion of this last point).

The Notchcroft governing core made a variety of comments in meetings and interviews about the character of the organisation and its vision. A number of discussions took place

about how best to communicate this effectively to the broader membership so that they would perceive the organisation in the same way. Some of the governing core expressed dissatisfaction about the efforts made to encapsulate this understanding of the CCG into a “little story” that was easy for members and others to understand and relate to—to encourage them to “buy in” to the CCG and what it stood for. However, it became clear that districts in Notchcroft had their own particular identities, interests and histories stretching back at least to the very first primary care-led commissioning initiatives. The different social dynamics and ‘vocabularies of practice’ (Thornton et al. 2012, p.94) between them suggested that they themselves represented sub-sets of different combinations of institutional logics within the CCG, and their distinctiveness shaped the development and form of the CCG itself. The existence of locales in addition to districts provided yet another level within the organisation that individuals could associate themselves with, creating potential for tensions generated by overlapping identities and roles.

The comments from the governing body framing Notchcroft as “a CCG prepared to take decisions that could make it unpopular if those decisions were necessary to benefit patients” appears to serve two purposes. First, to prepare all members for the possibility that the governing body could make decisions that they would be displeased with. Second, to establish the identity of the organisation as one guided fundamentally by acting in patients’ best interests, regardless of the challenges or consequences. There is a degree of righteousness in this, which suggests that even those that disagree with the governing body’s decisions should admire them on the basis from which they were made. Both of these examples speak to attempts to affirm the identity of the organisation, but also serve to establish an identity that might serve as a ‘filter for responding to strategic issues’ (Glynn 2008, p.418), which is coherent with the theory of identity as a strategic resource (see Chapter 5, Section 5.3).

Czarniawska (1997, p.41) argues that a valuable metaphor for the organisation is that of a ‘super person’—‘*homo collectivus*’—founded on assumptions about ‘collectivity and consensus.’ With this comes a need for the organisation to have an autobiography to

explain the nature of its relationship with other persons, both “super” and otherwise.²⁰ The comments from an individual in the governing core about the need for the CCG to have a “little story” that encapsulated its character and goals speaks to this. For the governing core, effectively delineating and projecting the CCGs autobiography was made challenging by the multiple groups that it was simultaneously accountable to and the relationships it held with a multiplicity of stakeholders, such as: providers, GP members, patients, public, HWB, local authority, CSU, NHS England area team. Checkland et al. (2013, p.1) note that ‘the accountability regime to which CCGs are subject to is considerably more complex than that which applied their predecessor organisations’, and that these accountabilities are not necessarily all compatible. From an institutional logics perspective this potential incompatibility can be understood as resulting from the CCG attempting to legitimise itself with a range of stakeholders each of which is associated with a different combination of logics with varying bases of legitimacy.

8.7: Chapter summary

In this chapter I present the membership organisation theme, which overarches and interacts with the three subsequent themes in the chapters that follow, and addresses research questions one and two. Whilst institutional logics are considered in relation to the data, the utility of the approach (research question three) is not considered explicitly.

I discuss Notchcroft CCG’s organisational sub-structure (with two levels of sub-division beneath the governing body), and its unusual form is traced back to responses to previous primary care commissioning initiatives. I argue that districts and locales reflect different institutional logics and, because of this, it was taken for granted that they should be part of the CCG structure when it was established. However, the functions of districts and locales did not make sense in the same way within the CCG. Fieldwork

²⁰ Czarwinawska (1997) claims that this need for organisations in contemporary western societies to establish and maintain identities is itself a reflection of the particularity of individual identity. She argues that individual identity should be recognised as existing in a particular form in its socio-historical context and not dismissed as some fundamental or enduring phenomena. As such, individual identity can itself be understood as an institutional logic, shaped by and entwined with the institutional forces of the state and the market.

revealed overlap and ambiguity in terms of their roles, duplicated activity and the prospect of breakdowns in communication between organisational levels.

In this chapter I also describe how it was the governing core, not just the governing body, that was concerned with getting the wider membership to “buy in” to the CCG and see the organisation as exhibiting a particular kind of identity. This included the nature of being a membership organisation, and the governing core’s understanding of this aligned closely with the national policy presentation. Discussions about commissioning amongst the governing core revealed how multiple institutional logics were called on in order to justify certain courses of action, and these sometimes appeared in tension with each other.

Chapter 9: NHS England: authorisation, assurance, and collaboration

This chapter is concerned with the relationship between Notchcroft CCG and NHS England, particularly the governing core of the CCG and the area team. During an interview three months before authorisation, a CCG manager explained that he understood the nascent relationship with the area team as multi-faceted with four main aspects: holding the CCG to account (*“parent child stuff”*), supporting the CCG to develop (*“to help us be the best CCG we can be”*), co-commissioning (*“...we should be sitting down with them as a co-commissioner beside us and saying, you know ‘let’s plan this one together’”*), and commissioning primary care from member practices [Int_Mng3_Jan13]. He went on to talk about how this relationship was emergent and evolving:

I think none of this is unequivocal, you know, no-one knows exactly how this is going to play out and how exactly it should... I think we need to work these things through together... what’s irritating is when someone thinks they do know the right way of doing it without any discussion.... And that’s what you can’t do because none of this is set in stone, no one knows what the rules are yet, you’ve got to kind of build those rules together. [Int_Mng3_Jan13]

This manager expanded on what he called the *“parent/child culture”*, which he equated with the area team acting as a restrictive and authoritative force upon the CCG. This manifested in things like the area team dictating when meetings between the CCG and the area team would take place and what would be on the agenda, which the manager perceived as symbolic. He stated that he believed that this approach was being driven not by the area team itself but by people in NHS England more centrally, and he suspected that this was likely to change to some degree post-authorisation [Int_Mng3_Jan13]. The extract above highlights the manager’s understanding of the dynamics in the reformed NHS as emergent, developing through interactive practices between organisations interconnected in various ways—the HSCA12 created the possibility for parties, such as the area team, to make unilateral decisions with implications for inter-organisational relationships.

9.1: Authorisation and assurance

The first governing body meeting that I attended, in October 2012, featured a lot of discussion about authorisation. As part of the authorisation process, NHS England conducted site visits with every shadow CCG. Each was assessed against 119 criteria across six domains (see Table 1, p.35) and issued a red, amber, or green (referred to as “RAG”) rating against each [GB_M1_Oct13]. A green rated indicator denoted that the CCG had met the standard defined by NHS England for authorisation, amber indicated that minor steps needed to be taken in order to meet the standard, and red meant that the CCG was failing to meet the standard and would have to produce evidence to show how they had successfully addressed the problem. Notchcroft received a site visit in September 2012 and was issued with red ratings on a small number of indicators [GB_M1_Oct13]. It became clear that the teams conducting the authorisation site visits were partially composed of staff from other shadow CCGs [GB_M1_Oct13]. During a break in the meeting, I spoke to a GP who told me that the governing body and some of the broader governing core were unhappy with the way that one of these assessors had judged the CCG, believing it to be unfair and based on a lack of knowledge on his part [GB_M1_Oct13]. Some of the “reds” that were issued were disputed by the governing core on the basis that, in their opinion, other CCGs were at a similar stage and designated “green”. In November’s governing body meeting, it was announced that NHS England had requested that the CCG submit evidence, within a 10-day time frame, to show how they had successfully addressed the problems associated with the red ratings.

Once authorisation was completed, the CCG became the subject of on-going assurance processes by NHS England, the basis of which is described in detail in Chapter 2 (Section 2.2.2). Concern was expressed at the governing body level in May 2013, one month after successful authorisation, about the extent of assurance processes. A manager remarked: *...that there would be quarterly checkpoints with NHS England and bigger ones annually, and there could be site visits. “It all feels quite extensive”* [GB_M7_May13]. The amount of work required to fulfil assurance related requests was a particular source of apprehension for Notchcroft’s urgent and emergency care service commissioning team (discussed in more detail in Chapter 11, Section 11.2), leading one GP to express concern that it had the potential to have a detrimental impact on the ability of the team to

conduct the work that they were being assessed on [UCT_M3_May13]. A GP aired these concerns with an area team representative at a governing body meeting and was told that assurance processes were *“about capturing what is already being done anyway rather than new work.”* [GB_M8_Jun13]

The governmental policy narrative presented the creation of CCGs as an endeavour whereby GPs would have a key role in developing unique organisations that varied according to local context and need. The White Paper stated: ‘Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality’ (Department of Health 2010, p.28). However, even before the authorisation process began, nascent CCGs were experiencing pressure to conform to a particular organisational form. A report identified that a patient population of less than 100,000 was a threshold below which a CCG might not be financially viable (NHS Alliance/NAPC Clinical Commissioning Coalition 2011). A CCG manager discussed this and explained that he felt that undergoing authorisation had made CCGs more similar:

it was sold as something very creative, and I think probably as a manager you know that it’s going to change a bit but I think in terms of selling it to the GPs it was sold as very creative, you know, “you can get on and do what you want.” [Interview Data]

...

yeah, well I, you know, this kind of “let 1000 flowers bloom and they can all be different, they can all look different” but, you know, the authorisation process has taken us through something... whereby... I mean you have to meet standards and thresholds in order to be a public body and be responsible for public money ...and I don’t have a problem with that at all, but I think it’s probably been a lot more... unifying, you know making us more uniform than anyone would have thought two years ago. [Interview Data]

9.2: The “lever”: ensuring continuous improvement in primary care

At a district meeting in March 2013, during a discussion about primary care performance assessments, a GP exclaimed that he had worked out the dynamic between the CCG and NHS England. It appeared to be a personal eureka moment for him. He explained it to the rest of the meeting:

GP8 said that there is a tension at play -- primary care is commissioned by the NHSCB [NHS England], but the CCG has responsibility for ensuring continuous improvement. ‘That is the lever.’ [Dis1_M3_Mar13]

The same GP then brought up this point at a locale meeting a few days later. He said that he wanted to “*labour*” it so that it was clear to everyone:

...the area team are responsible for commissioning primary care. The CCG commissions most of everything else. The CCG is a membership organisation but it has a role in ensuring continuous improvement—which is the task of the NHS England—of its members and there is an ‘inherent tension’ in this. [LocB_M1_Mar13]

The inherent tension stems from the fact that in order to fulfil its obligations towards NHS England it was necessary for the governing core of the CCG to assess the performance of member practices, and intervene when this was deemed unsatisfactory. Performance monitoring was not foreign to practices in Notchcroft because of the processes involved in some previous clinical commissioning initiatives and the Primary Care LES; however, in the context of the HSCA12, it aligned the governing core with NHS England: an appendage of the state and figure of authority. This threatened to undermine the legitimacy of the CCG as being *of* and *for* the members. There was agreement in a district meeting that one of the responsibilities of the remunerated CCG GP practice lead role (discussed in more detail in Chapter 6 (Section 6.7) and Chapter 8 (Section 8.3)) would be to “*look after*” this lever through the oversight of, and responsibility for, a development plan for their own GP practices, which would specify, amongst other things, areas that the practice needed to improve on and strategies for doing so [Dis1_M3_Mar13].

At the district level, a series of discussions took place about how members of the district board and associated CCG managers should interact with GP practices in order to ensure their continuous improvement. In District 1, where the opinions of locale leaders had been canvassed, a manager reported that: *'...some wanted the CCG to be very visible and to visit practices to this end, others wanted the CCG to be more hands off'* [Dis1_M1_Dec12]. The following exchange between two district GPs relates to this:

GP10: If the CCG is a supportive organisation then contact with other practices should be shaped by this role. The NHS CB [NHS England] are going to be looking at similar info. [to the CCG] – they will target underperforming practices. If the CCG can be supportive to practices that are struggling then it might be 'powerful' if the CCG and the practice can go to the NHS CB and say we've looked at this, these are the reasons things aren't right.

GP8: in general, in this kind of thing, being visible is seen as a good thing. Less visible equals less successful, but there needs to be a 'need' for it, a 'reason.' [Dis1_M1_Dec12]

This extract illustrates how ideas about the appropriate nature of the relationship between the governing core and member practices, in terms of the continuous improvement in primary care lever, were being developed through interactions at the district level. GP8's opinion that the interactions with practices should be related to particular problems that had been identified speaks to a concern that the CCG might be perceived by practices as meddlesome and impinging on their independence.

Overall responsibility within the CCG for primary care performance improvement lay with the governing body but was overseen by Committee 6, which was composed primarily of GPs who also sat on the governing body and district boards, as well as several managers. During fieldwork, the committee was in the process of refining an "achievement guide" that would contain regularly updated GP practice performance data across a broad range of indicators. This would be used by the committee as the basis for providing assurances to the NHS England area team and the CCG governing body about primary care quality. It was also intended as a resource for GP practices to utilise in the creation and maintenance of their own GP practice development plans [Com6_M2_Mar13].²¹ At a committee meeting it was stressed that the achievement guide was to help support GP

²¹ This was in addition to a primary care "dashboard" that NHS England required GP practices to complete for their assessment processes [GB_M8_Jun13].

practices rather than assess them, and consideration was given to the most effective way of communicating this to GP practices:

...this is not a performance tool. We want to support practices 'not give them a hard time.'

GP10 said that if it's a support tool and not a performance tool it's about how you tell the story. If you don't get the story right then 'suffer the consequences.' [Com6_M1_Jan13]

The desire from committee members for the achievement guide to be seen as tool for practice support played into a decision to change the red and green colours on indicators to a status bar [Dis1_M3_Mar13] because there were concerns that red could be interpreted as being, in the words of one manager, '*too punitive*' [Dis3_M2_Apr13]. Discussions about the construction of "*the right story*" to tell practices about the guide also occurred in district meetings where there was a sense that practices might not be receptive to it, seeing it as yet another addition to their heavy workload:

GP21: It all depends on how you sell it. If it's sold as "pulling everything together" ... (that would be best?) [all indicators in one place rather than multiple places]. That doesn't come out in the letter enough. GPs often don't read things carefully – at least I don't.

GP5: It's going to be important that locale leads explain this well to their locales. [Dis1_M2_Jan13]

This extract illustrates how the governing core, at various tiers of the organisation, was actively mediating information relating to GP practice monitoring and its presentation to those GP practices. However, an interview with a Notchcroft GP outside of the governing core revealed that she felt far from supported by the CCG and associated it more with '*a job to do, not a support for the practice*' [Int_GP11_Nov13]:

CCGs are notionally the practices or whatever but erm but the CCG is not there to support the practices...

the CCG feels like it's there to give us work to do as a salaried GP that's what it feels like, that's all I feel like I get back from the CCG. [Int_GP11_Nov13]

9.3: Specialised service commissioning and collaboration

Under the HSCA12, NHS England was given responsibility for commissioning a variety of specialised services (143 in total, including: cardiac surgery, secure mental health services and neo-natal care (NHS England 2014b)) in addition to primary care, dentistry, and ophthalmology. The rationale for this was that certain services were required by a relatively small number of patients over a broad geographical area, were high cost, and required specialist centres and staff to deliver, which meant that they would be prohibitive for CCGs to commission. Specialised commissioning became the purview of 10 of the 27 area teams. The costs of specialised commissioning were estimated in 2013 to be approximately £12 billion per annum, around 10% of the total NHS budget (NHS England 2013a).

A non-governing core GP explained that he believed that specialised commissioning had implications for the CCG's ability to effectively pursue the best interests of its patients. He reflected on treatment for certain types of cancer and noted that when cancer patients reached a point in their care they might be referred to a regional oncology centre, which was commissioned by NHS England as a specialised tertiary service. He highlighted that, because of this, should Notchcroft discover problems with the treatment of its patients within the tertiary service, the CCG would have to identify the correct person to speak to at NHS England (which was not always straightforward at this time of organisational flux and development) and bring their attention to the issues. However, Notchcroft CCG's perspective of the provider would only be one amongst a number of other CCGs' perspectives, and they might not identify similar problems affecting their own patients. Notchcroft CCG's concerns might not, therefore, prompt NHS England to take action and persuade the provider to alter their practices. Ultimately, Notchcroft would have little influence with the provider because the CCG did not hold a contract with them: *'How would we engage with that? I don't know the answer'* [Int_Oth5_Dec13].

Precisely this dynamic was the subject of discussion during a committee meeting in February 2013. The CCG had received the outcome of a *"peer review"* of local and regional cancer service trusts, which revealed that some of the hospitals had problems being *"able to identify acute oncology patients"* (which attendees expressed shock at),

along with breached waiting time targets for chemotherapy treatment [Com5_M2_Feb13]. There was uncertainty within the committee as to how the CCG had obtained this report and how they would be kept informed about related developments in the future. The following extracts illustrate the confusion around how the CCG would fulfil its responsibilities towards its patients and the communications processes with NHS England and specialist hospital trusts:

Oth6 said that he wanted to know how the CCG actually got the letters [about the outcome of the peer review] in the first place because they were addressed to [PCT chief executive] and [NHS England area team director]. He is concerned that in the future, with the changes underway, that these letters might end up in a post box that nobody opens.

GP1 said that part of the problem was that they weren't commissioning the service – the [NHS England area team] were in charge of commissioning chemo but these are the CCGs patients for which the CCG are responsible.

Oth7 says that she assumes that in the future it will be the [area team's] responsibility to disseminate info to CCGs...

GP1 said that he wondered if they should be working through the [area team] rather than the Trust as they are the commissioner.

Mng6: 'This is a test of the new system.' You're the commissioner [i.e. NHS England] but we're responsible for the patients.

Oth7: We need to understand who in the [area team] is picking them up.

Oth8 said that they might need to be more specific – direct the communications to specialist commissioning [a unit of NHS England that operated across area teams at a more regional level]. [Com5_M2_Feb13]

An exchange in a governing body meeting revealed that there was a lack of clarity about whose responsibility arranging care for certain groups of patients was. One example was mental health services where it was unclear which organisation should be orchestrating services for those *"in transition"* to adulthood from *"16 to 18 years"* old [GB_M5_Mar13]. During an interview, a non-governing core GP claimed that this kind of confusion about where responsibility lay between NHS England and Notchcroft was palpable for her practice and would hamper the ability of the CCG to affect service change [Int_GP12_Nov13]. A CCG manager expressed concerns that patients visiting trusts in Notchcroft for specialist care could *"fall in gaps between organisations"* if it was not

explicitly clear to NHS England and the CCG whose responsibility they were [Com5_M1_Dec12].

Post-authorisation, the NHS England area team took on statutory commissioning responsibility for the GP practices in Notchcroft and established a primary care commissioning team. The role of the Notchcroft CCG primary care management team, which was already well established and overseeing the Primary Care LES, overlapped and intersected with this. A CCG manager reported a positive and close working relationship. However, a problem arose when the NHS England primary care commissioning team planned to send a letter to all Notchcroft member GP practices requesting performance management data, which GP practices were already supplying in a slightly different format to the CCG primary care team. There was concern amongst this section of the governing core that GP practices would think that they had to effectively double their performance data reporting workload by supplying the CCG and NHS England area team the same data but in two different formats. In fact, the data that they were supplying to the CCG was sufficient to cover the requirements of the NHS England team as well but the letter did not reflect this. Before the letter was sent, the CCG primary care management team had requested that the NHS England team put out a joint letter instead, which would provide additional local context and explain all of this to GP practices. The NHS England team refused, explaining that the letter was produced at the national level and they were obliged to send out this standardised version. Instead, the CCG primary care team sent a follow up email to all CCG GP practices 10 minutes after they had received the one from NHS England. The email from the CCG's primary care team effectively translated the content of the area team's email to make it locally relevant and pre-empt the concerns of GP member practices. This was also done in the interests of maintaining a good relationship between the governing core of the CCG and those GP practices.

9.4: “Be brave and bold... but don’t step out of line”

I don’t think NHS England know who they are or what they want to be or what they are. I think they’re all busy the different aspects are busy jockeying for dominance for authority and power and influence and control erm and they want everything to be different 'cause we’re CCG not PCT so they keep telling us be brave be bold do what works for you but on the other hand don’t dare step out of line too much. We only want you to be brave or bold in this capacity and don’t do this and do that and do the other. So they’re they’re totally erm split. On the one hand they’re telling us to do something erm unique erm carry out the Act as it was intended but on the other hand don’t carry it out too much because really we still need to be in charge.
[Int_Oth3_Nov13]

The extract above from an interview with a governing body member highlights his perception of the inconsistencies in the NHS England area team’s behaviour. The area team appeared to be unsure of its identity and pre-occupied with trying to legitimise itself through increasing its control over the organisational field—an example of this is provided in a later chapter in relation to the urgent care system (Chapter 11, Section 11.2). The area team’s communication with the CCG was consistent with the key messages of the narrative of the reforms, as explained in Chapter 3, but its actions did not appear to align with this. This can be explained because the legitimacy of the area team was bound up with its exercising of authority over CCGs. Of relevance to this is that a number of staff from the PCT, including a very senior figure, had taken up posts with the area team
[GB_M2_Nov13].

The same interviewee said he believed that the area team was not aware that a redistribution of power had taken place as a result of authorisation. He understood that the CCG becoming a statutory body on April 1st 2013 meant that the area team should no longer see itself as the dominant party in the relationship. In the first post-authorisation governing body meeting in April 2013 the dynamic of interaction between governing body members and the representative from the area team felt more tense: governing body members asked abrupt questions of the area team representative, and pressed him to clarify his answers; his voice wavered and he seemed more hesitant in his responses than he had in previous meetings. One area of questioning related to a local hospital where a lot of patients from one of

Notchcroft's districts attended. The area team had instigated a quality review of the hospital but without consulting or informing the CCG, or the district, directly. After fielding a series of forthright questions and complaints from one of that district's GPs, the area team representative left the meeting:

[Area team rep] collects his things and thanks the CCG for having him. He says that in the future people would be welcome to submit questions to him ahead of time so that he can give more extensive answers. [I think again what a strange and awkward dynamic it is for him to come to this meeting be grilled and then leave – it's like he's on trial.]

[Area team rep] leaves the room. There is some muttering that I can't hear. [I see a look that GP1 is giving someone that makes me wonder what he thought of that whole exchange – he looks somewhat sceptical and unimpressed.] [GB_M6_Apr13]

There was awareness from that district's members, expressed at the following district meeting, that the treatment of the area team representative had been firm:

GP18 said that she didn't think that the [NHS England] area team would do something like that again after the governing body meeting yesterday [and GP19's questioning of the area team rep]. She laughed a bit.

GP19 asked if she had come across as being firm when she talked to [area team rep] and GP18 said that she had. GP19: Oh, good. [Dis2_M2_Apr13]

These last two extracts relate to the relationship between the CCG governing body and the NHS England area team pre- and post-authorisation. I perceived a change in the atmosphere of governing body meetings post authorisation. In the first such meeting, governing body members' questioning of the area team representative was more combative than I had witnessed previously, which suggests a process of relationship re-negotiation through interaction. I witnessed the story of this interaction, and its potential significance to the relationship between the organisations, being relayed to others in the governing core at the district level of the CCG.

9.5: Conclusion

Successfully negotiating the authorisation process was a requirement for all CCGs in order to establish themselves as statutory organisations. From an institutional logics perspective, processes of authorisation and assurance represent sets of material practices that CCGs were required to successfully engage with in order to legitimate themselves within the organisational field. The fourth domain in both the authorisation and assurance assessment frameworks (see Table 1 and Table 2, p.35) related to the membership organisation concept and the norms underpinning it. CCGs had to demonstrate that their member GP practices were broadly supportive of the organisation, and that the CCG had established governance systems that provided democratic mechanisms whereby members could exercise their rights to shape the organisation and the governing body. As such, some of the key explicit and implicit messages of the policy narrative were transposed into a formal legal framework legitimated by the state. Furthermore, CCG members were co-opted into the bureaucratic processes associated with this and helped to assess the readiness of other CCGs. While this may have been necessary and beneficial (to both the objective of the authorisation process and the individuals from different CCGs, e.g. getting to see how others are doing things), it does represent a blurring of the boundaries between local CCG membership organisations and governmental bodies. One of the effects of authorisation, and the processes of organisational establishment that occurred along with it, was the exertion of force on CCGs to become more similar in character—what DiMaggio and Powell (1983, p.150) refer to as ‘coercive isomorphism’—which contrasts with the initial emphasis in policy rhetoric on CCGs having a great deal of control over their developing form and operation to suit their local context.

The “lever” of ensuring continuous improvement in primary care represents a governance tool that embeds the performance management logic associated with NHS England into the intra-organisational dynamics of Notchcroft CCG. The appropriate way to approach carrying out this function was the subject of debate at the district level. There was concern that GP practices would feel criticised and unduly harassed by the governing core of the CCG, that they might come to associate the CCG with the authoritative presence of the state. In this context, the governing core of the CCG explicitly considered how its

interactions with GP practices, predicated on assessment, should be presented to the members—what was the right story and how should it be told? The tension was one between the CCG as an inclusive and representative enterprise and the CCG as a critical assessor of practices and a source of additional work.

The division of responsibility between NHS England and Notchcroft CCG for commissioning particular services was a cause of confusion and concern. Confusion stemmed from a lack of clarity about whether commissioning for certain groups of patients was the remit of one or the other, and ambiguity over the most appropriate approach for clarifying this given the organisational uncertainties prevalent in both the CCG and the NHS England area team around the time of CCG authorisation. There was concern expressed by the CCG governing core about groups of patients “falling between gaps” in commissioning and this not being identified until harm had already been caused, but also that the CCG would lack sufficient influence over the specialist providers that NHS England were commissioning and be hamstrung in their duties to look after the wellbeing of their patients. The NHS England primary care commissioning team’s communication with Notchcroft CCG GP practices was dictated nationally. Consequently, the CCG primary care management team felt the need to actively translate the content of such communications for member GP practices in order to make their local relevance explicit. The purpose of this translation was also to reduce the likelihood that GPs would become aggravated with “the CCG”, which would further hamper efforts to elicit member “buy in.”

The NHS England area team’s relationship with Notchcroft CCG was multifaceted, incorporating assessor, commissioner, and co-commissioner. Elements of its role were highly resonant with the performance management duties of the PCT, and a number of PCT staff members had migrated into the area team as a result of the changes associated with the HSCA12. Some of the Notchcroft governing core perceived a gap between the tone of communications, espousing the policy message of local empowerment, and behaviour from the area team towards the CCG. From an institutional logics perspective, this can be understood as an example of loose coupling (Thornton et al. 2012) or organisational cognitive dissonance. One

governing body member perceived this as the result of an attempt by the area team to protect their relevance in the reformulated organisational field.

9.6: Chapter summary

In this chapter I consider the multi-faceted relationship between the CCG and NHS England, addressing research questions one and two. I describe how Notchcroft CCG's governing core managed systemic forces that threatened to undermine their efforts to elicit member "buy in" to the membership organisation vision. This involved actively mediating communication from the NHS England area team to GP practices, and tailoring their own approach to communicating with GP practices in the context of performance monitoring. This was part of their responsibility towards NHS England—"the lever"—to assist in the continuous improvement of primary care.

Some of the governing core perceived a disjuncture between communications from the area team, which were consonant with the policy message of CCGs as autonomous membership organisations, and their behaviour towards the governing core, which was dictatorial. I hypothesise that this was a result of the area team feeling it necessary to assert their legitimacy in the organisational field.

Chapter 10: NHS 111

This chapter focuses on the story of a centrally imposed and nationally standardised service that was handed to CCGs to implement locally. It is divided into three sections: first, the NHS 111 urgent telephone service is introduced and explained; second, the preparations for launching the service in Notchcroft are discussed; third, the story of the service launch, both locally and nationally, is told. In this chapter, particular care has been taken to protect the anonymity of participants. As such, various details have been generalised or omitted. This process has resulted in a change to the conventions of identifying data extracts employed in the rest of the thesis. The general [Interview data] is preferred to more specific data extract descriptors.

10.1: NHS 111: a new, national urgent care telephone hotline

NHS 111 is a free to call national telephone line for urgent but non-emergency care, open every day of the year. The impetus for a service of this kind emerged from recommendations in the “Our NHS, Our future” report (Department of Health 2007), which suggested it would reduce levels of patient confusion about accessing appropriate unplanned care outside of GP opening times. When the Coalition Government came to power in 2010 they stated a commitment to a new 24/7 urgent care line in the *Equity and excellence: Liberating the NHS* White Paper (Department of Health 2010). In August 2010, the Government announced, to some public dismay, that this new service—NHS 111—would replace NHS Direct (BBC News 2010b), a nurse led telephone health advice service that had been in operation since 1998. The launch date was set for April 2013.

The form and function of NHS 111 was specified nationally: calls would be answered by an “advisor” who would ask a series of questions using a computer decision support service called NHS Pathways (Turnbull et al. 2014). This tool would use an algorithm to determine the appropriate course of action for a patient’s clinical need, referred to as a “disposition”: a direct booking of an ambulance in an emergency situation, a booking or referral to a service for a face to face consultation, information or advice, or signposting to an alternative service (South West NHS PCT Cluster 111 leads 2012). When a referral was required, advisors would have access to a Directory of Services containing a range of

information about local services. Advisors would share a call centre with a nurse whom they could consult if they were unsure of the correct disposition in a given situation. The NHS 111 service specification identified four core principles: '1) Completion of a clinical assessment and information on the first call without the need for a call back. 2) Ability to refer callers to other providers without the caller being re-triaged. 3) Ability to transfer clinical assessment data to other providers and book appointments where appropriate. 4) Ability to despatch an ambulance without delay' (NHS 111 Programme Team 2011, p.2).

The DH announced that the contracts for the service would be put out to tender across 46 regions in England. The procurement process was the responsibility of PCTs, and then PCT clusters (see Chapter 2, Section 2.2.1), once they had formed, with input from shadow CCGs in some cases. A pilot scheme was launched across four sites in 2010 (Turner et al. 2012), followed by another eight sites in August 2012 (NHS England 2013b). National responsibility for the service was handed over from DH to NHS England in November 2012 (NHS England 2013b). Contracts were awarded in 2012 and won by a mix of different providers: commercial organisations, ambulance trusts, out-of-hours providers, and social enterprises. These contracts factored costs per call of around £8, a significant reduction of the £20 per call cost of NHS Direct (Calkin 2013). This was made possible by a reduction in the number of clinical call centre staff, justified by the use of NHS Pathways (NHS England 2013b). CCGs were responsible for "mobilising" the service locally to meet the April 2013 launch date and were liable to face fines of £25,000 per day for delays for which they were at fault [GB_M3_Dec12]. The cost of the service was also CCGs' responsibility but this was justified on the basis that NHS 111 would reduce demand for accident and emergency services as a result of directing patients to the appropriate care and this would offset the cost, although data from the pilot sites failed to provide evidence that this was the case (Turner et al. 2012).

10.2: Local preparations

In October 2012, NHS 111 appeared in the agenda of a Notchcroft CCG governing body meeting for the first time. A number of governing body members reported knowing nothing about it and requested a paper to be presented on it [GB_M1_Oct12]. It became one of the most discussed topics at meetings I attended until around May 2013.

Notchcroft assembled a mobilisation team, which included GPs and managers, which took responsibility for launching the service. One of the main tasks of the mobilisation team was to raise awareness of the service and its launch amongst the membership, which proved a time consuming process. They attended numerous different committee, district, and GP practice meetings. Every general practice needed to be well informed because they would have to make changes to their systems, for example: out-of-hours answer phone messages had to be changed on the launch day to tell patients to hang up and call 111 instead of connecting to the out-of-hours provider, and an NHS.net email account would need to be monitored for “post event messages” each time one of their patients called the service.

The national launch window for NHS 111 was February to April 2013. Twelve pilot regions were up and running at this time but the vast majority, including Notchcroft CCG’s region, were set to launch during this period. The Government NHS 111 team requested a “soft launch” of the service. This meant that NHS 111 would not be advertised and calls to existing services would be routed to NHS 111 so that it was only necessary to deal with existing call volumes. In the months leading up to April 2013, Notchcroft CCG was primarily occupied with ensuring that they would successfully meet outstanding authorisation conditions, and minimal attention had been devoted to NHS 111:

...it just hadn’t hit the radar, because the CCGs as organisations were so busy setting themselves up that they hadn’t seen this meteorite that was coming at them and so hadn’t really put any effective mobilisation in place. [Interview data]

The difference in geographical area covered between NHS 111 regional contracts and CCGs proved problematic. Each CCG in the region needed a mobilisation team in addition to a regional team. The latter already existed but had been severely weakened because it was composed primarily of PCT staff: *‘...so the people who knew all about it left, new people came in and had to play catch up’* [Interview data]. Consequently, it was essential for representatives from each CCG in the region to quickly develop working relationships and processes with the mobilisation teams of other CCGs; this was a difficult task because CCGs were not yet established. The head of the regional mobilisation team was a PCT director who was facing redundancy when the PCT was abolished in March 2013:

...none of the CCGs had realised the fact that when he'd taken his redundancy and left there was nobody who was going to implement it at all. And so, one of the first things that [we] had to do was get the CCGs to say we need to sort that out, and that again was cobbled together. [Interview data]

This problem was solved in early 2013 by this person becoming an employee of one of the CCGs. It was also unclear to the CCG mobilisation team how the fines of £25,000 per day would be levied (i.e. per CCG? Split across the region?) should CCGs be responsible for delays in the launch of the service—the processes for holding CCGs to account did not map onto the NHS 111 regional demarcation.

There was considerable negativity and scepticism towards NHS 111 from GPs. It became clear to Notchcroft's governing core that some members thought that NHS 111 was the first major act of the new CCG and not a national policy. This clearly had the potential to undermine the idea amongst the broader membership that the CCG was a grassroots champion of the local health professional. It threatened to diminish the stock of credibility that the governing core believed they enjoyed and needed to build on. The most effective way to "sell" [GB_M3_Dec12] NHS 111 to GPs was discussed in governing body meetings and it was decided that a key message must be that the Government imposed the programme. This was emphasised in many meetings, particularly during CCG-wide engagement events [CCG5yr_M1_Jan13].

GPs involved in implementing NHS 111 were in a particularly dissonant position because their professional beliefs as GPs about the service conflicted with responsibilities for overseeing it. On the issue of explaining NHS 111 to members one said:

Yes, it took a long time to get that message through, and it was a very careful balance between getting that message across and not just going, "I'm only doing it because the Government said I've got to do it," and not whining about it. [Interview data]

Attending a variety of meetings provided an opportunity to observe how Notchcroft's mobilisation team adjusted the language and tone of communication for different audiences. District meetings were often an opportunity for members to talk in a less

calculated fashion. In one, approximately three months before the launch, a mobilisation team member revealed that he found the details in the launch plans for the service ‘worrying’, [Dis2_M1_Dec12] yet in the public governing body meeting the day before he had been more optimistic in tone. He revealed that a manager had suggested he present a ‘positive and in control message’ at the governing body meeting [Dis2_M1_Dec12]. A candid exchange between a GP and a patient representative at a district meeting provided insights into the GP’s thoughts on his perceptions of the objective of NHS 111. The patient representative had just relayed a story about an unsatisfactory call to NHS Direct some years before; the GP responded:

‘This will be worse. Factual evidence suggests that it isn’t going to work in the way it is supposed to (i.e. reducing emergency admissions and saving money) but it is being ignored. NHS Direct turned out to be very expensive, but the Government can’t just get rid of it [because there would be an outcry?]. It’s cheaper to de-skill the service... and then get rid of it. “NHS Direct was an expensive luxury that didn’t work and we can no longer afford”’
[Dis1_M1_Dec12]

In one governing body meeting, a member of the mobilisation team was explaining the process of what should happen when a patient calls NHS 111. He used the term ‘*patient disposition*’ and someone joked that it sounded a lot like ‘*patient disposal*’, prompting laughter from attendees [GB_M3_Dec12]. A representative from a local anti-privatisation campaign group sitting to my right turned to me and commented that this was a ‘*Freudian slip*’ [GB_M3_Dec12]. The mobilisation team member laughed and commented that he felt awkward using the “official” terms but the central NHS 111 mobilisation team insisted on it.

In the weeks leading up to launch in Notchcroft, a staffing review of the provider had been conducted by NHS England and not identified any problems. Just weeks before the launch, the telephone system of the provider was tested by activating the lines for a period of several hours. This revealed a lack of capacity but the provider conducted a root cause analysis and assured Notchcroft that the issues had been resolved. NHS England requested to see the data and analysis conducted by the provider and was satisfied that the issues had been rectified [GB_M5_Mar13].

10.3: Service launch

Many regions across England experienced problems shortly after launching: calls went unanswered or patients were kept on hold for extended periods (Johnson 2013). In many cases the problem lay with the capacity of the providers, who had underestimated the average length of calls (Roberts 2013). The NHS 111 service in Notchcroft's region, and in numerous others, was suspended within the first days of operation and contingency plans had to be implemented within each CCG. The service then resumed but at a drastically reduced capacity and in parallel with alternative services [GB_M6_Apr13]. Notchcroft CCG and others in the region were exonerated of any responsibility for the failure because it was due to problems experienced by the provider.

Easter weekend 2013 (March 29th – April 1st) proved a particularly difficult time in several regions—three deaths and 22 “Serious Untoward Incidents” occurred (Kaffash 2013). NHS England commissioned an independent review into the problems of the service launch. The report found that for areas experiencing provider related service failures the ideal response would have been to reinstate GP out-of-hours services but this was not always possible as many were decommissioned or had their staff levels reduced to coincide with the launch of NHS 111 for cost reasons (NHS England 2013b). This also meant that some PCTs and CCGs (CCGs were only legally responsible after becoming authorised in April 2013) were effectively forced to launch NHS 111 despite having concerns about the readiness of the provider because their GP out-of-hours services had been wound down. The report also noted that the findings of the pilot study, that ambulance call outs rose in the pilot sites by approximately 8% over a 13 month period compared to 3% in the rest of England (Turner et al. 2013), had not been used in order to improve the service pre-launch. It was noted that concerns raised by professional associations and local mobilisation teams, including Notchcroft CCG's, were valid but not acted on by the central NHS 111 team (NHS England 2013b).

After the failure of NHS 111 to launch successfully, the CCGs in the area came together and agreed a joint position on conditions of a re-launch to present to NHS England. They would argue that across the region, service providers (whether out-of-hours GPs or others) should be able to re-triage callers that were diverted through NHS 111 rather

than them having to act on the basis of the NHS 111 computer assisted triage. One of Notchcroft CCG's governing body members believed that, as a group of CCGs, they were then in a more powerful position to negotiate because they had had some time to develop relationships. It had already been made clear by NHS England, however, that the term "re-triage" was not to be used: "definitive clinical assessment" was to be used instead, perhaps because one of the core principles of NHS 111 was for there not to be a need to re-triage (NHS 111 Programme Team 2011, p.2).

NHS 111 came to be seen as farcical by a broad range of GPs and CCG members. It was widely perceived that the DH and NHS England had had no interest in the evidence from the pilot and were intent on pursuing the service in the form that they had decided on. NHS 111 was used on a number of occasions as the punch line of a joke. One such incident, around two months after launch, occurred at a regional level meeting involving representatives from all regional CCGs and a number of other organisations, such as local authorities. The 80 or so attendees were asked to imagine being a frail 85 year old with co-morbidities and to shout out what they would want from an urgent care system. The answers, including *'timely access'*, *'someone visiting that I know'*, *'better integration'*, were written on a flip chat. Someone said *'to know where to get the right information day or night'* to which another responded *'111'* and the majority of the room burst into laughter [UCT_M2_May13].

10.4: Conclusion

NHS 111 was a highly prescriptive, top-down policy initiative. Its presentation by Government was on the basis that it would make the process of accessing the appropriate care outside of general practice hours more straightforward for patients; this would have the knock on effect of reducing unnecessary A&E admissions and making the health service more efficient and cost effective. Notchcroft CCG was handed responsibility and accountability for launching the service locally after a provider had already been commissioned. The CCG had little control over how the service would be delivered; and the mobilisation team had to ensure that Government requirements, initially from the DH and then NHS England, were met. This undermined one of the core principles of the HSCA12: in this scenario, the empowerment of local health professionals

to control their local healthcare environments was notably absent. Crucially, NHS 111 actually undermined the efforts of the governing core of the CCG to establish their legitimacy and generate “buy in” amongst the members to the idea of being an active part of the membership organisation because some thought that it was a CCG initiative. The mobilisation team and governing core devoted considerable time to raising awareness of NHS 111 amongst the broader membership at multiple organisational levels and emphasised that this was not the case. Furthermore, the implementation of NHS 111 occurred at a time of profound flux in the health service. Notchcroft, like every CCG in the country, was busy ensuring that they would be successfully authorised, and preparations for the local launch of NHS 111 had to compete with these processes. Another way that NHS 111 undermined the aims of the HSCA12 in relation to CCGs was that it was designed on the premise that patients’ needs could be identified and dealt with by non-clinical call handlers using a computer based decision making protocol, and the behaviour of healthcare professionals should be based around these initial judgements. This is the antithesis of the locally attuned professional knowledge that the HSCA12 valorised and CCGs were intended to embody.

From an institutional logics perspective, the policy presentation of NHS 111 resonates with the institutional logic of patient-centred choice in its assumptions that better information access for patients would lead to a reduction in the inappropriate use of emergency services and, therefore, increase efficiency in the NHS. A national level team oversaw the NHS 111 implementation process. They specified a particular ‘vocabulary of practice’ (Thornton et al. 2012, p.159) for the policy that CCG and regional mobilisation teams were required to adopt. This included terms, such as “patient disposition”, to describe the decision about what kind of care a patient requires as a result of a call, and “post-event message”, to describe the multi-page report emailed to a GP practice whenever one of its patients called the service. The tone of such language is generalising and objectifying and suggests a connection to a performance management institutional logic. I observed examples of this language having a jarring effect on those in the CCG governing core, where a medical professionalism logic was prominent. Those in the CCG mobilisation team sometimes expressed recognition that the terminology they were required to employ when talking about NHS 111 was not consonant with their usual vocabularies or practice when communicating within the CCG. This was part of a broader

challenge for the mobilisation team in reconciling the dissonance between their professional and CCG identities with their identity as a an implementer of NHS 111.

10.5: Chapter summary

This chapter, relevant to answering research questions one and two, concerns the NHS 111 urgent care telephone line: a national policy that CCGs were given full responsibility for launching. NHS 111 undermined key principles of the HSCA12 as it had significant implications for the local health systems that CCGs were supposed to have autonomous control over. CCGs had little influence over how NHS 111 would operate locally, and the launch date set by Government coincided exactly with CCGs' busy final preparations for authorisation. NHS 111 was not well received by Notchcroft GPs, and this undermined the governing core's efforts to encourage these GPs to "buy in" to the organisation because many thought it was a CCG initiative. Some of those in the governing core involved in launching the service experienced identity dissonance as a result of a clash between their opinions about the service as GPs and their responsibilities for overseeing its establishment.

Chapter 11: Commissioning activities

This chapter is focused on the commissioning activities of Notchcroft CCG. The three themes presented below were selected on the basis that they each relate to particular dimensions of the objective and research questions. They attend to: how those in the governing core conceived of themselves as commissioners and the necessary mind set for such a role; formal and informal responsibilities of and within the CCG (with particular attention to urgent and emergency care commissioning), which reveals how official commitments were interpreted and enacted; and, competition and patient choice, which focuses particularly on key concepts presented in the HSCA12 itself.

11.1: “Do we think as GPs, as practices, or commissioners?”

GP17 pondered on the appropriate mind set for making such decisions: “do we think as GPs, as practices, or as commissioners.”

GP18 added that it was important to be thinking as all three, as “clinical commissioners.” [Com6_M1_Jan13]

The above extract from a committee meeting relates to a discussion about whether handheld Doppler devices (to assess lower limb circulation) should be procured for all CCG GP practices. The interaction demonstrates how the commissioning endeavours of the CCG were being constructed and developed inter-actively by the governing core. GP17’s comment suggests that he recognised himself as having three identities—GP, GP practice, commissioner—and that these were associated with different ways of thinking or mindsets, which may not be simultaneously compatible (Thornton et al. 2012). GP18’s response was that being a clinical commissioner involved combining these into one mindset. In practice, there were a number of examples where the logics associated with one or another of these identities appeared at odds. The following extract suggests an assumed distinction between thinking from a commissioning perspective, which is equated with finances in this case, and thinking from a clinical perspective:

Oth9 said that he had concerns about 'follow ups' because they seemed like a license to 'print money.' Some contracts will over perform and there's a danger of getting 'nasty surprises.'

Oth3 said that he felt 'from the voice of the patient' that follow-ups were reassuring.

Oth9 said that he was only thinking about this from a commissioning perspective. [Com4_M1_Jan13]

In another committee meeting, a GP explained that what defined clinical commissioning was the first hand, professional knowledge of local healthcare contexts that they possessed:

GP6 said something about having more 'soft intelligence.' [I think he was saying that clinical commissioners had more soft intelligence about what was really going on than external assessors.]

GP20: "We know what it's like to work in those places. We've worked on the ground, and that's what clinical commissioning is all about."
[Com5_M3_Apr13]

Some governing core GPs that were heavily involved at multiple levels of the organisation found that they had to scale back their clinical sessions in their GP practices in order to accommodate a growing CCG-specific work load. Even before the CCG was authorised, one governing body GP told me that she had to drastically reduce her clinical sessions because the extent of CCG commitments had '*snuck up*' on her [Dis1_M2_Jan13].

11.2: Responsibilities

This theme focuses on the commissioning responsibilities of the CCG, both formal and informal, and the interactions and social practices associated with these. CCGs had a range of formal duties enshrined in statute as part of the HSCA12. One of these was the responsibility for spending the majority of the English NHS's commissioning budget. As discussed in Chapter 3, this redistribution of responsibility from PCTs to GP-led commissioning organisations was framed as logical primarily because of the local knowledge and professional expertise of GPs. However, a range of people in Notchcroft CCG (both within and outside of the governing core) expressed the sentiment that the

responsibility was essentially a “poisoned chalice” because of financial constraints and broader changes to the NHS that the HSCA12 introduced, CCGs were “made to fail”. A GP expanded on this perspective during an interview:

I think that the the general thrust of the policy is to try and actually create something which doesn't work so that in a few years' time the government can say well you know we tried everything else GPs said you know we can we can deal with it so we called their bluff and have now made them deal with it they haven't succeeded. [Int_GP10_Aug13]

A CCG manager identified that the HSCA12 had brought about an increase in the number of organisational players (including commissioners and service providers) within the healthcare system, and that the “*footprints*” of these players was now more varied than before the reforms. He believed that this would create challenges for the CCG [GB_M3_Dec12]. One of Notchcroft's districts was primarily composed of practices with many patients that lived in areas outside the CCG's boundary. When these patients were referred to a hospital it was usually one that was more closely affiliated with neighbouring CCGs because they were closest to where they lived. Notchcroft CCG, and the single district whose patients were commonly treated outside of Notchcroft boundaries, had little input into the negotiation of contracts with these hospitals and, consequently, had little control over their activities. This was a source of concern for Notchcroft members in the relevant district because they felt that they lacked influence over the care that those providers delivered to the patients that Notchcroft CCG was responsible for. This speaks to a broader tension in the CCG model; not only was the CCG responsible for commissioning services, but also the care that the CCG's patients received irrespective of where it was delivered or whom it was commissioned by. This was a consequence of the organisation being comprised of individual GP practices that together had a duty of care over the entire population of Notchcroft.

Discussion at a committee meeting centred on the responsibilities of the CCG in terms of policing trusts' performance. A manager explained that his understanding was that the CQC were ultimately responsible for trusts' performance and it was the job of the CCG “*to note and keep an eye on how they are doing*” [Com5_M3_Apr13]. One GP committee member noted that a recent CQC visit to a local hospital trust had resulted in a ‘*glowing report*’ but a two hour trip to the trust by some of the

CCG's governing core had revealed multiple, significant problems: "*I think we need to do more than just note*" [Com5_M3_Apr13]. This incident suggested that the governing core of the CCG felt that their responsibilities for monitoring trust performance would have to extend beyond what was officially laid out in guidance because they were better placed to assess problems with *their* local trusts (which would impact on their patients) than a centralised assessment organisation.

At the first post-authorisation governing body meeting, a discussion took place about the need for the CCG to be protective of its domain of responsibilities and to be aware that other organisations might try and take control from them:

Oth3 said that in terms of keeping control of decision-making he thought it best to start off 'extra tight' as lots of organisations would want to take decision-making away from the CCG, and as Notchcroft was the 'major health player' [it should make sure it keeps control even if that puts other CCGs out?]

GP7 said that he agreed and encouraged other governing body members to support this idea. [GB_M6_Apr13]

An example of this occurred in relation to urgent and emergency care, which was explicitly identified as one of CCGs' commissioning responsibilities in the HSCA12. An urgent and emergency care programme team, composed of governing body GPs and CCG managers, was established within the CCG and held weekly meetings where they assessed the performance of local trusts and considered how the urgent and emergency care system could be improved. The team were instrumental in establishing a regional network with other local CCGs, local authorities, care providers and trusts for the purpose of co-ordinating care across the region. In May 2013, during one of the team's meetings, a discussion took place about attempts by the NHS England area team to establish some kind of regional urgent care "*oversight group*" [UCT_M3_May13]. Members of the team were concerned that this would actually function as a board at a level above the network that they had helped to establish and disempower the CCG:

Person A: "I think there's a danger that it could easily become top-heavy [i.e. top down control, if it became a board] if CCGs let it.

... I think once it's defined as a board and we have to go and present to it we've lost."

Person B: "They can't pass the terms of reference if they haven't been seen and approved by everyone [all CCGs in the area] can they?" [UCT_M3_May13]

They hypothesised that the area team's actions could be influenced by Notchcroft's neighbouring CCGs being less *"on top of"* urgent care commissioning and management and, because of the regional level relevance of urgent care, Notchcroft were being *"tarred with the same brush"* [UCT_M3_May13]. One of the urgent care team suspected that the area team were pursuing the development of the group because they were *"desperate to look good to the [name of higher regional tier] of [NHS] England"* [UCT_M3_May13]. In the same meeting, another team member reported that at a recent strategy event the regional ambulance service had *'thrown their hat into the ring'* to co-ordinate urgent care across the whole region [UCT_M3_May13], which prompted another team member to exclaim: *"Everyone's trying to take control"* [UCT_M3_May13].

The issue of the urgent care oversight group continued in subsequent urgent care team meetings [UCT_M4_May13]:

Person A referred to someone [from NHS England area team] and said that they were *"still hell bent on setting up this board."*

Person B: "It's a silly idea. The [regional urgent care group] will become a slave to the LAT [area team]. What can the area team actually do if we say we don't want it?"

...

Person B: "We'd be statutory responsible but playing tune to someone who's not (NHS England area team) – we'll be running around in circles."

...

Person A: "What do [neighbouring CCG1] and [neighbouring CCG2] think?"

Person B: "They agree."

Person A: "I think we should formally send a letter signed by all of the clinical leads." (of the CCGs) [UCT_M4_May13]

During the same meeting there were discussions about an A&E recovery plan that the NHS England area team had requested all local CCGs produce as part of assurance processes. One of the team members complained that a draft of Notchcroft's plan had been sent to the NHS England area team but this had then been returned to Notchcroft later than agreed and with a request for responses to all comments within 24 hours [UCT_M4_May13]. This prompted a discussion about how the urgent care team could deal with what they perceived as such unreasonable requests; one suggestion was swamping the area team with data that they did not have the capacity to deal with:

Person A: "This is a joke. This is micro management."

Person B: "This isn't about the CCG. It's about the LAT (NHS England area team) looking good to regional office."

...

Person A said something about being asked for data [on GP A&E diversion?] by the LAT (NHS England area team) and just sending them a year's worth of data – "I haven't heard back from them."

Person B laughed at this: "Just send them absolutely everything."
[UCT_M4_May13]

The urgent care team felt that NHS England was over stepping their jurisdiction and attempting to wrest control over the urgent care system that Notchcroft CCG were responsible for commissioning. In addition, the workload necessary for the assurance process was perceived as so significant that it was interfering with the ability of the urgent care team to carry out the work that they were being assessed on [UCT_M4_May13]. An urgent care team member explained during an interview that the CCG needed to actively resist the NHS England area team's attempts in order to stop them gaining legitimacy with providers as the de facto contact for urgent care issues. When talking hypothetically about the impact of an urgent care oversight group headed by NHS England he said:

...it confuses the providers about who is commissioning them who is responsible for the commissioning it's the CCG it's not NHS England and I think if we don't start being firmer and actually batting back NHS England I think you lost that control and providers will start to go to NHS England or play one off against the other and different things so I think the CCGs really need to maintain they are in charge and it's kind of it's their role their responsibility.
[Interview data]

A report published in November 2013 on the first phase of a national urgent and emergency care review by NHS England advocated the creation of a series of urgent care networks (NHS England 2013c). In May 2014, plans to instantiate these networks across England in 2015/2016 were announced (Benger 2014). The implications of these changes to Notchcroft CCG and the regional urgent care network it was involved in establishing are unclear. However, it may be that the area team's attempts to initiate an urgent care oversight group were a centrally instigated precursor to these national urgent care networks.

11.3: Competition and patient choice

As noted in Chapter 3, one of the three principles articulated as guiding the Coalition Government's NHS reforms was '...giving patients more information and choice' (NHS Commissioning Board 2012a, p.4). The main mechanism in the HSCA12 for expanding patient choice was the extension of the AQP scheme (Chapter 2, Section 2.1.2), which can be traced back to a mechanism launched in 2008 allowing patients to choose elective surgical services (The NHS Confederation 2011), to a broader range of healthcare services. This expansion of AQP began in April 2012, one year before CCGs were authorised. PCT clusters selected a number of services from a list of community and mental health services to open to AQP. Contracts were established with a range of providers including private businesses, foundation trusts, and small enterprises.

AQP represented the latest government initiative to increase patient choice in a lineage stretching back to the 1970s, but particularly prominent with the Thatcher Government in the late 1980s and early 1990s (Greener 2009). In many cases, patient choice reforms are understood as a means of increasing efficiency, responsiveness, and quality within the healthcare system. This conceptualisation is predicated on assumptions about patients as

rational consumers making decisions that will create a more competitive market of care provision (Greener 2009). This was the understanding of AQP from one GP:

AQP or whatever they want to call it at the moment... Well the idea was to try and bring in competition because some bright spark decided that competition was good and if you brought in competition then actually you drove up standards we know it's worked in the railways. [Int_GP10_Aug13]

A manager explained that the guidance provided by the Government on AQP stated that by April 2014 the CCG would have to “...answer questions about why we’re [the CCG] not offering choice” [Com7_M1_Jan13] if they had not extended the number of services opened up to tender under the scheme. A GP on the committee raised the question of whether the CCG could stall the process [Com7_M1_Jan13]. At the district level, too, there was some resistance to the idea of increasing AQP. GPs in district 1 expressed concern that the greater diversity of providers would fragment care and lead to confusion for patients, some of whom had been arriving for consultations with their GP with flyers for services that the CCG were not commissioning:

GP4: My concern with this is that it’s just going to end up a sprawling mess with patients all over the place.

Mng5: By the end of the year we’ve got to have shown how we’ve extended the choice agenda.

GP3: “We’ve chosen not to!” (laughter at this quip.)

GP8 [seemed to pick up a serious point from this joke]: Do we have evidence about this from patients? Do they want more choice? The patient voice is becoming more and more important in the context of this Government. Perhaps we should be trying to capture it.

GP3: Good idea. [Dis1_M2_Jan13]

In the above extract, GP8 suggested that the CCG should collect evidence about what patients wanted in terms of services and whether this included increased choice. He identified that one of the key policy principles of the NHS and its reform was patient-centeredness. If the CCG collected evidence that suggested that patients did not want more choice then they would have a valid justification for not increasing AQP contracts. In the governmental policy presentation, the notion of patient-centeredness was inextricably linked with increased patient choice over services, and patients as health

consumers exercising choice was assumed to offer benefits of increased health service efficiency through competitive forces. This is identified as the patient-centred choice logic in Table 8, Chapter 5 (Section 5.5). GP8 suggests destabilising this logic by highlighting the prospect that two of its elements, unproblematically bound together in the policy, could actually be decomposed into separate logics—a course of action which would be justifiable according to the requirements of Government, enforced by NHS England.

In another district, a GP envisaged that the extension of AQP would create “*dozens*” more contacts, and a duplication of services that would cause confusion [Dis3_M2_Apr14]. A group of GPs in the same meeting discussed the redesigning of a musculoskeletal care pathway but expressed concern that the services forming part of it were going to be AQP contracts, the problem being that this would reduce the level of influence that the CCG had over the care pathway as a whole by fragmenting its stages [Dis3_M2_Apr14].

11.4: Conclusion

Members of Notchcroft’s governing core talked about what it meant to be, and think like, clinical commissioners. From an institutional logics perspective, individuals are understood as having multiple identities, which are ‘...embedded in institutional logics’ (Thornton et al. 2012). These logics facilitate the construction and application of mindsets or schemas (Thornton et al. 2012, p.88), which shape how people deal with situations and what they hope to achieve from them. Discussions that occurred during meetings suggested that the mindsets of commissioner, clinician, and GP practice member do not necessarily exist in perfect harmony.

The HSCA12 reconfigured the key organisational players within primary care and healthcare commissioning as well as the jurisdictions, responsibilities, and inter-relationships of those players. This process was evolving during the fieldwork period and a source of frustration for those within and outside the governing core of the CCG. Crucially, these fuzzy boundaries and mismatched accountability dynamics had the potential to adversely impact on sub-groups of patients. In the case of the CCG district with a large proportion of patients treated in hospitals with little contractual association

with Notchcroft CCG, the issue is starkly illustrated—the CCG has little leverage with those hospitals because they were not directly accountable to Notchcroft in the way they were with their main contract holders. Therefore, the CCG had limited influence to affect change in those services should problems have arisen, which meant that a sub-group of patients were less well protected by the CCG than those that attended Notchcroft’s primary hospital contractors. The concerns raised in a committee meeting about the validity of hospital inspection assessments by the CQC make this issue a particularly pertinent issue, but they also speak to feelings amongst the governing core that the CCG had an informal responsibility to personally police local provider trusts in the interests of their own patients. This was precisely because of the local knowledge and professional expertise that they perceived themselves, as local clinicians, as embodying.

The HSCA12 also created uncertainty in the institutional field more broadly. The governing core perceived a variety of players as being keen to establish legitimacy and position themselves as responsible for overseeing and controlling certain functions in the new system. One particular example of this related to the regional oversight of urgent and emergency care, something that was, according to the HSCA12, the responsibility of CCGs. The NHS England area team’s efforts to establish an administrative super structure were perceived as an attempt to do this. A member of the CCG urgent care team expressed concern that if the area team were successful in establishing and presiding over a board that the CCG had to go and present to, then Notchcroft would have “lost”. The area team would come to be seen as the legitimate force for regional urgent care matters and once this became taken for granted the formal “rules” set out in the HSCA12 would not matter.

The HSCA12 explicitly presented the idea that patients choosing from an extended range of services offered by a broader mix of providers would drive efficiency improvements in the health service through forces of market competition. The primary means of realising this aspiration was the extension of the AQP scheme, which required CCGs to open more service contacts to multiple simultaneous providers *or* explain why they were not offering their patients choice. Sections of the governing core expressed concern that increased service competition would fragment care provision and make the process of overseeing such provision as commissioners increasingly unmanageable. The conflation between greater

competition between service providers and patient choice, and the norms underlying these ideas, was conceptualised in Chapter 5 (Section 5.5) as the institutional logic of patient-centred choice. Discussions in a district meeting about possibilities for decomposing or subverting this logic provide insights into how institutional change can occur and, potentially, be driven from a local level.

11.5: Chapter summary

In this chapter I focus on the commissioning related work of the CCG governing core, and in doing so address research questions one and two. Discussions amongst the governing core about the appropriate “way to think” as clinical commissioners were presented, suggesting that such activities required multiple mindsets that may not have been neatly compatible. From an institutional logics perspective, these mindsets reflect different identities embedded in different logics.

The HSCA12 required CCGs to make more services available through AQP in the interests of increasing patient choice and system efficiency. This reflects the patient-centred choice logic in the policy presentation. At the district level, there were discussions amongst the governing core about the possibility of decomposing or subverting the logic by asking patients whether they wanted such choice and formally recording responses. This illustrates the potential for locally driven institutional change.

In the context of uncertainty in the organisational field caused by the reforms, some of those in the governing core expressed concern that other organisations would try and take over the CCG’s responsibilities and this needed to be actively guarded against. I explore one particular example of this: the CCG’s urgent care team’s sense that the NHS England area team was attempting to seize control over urgent care oversight at a regional level.

Chapter 12: Discussion

12.1: Introduction

The aim of this research was to create and explore a contextualised account of the enactment of the HSCA12, and consider the experiences of a particular CCG in relation to the form and function of the policy as it was constructed at the governmental level. The objective was to produce a detailed, contextualised account of the creation and early operation of a CCG with special reference to its officially intended status as a “membership organisation.”

In pursuit of this aim and objective, I identified three research questions. With special reference to the policy that CCGs should be “membership organisations”—constituted by and accountable to their member GP practices:

1. How do those involved with the CCG conceptualise the organisation and enterprise in which they are expected to participate?
2. How do these conceptualisations shape action on the part of those involved with the CCG and manifest in the work of the CCG?
3. Is the institutional logics theoretical perspective useful in enhancing understanding of the organisational conceptualisations and actions of those involved with the CCG, and what critical reflections can be made about the approach and its application in this case?

The results chapters (8—11) addressed the three research questions to differing extents. In this chapter I will develop the analysis of the content presented in the results chapters and attempt to articulate its relevance to addressing the research questions. To facilitate this, the first part of this chapter (Sections 12.2—12.3) is sub-divided according to the first two research questions. Three “master themes”—*“Buying in” to the membership organisation*, *Protecting responsibilities* and *Organisational structure*—incorporate elements from one or more of the results chapters and are considered in relation to each research question. In other words, these master themes pull together content from the different results chapters to address these research questions and constitute the main findings of the study. Research question three is then addressed in Section 12.4.

Chapter 1 and Chapter 6 (Section 6.3) contained Figure 1, which presented a metaphor for this study as a series of concentric circles, like a target, with Notchcroft CCG in its centre. This is particularly useful to consider whilst reading this chapter because I call on content from all of these circles. It is the interaction of ideas between these circles that characterises the contextually sensitive methodological approach adopted in this study, and it is in this chapter that it is most clearly visible.

12.2: How do those involved with the CCG conceptualise the organisation and enterprise in which they are expected to participate? (Research question one)

12.2.1: “Buying in” to the membership organisation

This master theme is about the need felt by those in the governing core to get Notchcroft GPs and others to “buy in” to the idea of being CCG members in a way that went beyond their legally ascribed status. The significance that the governing core associated with being a member matched closely the ideology of CCG membership organisations presented in the policy. The CCG was understood as striving to be a democratic, “bottom up”, locally sensitive, inclusive and transparent organisation. These qualities were conceived of in contrast to the previous NHS structure of PCTs and SHAs, which were top down and dictatorial. The governing core believed that the CCG represented a “cultural shift” away from this. They perceived their prospects of success in realising these organisational qualities to be contingent on the extent of active participation from members.

Some of those in the governing core expressed an understanding of Notchcroft as an organisation willing to be uncompromising when necessary in order to protect against systemic pressures that had the potential to negatively impact on the patient population. It was affirmed in public meetings that the CCG was willing to take decisions that might make it unpopular in the organisational field (with other CCGs, service providers, commissioners, and other organisations) if these were in the best interests of patient care. This was a dimension of the organisation’s identity that the governing core felt

important to communicate to the broader membership. There was a belief that, by telling the right story about the organisation and its character, the broader membership would be more engaged with its work and invested in its success. This project of “winning the hearts and minds” of the members was seen as open ended.

In interviews and small private meetings, those in both the governing core and the broader membership talked about their understanding that the HSCA12 and the introduction of CCGs was a “poisoned chalice” or “double edged sword” for GPs. These phrases speak to a sentiment that the odds were stacked against CCGs being successful because of: the limited economic resources afforded to them, changing population demographics and the potential for increased healthcare demand, and their interdependence on other organisations whose very existence was highly uncertain. At worst, CCGs were “made to fail” by a Government that sought to weaken the power and legitimacy of health professionals in general and GPs in particular. Despite this, the CCG was perceived as an opportunity to effect some positive change.

Those that I interviewed outside of the governing core expressed a range of opinions about the CCG. What most shared was a lack of basic understanding about the CCG as an organisation in terms of its structure and operation. However, even those that were highly sceptical about what the CCG could achieve expressed a belief that there were those in the governing body with ability and the best of intentions for improving healthcare services. These interviewees recognised that if they had an issue with a service, for example, they were more likely to find someone that would listen to them in the CCG than they would have in the PCT. However, it was noted by some that the complexity of the evolving health and care system, and ambiguities about who held responsibility for what, would likely mean that the CCG would find it did not have as much control over the operation of the healthcare system as expected or desired.

12.2.2: Protecting responsibilities

The story of the urgent care team, outlined in Chapter 11 (Section 11.2), illustrated how the team perceived their ability to fulfil their statutory responsibilities in commissioning urgent care services to be under threat. The primary offender was the NHS England area

team, which was perceived as compromising the urgent care team's ability to work effectively by requiring a disproportionate amount of their time to be spent on fulfilling extensive reporting requirements. The area team was also attempting to establish some kind of regional urgent care commissioning oversight group. The CCG urgent care team believed that being required to attend such a group, orchestrated by the area team, and having to provide justifications for decisions that they were legally responsible for taking, would create an inappropriate power dynamic. It would diminish their legitimacy and potentially confuse providers about who was in charge. The hypothesis was put forward that the area team's actions were driven by a need to try and justify its own existence with the regional centres, and other organisational levels, of NHS England. This specific example was part of a broader feeling, discussed at governing body and committee levels, that the CCG had to be aware that organisations within the newly reformed NHS were going to be vying for control over domains of activity and responsibility. The CCG needed to be actively vigilant against having their domain of responsibility diminished and minimise actions that could provide opportunities for others to lay claims.

12.2.3: Organisational structure

Notchcroft's structure of districts and locales was unusual. Most CCGs had one level of sub-division below the committee level (Checkland et al. 2012b) where Notchcroft had two. However, two of the three districts were not geographically based, i.e. they contained locales from all over Notchcroft. When I asked CCG members within the governing core about the purposes of districts and locales, I received broadly similar answers for both. They were both seen as having a role in engagement and communication with, and representation of, GP practices and addressing local variability within Notchcroft. Their existence was generally seen as inter-dependent and mutually constitutive.

I attended multiple meetings for each district and found that the atmosphere and dynamics of communication varied between them. Several interviewees talked about their perception that the districts possessed different personalities—one was reflective and inclusive, another was more pragmatic and motivated to be at the forefront of changes, whether or not the group as a whole was subscribed to them. Districts were also

explicitly perceived as loci of particular sets of interests that needed to be represented at the committee and governing body levels. As noted in Chapter 8 (Section 8.5), my attendance at locale meetings was limited as a result of having to make pragmatic decisions about which meetings I observed. Consequently, I am unable to comment on differences in character between them or the interests that those within locales felt that they represented.

12.3: How do these conceptualisations shape action on the part of those involved with the CCG and manifest in the work of the CCG? (Research question two)

12.3.1: “Buying in” to the membership organisation

I witnessed a number of governing core initiatives aimed at increasing “buy in” from the broader membership, including surveys to gather opinions from GPs, practice nurses and practice managers on potential new services and commissioning plans. A number of public and private (CCG membership only) events were organised, one of which was a five-year strategic plan event. Members of the governing core went to great lengths to try and ensure that a representative from every GP practice in Notchcroft attended. The governing core introduced themselves to attendees at the start of the event. Some presented explanations of the NHS policies relevant to the CCG and how they were being addressed. Breakout sessions, each chaired by a member of the governing body, took place and attendees were asked to contribute ideas to how the CCG should deliver outcomes in relation to primary, secondary, and community care services. The governing body members emphasised that when talking about “the CCG” it meant all of the members, not just those in the governing body, and that the CCG was different from the PCT because there was no separation between GP practices and the governing body—all governing body members’ contact details were available on the intranet and they could be reached directly.

In November 2013, towards the end of the fieldwork period, there was a sense, expressed at committee and district level, that the CCG had failed to craft and disseminate an appropriate “little story” of the organisation. The governing core wanted

the membership, the public, and others to get a sense of the “cultural shift” that they believed the CCG represented (see Chapter 8, Section 8.5). This was something that had been identified as very important at governing body, and other, meetings around the time of authorisation. If they had been more proactive towards this, it was argued, “buy in” amongst the membership would be greater. Similar regrets were expressed by some at the committee and district level that the CCG had not more visibly responded to the issues raised by member practices, particularly at the time of becoming authorised in April 2014. The demonstrable “quick wins” that some of the governing core had advocated pursuing had not occurred in sufficient volume to differentiate the CCG from the PCT and demonstrate that it was a “grass roots” organisation that valued the input and work of the health professionals in its member practices.

The HSCA12 created certain intra and inter-organisational dynamics that presented challenges to the governing core in increasing member “buy in.” One of these was “the lever” for ensuring continuous improvement in primary care (Chapter 9, Section 9.2). This made the governing body of the CCG responsible for monitoring the performance of member GP practices and connected the activities of the governing core of the CCG and the NHS England area team. The reality of this kind of oversight role, which was primarily conducted via one committee and at the district level, created some tensions within the governing core about the nature of performance related contact with GP practices.

12.3.2: Protecting responsibilities

The urgent care team discussed strategies of resistance against the perceived incursions of the area team. The area team was perceived as having limited capacity to carry out in-depth evaluations. Responding to their request for Notchcroft performance data by sending them a large amount of “raw” information meant that the area team’s time would be spent sorting through and making sense of it, rather than making further requests of the urgent care team. In relation to the area team’s proposed regional urgent care oversight group, the CCG urgent care team questioned what legal rights the area team had to instantiate such a governance structure without the permission of the other local CCGs overseen by the area team, which together held statutory responsibility for urgent care commissioning across the region. One proposed strategy to mitigate the

proposal was for the CCGs to work together to produce a letter to the central NHS England department, jointly signed, rejecting any such area team-orchestrated regional group.

12.3.3: Organisational structure

Before the CCG was formed there was debate in Notchcroft about whether there should be one or three CCGs based on the pre-existing district model. Those that wanted a single CCG, primarily those in the largest district, claimed that it was the most sensible for economic reasons. However, the two smaller districts were concerned that their interests would be overlooked in a single CCG. Maintaining existing districts within a single CCG was described by one interviewee as means of placating the members of the smaller districts. This demonstrates how the pre-existing organisational units of districts shaped the form and function of the CCG through the sets of interests that they represented.

The consequence of a structure with districts and locales was a preponderance of monthly meetings. A major feature of these meetings was feedback from committee and governing body meetings. It was often governing core members that attended both district and locale meetings and repeated the same summary from other meetings. This represented a significant time commitment from those members. Districts and locale meetings also provided spaces where dissatisfactions about aspects of the CCG were vented. Decisions made at higher and lateral levels of the organisation were questioned critically. Concerns articulated at the district or locale level would then sometimes be expressed by members of the governing core at committee or governing body meetings but more frequently did not extend beyond the meeting where they originated. Ultimately, the operation of districts and locales led to organisational inefficiency because of duplicated activity and greater opportunities for breakdowns in communication.

12.4: The application of institutional logics

In this study, my stated intention was to use institutional logics as a sensitising device—a lens to cast over the data—and to ask if this process adds “narrative value” (Spence 1984). This is articulated in research question three (Section 12.1). In this section, I will

address this question by considering events from Notchcroft related to the master themes employed in the two preceding sections: “buying in” to the membership organisation; protecting responsibilities; organisational structure. In the following subsection (12.4.1), I will reflect on the application of institutional logics in this study more broadly, explain my interpretation of the theory, and consider the strengths of limitations of the approach.

The institutional logics approach understands that different logics have different basis of accountability and legitimacy. The HSCA12 framed CCGs as legitimate precisely because of the expertise of health professionals, particularly GPs. This legitimacy was associated with a societal level professional logic, and, at the organisational field level, with the particular stock of legitimacy afforded the GP profession. However, in order for CCGs to enjoy sufficient legitimacy in practice to be viable organisations they required the support of, or at a minimum the acquiescence of, a critical mass of GPs. The Government attempted to ensure this by changing the GMS contract to obligate all GP practices to be members of a CCG, and for every GP practice to nominate a practice representative to take responsibility for communicating with their CCG. The content of the HSCA12 policy vision and the statutory requirements placed upon CCGs and GP practices drove a set of symbolic and material practices to realise, and legitimise, the CCG as a membership organisation.

The governing core of Notchcroft needed members to “buy in” to the CCG to legitimise their position in overseeing the organisation, but they were also legally obligated to do so and assessed on their performance in this respect. The HSCA12 stated that CCGs ‘must secure that there is effective participation by each member of the clinical commissioning group in the exercise of the group’s functions’ (2012; schedule 2, paragraph 6). This requirement was a feature of domain four of the assurance framework (NHS England 2014a)—demonstrating “robust governance arrangements”—the basis against which CCG performance was assessed by NHS England (Chapter 2, Section 2.2.2).

What members were supposed to “buy into” was the idea that GP practices were all in this together: part of a democratic, peer-orchestrated membership organisation. However, there were aspects of the practical details of organisational operation and

governance arrangements that did not resonate with this. Around the time of authorisation, the CCG governing core was working hard to “sell” the “cultural shift” that the CCG represented to members. It was then that the responsibility for implementing NHS 111 was handed to the CCG, in practice a section of the governing core. This served to undermine the process by connecting “the CCG” with an undesirable enforced reform in the minds of some members. This required considerable effort on the part of the governing core to ameliorate. More generally, the CCG’s duty towards the NHS England area team to ensure continuous improvement within primary care—“the lever”—aligned the governing core with them and with the previously dominant performance management logic associated with the PCT.

Some of those in the CCG experienced dissonance between their role within the governing core with that of being a GP. This can be explained as a result of a clash between the logics that underpinned them. For example, a member of the governing body expressed discomfort from attempting to reconcile their performance management logic related activities in the governing body with their medical professionalism logic driven activities in the locale. This GP attempted to reduce this dissonance by explaining his feelings of awkwardness to his fellow locale members and treating the messages that he had to communicate from the governing body, and the language they were couched in, with playfulness and flippancy (see Chapter 8, Section 8.5).

The governing core was accountable to the area team and the broader membership and strove to maintain and increase legitimacy with both. These accountabilities were embedded in different logics and, therefore, had different foundations. The managerialism related logics that determined the accountability relationship with the area team involved performance appraisal, financial statements and plans—much of the work of the governing body was rooted in these logics. Professionalism related logics were most relevant to the governing core’s accountability relationship with the broader membership. For the governing core, “telling the right story” to increase member “buy in” was about convincing members that the CCG was focused on their interests as a localised professional community and not just a new face on the old managerialist order. The institutional logics approach is valuable here because it brings this dynamic, and the

antagonism between the underpinning logics that the governing core had to manage, to the foreground.

The problematisation of the HSCA12 in Chapter 3 shows how NHS management and, by extension, PCTs were constructed as a major element of the problem with the NHS. This can be understood as a Governmental attack on the institutional logics associated with managerialism itself, which represented an important historical shift in the NHS away from the dominance of logics of professionalism (Currie and Guah 2007). The policy suggested that these managerialism related logics had become too pervasive, too entrenched. The result of this was self-inflating bureaucratic workloads and excessive top down managerial control over professionals that was not improving the care patients received.

Crucially, in Notchcroft, many of the staff previously employed by the PCT migrated to NHS England with the statutorily sanctioned denouncement of their previous work, and identity, undoubtedly ringing in their ears. However, as the details of the functioning of the new system were established it became clear that the work of the area team had many similarities to that of the PCT and SHA. They would be responsible for assessing the CCG and its member practices on the basis of economic performance, healthcare outcomes, and governance arrangements. They would perform a role predicated on the same set of managerialist logics that had underpinned PCTs and SHAs and were identified as “something rotten” within the NHS by the HSCA12.

From the outset, the area team overseeing Notchcroft were, at best, the recipients of mixed messages from Government and, at worst, operating with a sense of illegitimacy, yet it was they that held the power to decree the legitimacy of the developing CCG. The assurance process was, despite the power dynamic just identified, officially intended to be a collaborative endeavour among equal partners. However, some of the Notchcroft governing core perceived the behaviour of the area team as dictatorial and “top down,” suggesting continuity with previous managerialist logics. This approach from the area team may have been an attempt to assert the importance of these logics, and their own identity invested within them, in response to the position of uncertainty that they occupied within the organisational field. From this perspective, the perceived attempts of

the area team to obtain a position of control over regional urgent care can be seen as an attempt to emphasise the indispensability of the organisation and reassert the legitimacy of these logics.

In this analysis, I have drawn a link from the normative content of the policy presentation to the inter-organisational dynamics of the fieldwork context. Applying the institutional logics lens to this offers an extra dimension to the explanation. Identifying the relationship between normative policy content and a performance management logic allows the HSCA12 to be contextualised in the socio-historical development of the NHS. Recognising that these logics underpinned the work and identity of managers in the PCT that found their way to the area team, to carry out similar functions, provides reasoning for the (perhaps subconscious) motivations and behaviour of the area team in Notchcroft.

Having identified that the presence of districts as well as locales in the CCG can be seen as counterproductive, I will now consider whether the institutional logics approach is useful in explaining their continued existence. Before the CCG was formed, under previous clinical commissioning arrangements, districts had a role in the assessment of population healthcare need and the commissioning of services. Locales also developed as a result of previous clinical commissioning arrangements but their purpose revolved primarily around professional peer support and collaboration. They became *institutionalised* in Notchcroft as a result of their assemblage around a number of purpose built local healthcare facilities, and because they were an instrumental feature of the remunerated objectives of the Primary Care LES for GP practices (Chapter 6, Section 6.7). Locales, in particular, became a key part of apparatus for delivering the vision of the CCG.

The social practices associated with districts and locales were well embedded in Notchcroft, making their continued existence in the CCG a sensible proposition. The personalities of districts represent different institutional logics at the sub-organisational level. The fact that those people affiliated with each were understood as responding more positively to particular vocabularies and communication styles is an indication of this. Support for this interpretation comes from Glynn's (2008, p.413) understanding that organisational identity represents 'a form of institutional bricolage.' These different personalities may have influenced the decision to retain districts in the CCG as they

reflected groups of members that felt they had a shared set of interests that needed representing and protecting. Additionally, the variation between districts, their *local specificity*, exhibited consonance with the decentralism and localism espoused as positive in the HSCA12. This reinforced the notion that districts were a necessary feature of the CCG structure despite the fact that many of the responsibilities that districts held pre-CCG became the purview of the governing body in the CCG.

Having identified that districts embody different logics it seems reasonable to delineate and compare these. Whilst this would be an interesting exercise, it would not add any explanatory value to this analysis or assist me in addressing the research questions. For the purposes of this study, the crucial point is the effect of these logics on the organisation, which appears to be the stifling of a rationalisation of the organisational structure.

Notchcroft CCG can be thought of as a hybrid organisation—i.e. an organisation that incorporates ‘competing institutional logics’ (Pache and Santos 2013, p.972). I have identified multiple logics embedded in the HSCA12 that the governing body of the CCG had to reconcile in practice. However, the institutional analysis of the organisational form of Notchcroft CCG illustrates that its structure and operation were also shaped by the logics expressed at the sub-organisational level (i.e. districts and locales). The hybrid work of the CCG governing core was, therefore, simultaneously influenced by national and local institutional forces. Yet these local institutional forces were themselves partial responses to previous national health policy reforms that emerged in negotiation with the local context. This recursive relationship between national policy and local enactment provide evidence that national policy cannot be transferred into practice in a straightforward way. The multitude of local contexts in which it is realised hold the potential for so much complexity and diversity that the creation of a ‘clockwork universe’ (Timmins 2012, p.34) is an impossibility regardless of the degree of specificity in policy guidance and statute.

Cooper et al. (1996) employ the concept of sedimentation as a metaphor for the transformation of institutional logics (although they use the term “archetype”) at the organisational level. One might expect sedimentation to simply refer to the laying of one stratum on top of another. However, Cooper et al. (1996) suggest that the geological

environment allows for variation in the sedimentation process: layers may be ruptured at certain points with elements of underlying strata puncturing the surface, or multiple strata may lie side by side at other points. They argue that the institutional strata within an organisation (or at any other level of analysis) are not uniform. They are in a state of constant change (the speed of which is not uniform either) and this process is influenced to some extent by what has gone before—i.e. the characteristics of the layers of sedimentation in that location. This metaphor is useful for understanding the structural characteristics of Notchcroft CCG. It highlights how local historical responses to policy can have a cumulative effect, increasing complexity and shaping organisational form and function.

The continued existence of districts and locales is the kind of scenario that has frequently been addressed from a new institutionalist perspective—“why do particular organisations, or organisational forms, endure?” As such, it makes sense to consider the utility of an institutional logics lens by comparing it with a common new institutionalist explanation to explore whether it adds value beyond that. The concept of path dependence (Chapter 5), associated particularly with historical institutionalism, is applicable (Pierson 2000). A path dependence explanation would postulate that districts have endured along with locales in Notchcroft CCG because of the social investment already sunk into them and the purposes that they have fulfilled over time. This has created a kind of organisational inertia that makes them resistant to change, notwithstanding some kind of “exogenous shock” (Pierson 2000).

This explanation rings true in Notchcroft: districts and locales both had well established purposes pre-CCG. Their previous importance was assumed to carry over into the future as part of the CCG. An institutional logics perspective recognises the validity of this explanation but also suggest that the personalities of districts are an important factor in reinforcing the endurance of the sub-organisational forms. Members of each district felt an attachment to them and perceived the bodies as a way of promoting shared views and protecting mutual interests. Their variation was also resonant with the localism norm in the policy presentation. One of the major advantages of the institutional logics approach, above other institutionalist perspectives, is that it has allowed connections to be drawn between dominant logics in the historical development of the organisational field of

English healthcare, the logics embedded in the presentation of the HSCA12, and the institutional forces in the CCG itself.

12.4.1: Reflections on the application of institutional logics

My utilisation of the institutional logics approach has involved considering its central theoretical assumptions (Chapter 5) and treating it as a sensitising device. Guiding this process has been an awareness of the essence of the approach, which I understand as the examination of cultural continuity and change, and what is taken for granted in a particular social context. My analysis has focused on the content of the HSCA12 policy, the events that occurred during fieldwork and the meanings ascribed to events and social practices by those in the CCG. It is to this that the logics lens has been applied. In this way, I have endeavoured to focus on the consequences of logics in action.

Institutional logics purists, most of whom would likely disagree with each other about the finer points of the meta-theory, may take issue with my broad approach to its application. Thornton and Ocasio (2008, p.108) suggest that ‘the breadth of the meta-theory may have encouraged imprecision in research, and it could be inferred that any logic or interpretive scheme, at any level of analysis, may be characterized as an institutional logic.’ They go on to state that institutional logics are ‘more than strategies or logics of action as they are sources of legitimacy and provide a sense of order and ontological security’ (Thornton and Ocasio 2008, p.108). As a point of theoretical distinction between what does and does not constitute an institutional logic, provision of ontological security is a reasonable criterion. However, in an empirical setting where the analytical focus is on intra-organisational experiences and national policy change, identifying whether someone, or some group, exists in a state of ontological security is, at best, an unproductive aside.

A common criticism levelled at the institutional logics approach is that the concepts used are broad and rather nebulous (Hasselbladh and Kallinikos 2000). I agree that employing institutional logics to empirical work requires a degree of conceptual abstraction, but a value judgement on this should only be made on the basis of the value it does or does not add to the process and findings. Thornton et al. (2012) have developed a comprehensive

meta-theory and methodological toolkit that aspires to assist researchers explore the presence and interaction of institutional logics across a range of scales, from the individual to the societal. It is impressive in both its breadth and detail. However, the model covers so much, at so many potential levels, that trying to incorporate multiple aspects of it presents a high likelihood of running into analytical difficulties.

The institutional logics approach understands that logics exist at multiple social levels and that it is cross-level interaction effects that partly explain the on-going evolution of logics in a society (Thornton and Ocasio 2008). This conceptualisation is integral to the theory, and the way that *embedded agency* (the idea that individuals are partially autonomous but their beliefs and practices are shaped by combinations of logics) explains the recursive relationship between structure and agency. This is one of the major conceptual advantages that the approach enjoys beyond other new institutionalist theory, yet most institutional logics research grants primacy to one level and organises analysis in relation to that (Thornton and Ocasio 2008).

In this study, I have identified prominent logics at the organisational field level and highlighted the existence of logics at the intra- and organisational level. As noted above, my intention to employ the institutional logics approach as a sensitising device influenced my decision to resist an explication of the logics at play within Notchcroft CCG itself. However, the analytical process led to a consideration of the inherent challenges in undertaking multi-levelled institutional logic analysis. Attempting to study institutional logics across levels creates problems because it becomes difficult to credibly assert the substrate or entity (e.g. individual, organisation) to which an institutional logic belongs. At a single level of analysis, it is relatively straightforward to delineate a logic and relate it to an entity at that level. The logic is understood as being inter-related to logics at broader levels but the nature of these relationships need not be specified in detail. When one attempts to traverse analytical levels, the certainty with which a logic was applied to an entity at one level begins to break down as its relevance to entities at other levels comes into focus.

A more detailed explanation is that each entity in society can be understood as a node or nexus point for institutional logics. The combination of logics that meet at the node and

their strength of connection to it is constantly evolving, as are the logics themselves as their constituent elements have the potential to become parts of different logics. This conceptualisation is entirely compatible with Thornton et al.'s (2012) understanding of society as an evolving, modular inter-institutional system. Mapping these logics and their cross-level interactions is akin to attempting to construct a working model of a social world—a 'clockwork universe' (Timmins 2012, p.34) of the kind Lansley intended with the HSCA12 itself—and is an insoluble task. There is simply too much complexity at play and establishing the boundaries between institutional elements will always be a subjective endeavour dependent on the perspective and objective of the analyst. This may explain why institutional logics research aiming to explore multiple-levels (seemingly) inevitably tends to privilege one (Thornton and Ocasio 2008).

The application of institutional logics in this study is more modest in its scope and claims than evangelists of the theory suggest possible. However, it has proved useful for its ability to illuminate puzzles from the fieldwork context. Its conceptual elements have been employed to develop insights unlikely to have arisen independently from its use. By bringing unspoken assumptions to the foreground, it has provided a partial illustration of the change processes associated with the HSCA12 and its enactment in Notchcroft CCG. The institutional logics approach has provided a way of conceptualising the NHS (i.e. as an organisational field), and a means of understanding dominant ideologies at different periods in its history and linking these with the ideological content of the HSCA12 (Chapter 5, Section 5.5). This logics-based understanding of NHS policy reform has helped to clarify the uncertain basis on which the NHS England area team were operating—the performance management logic central to their work was portrayed negatively in the HSCA12. This provides an explanation for their inconsistent behaviour towards the CCG. The institutional logics approach has also helped to explain Notchcroft CCG's unusual, and seemingly inefficient, internal structure and clarify the socio-historical forces that have contributed to its endurance (Chapter 8, Section 8.3), which include intra-organisational identities and sedimentation from previous primary care commissioning initiatives. It has also proved useful in clarifying the nature of the difficulties that the CCG (the governing core, in particular) faced in regard to managing the multiple accountability relationships set out in the HSCA12, some of which were associated with different logics and had differing bases of legitimacy that were hard to reconcile in practice.

In relation to the gaps in existing institutional logics scholarship (identified in Chapter 5, Section 5.4), this study makes a contribution to the institutional logics literature by responding to calls for research that investigates how multiple institutional logics relate to organisational practice (Greenwood et al. 2011; Lounsbury 2007), and by applying an institutional logics perspective to the 'intraorganizational dynamics of practices and identities' (Thornton et al. 2012, p.134). It also makes a broader theoretical contribution by combining a problematisation of policy (Chapter 3) with the institutional logics theoretical perspective. The joint application of these complimentary approaches has conferred analytical benefits to this study. As employed in this study, problematising policy involves explicitly identifying key messages and exploring its ideological content. It is an exposition of the taken for granted, and institutional logics is essentially concerned with the same endeavour. Their combination has allowed the critical analysis of a policy to be extended to the exploration of social practices associated with embedded systems of meanings in an organisational context.

12.5: The problematised policy and the enacted policy

This section builds on the responses to the three research questions developed above and considers how the policy as *enacted* in Notchcroft CCG resembles the policy as *problematised*. As such, the analytic gaze now shifts between the problematised understanding of the HSCA12 developed in Chapter 3 and the account of its enactment developed in Chapters 8-11. In the conceptualisation of the study as four concentric circles (see Figure 1, below) this process can be understood as the simultaneous consideration of the second outermost circle (*HSCA12 story / Problematised membership organisation*) and the central circle (*Notchcroft CCG*).

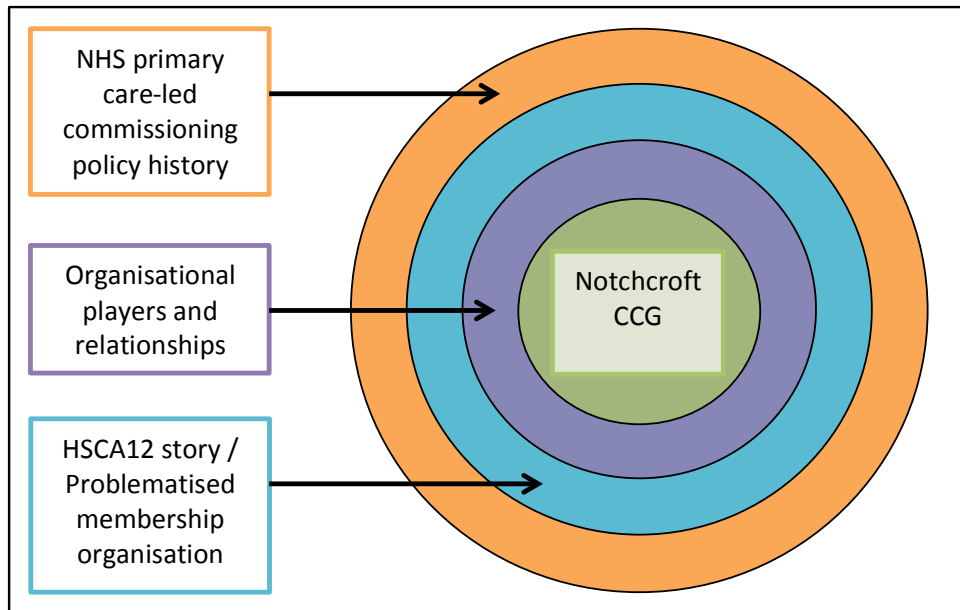


Figure 1: Conceptualisation of the study as four concentric circles

I will begin by recapping the key points from the problematisation of the HSCA12, and associated documents, but suggest returning to Chapter 3 for a more comprehensive picture. The major problem-to-be-solved by the policy was the prevalence of non-clinical managers in the NHS, who were framed as disconnected from patients' needs and responsible for making the health service inefficient. CCGs were presented as the solution. They would be composed primarily of GPs who possessed valuable professional expertise and were in touch with the health needs of the local population they served. Consequently, CCGs would make more efficient commissioning decisions and orchestrate provision of health services more attuned to patients' needs and wants. Power would be devolved to CCGs—from the centre to the locality—and they would have autonomy to shape their local health services, but they would also be subject to scrutiny and held accountable if they failed to discharge their statutory responsibilities in accordance with Government-specified standards of good governance, financial prudence, and integrity. CCGs were framed as novel and valuable because they were *membership organisations*—i.e. composed of, and accountable to, their members. Every GP practice in England would be a member of a CCG, and every GP was presented as having a duty to engage with their CCG and ensure that they were governed appropriately by the elected governing body. This responsibility to be a good member was bound up with the capacity to be a good doctor.

Before considering the experiences of policy enactment in Notchcroft CCG in relation to the problematised policy understanding outlined above, I will first attend to a potential argument against the merits of such an exercise. In brief, this argument posits that it is naïve to treat Governmental policy narratives as anything other than rhetorical devices employed in a calculated way to ensure the acquiescence of relevant groups. This perspective speaks to a disjuncture between what policy makers say is the aim of a policy and their true motivations for it. This is certainly a valid perspective. However, its validity does not render the exercise any less useful for two main reasons: first, the language and ideas employed in policy presentation are, to some extent, intended to help “sell” the policy. To do this they call on dominant societal ideas and discourses that have a certain weight and legitimacy—i.e. institutional logics (Thornton et al. 2012). Examining these ideas and discourses provides opportunities to situate policies in social and historical context, and critically explore the application of such ideas as tools, considering what makes them effective or not in a given setting. Second, as I have shown with the case study of Notchcroft CCG, policy narratives are valid because of the very real implications they have for policy enactment. This goes beyond just reform of the landscape of organisations to the way that people conceive of their work and their purpose. For example, in Notchcroft the governing core talked frequently about acting in a way that was true to the principles of the CCG’s membership organisation status, i.e. being inclusive, transparent, and accessible to members. This was coupled with legally sanctioned requirements for the CCG to demonstrate that it was behaving in a way that reflected these principles. In short, this exercise is valuable because policy narratives have implications for the work people do and what they think about it, and offers insights into dominant ideological forces at a societal level.

It is not possible to make definitive statements about some of the assertions relating to CCGs in the HSCA12 on the basis of this study and the data available. It is not possible to, for example, make an informed judgement about whether CCGs are making better decisions than PCTs about what services patients’ need, commissioning accordingly and increasing health service efficiency as a result. It is possible to make some statements about the changes to NHS organisations made in the interests of reducing the prevalence of managers, issues of CCG autonomy and accountability, and CCG membership organisation status. I will address these issues in the remainder of the section. However,

it is important to recognise that what follows only relates to the fieldwork context of Notchcroft CCG. While similar issues may be faced by other CCGs the enactment of the policy could look very different in such contexts and no claims of generalisability to them are made.

The major problem identified in the HSCA12 was that PCTs had become overly heavy with managers who were disconnected from patients and adding to an overly bureaucratised NHS. Fieldwork in Notchcroft revealed that as the new system structure emerged, some employees of the PCT came to work for the CCG, others to NHS England and their area teams, and others to CSUs. A lot of the same management work still needed to be done but it was now split over a range of organisations. The governing core of the CCG and NHS England took on the bulk of the commissioning management functions that were the responsibility of the PCT. There was certainly a devolution of responsibility in Notchcroft to a local, health professional-driven membership organisation—the CCG unquestionably enjoyed control over the procurement of many local services, and they had access to performance data for service providers that they could use to inform their decision-making and communications with them. However, in practice, only a small sub-set of GPs and others in the governing core were directly involved in major organisational operation and decision-making processes. For those GPs, it became increasingly difficult to maintain their clinical practice alongside their CCG duties over the course of the fieldwork period. Several GPs had reduced their clinical session hours in order to keep on top of an expanding CCG workload.

In the policy, high levels of CCG autonomy and accountability were presented as mutually inclusive aims of the reform. Checkland et al. (2013, p.1) questioned whether the unprecedented ‘accountability regime’ that CCGs were subjected to would interfere with their ability to operate autonomously and exercise independent decision making power. Fieldwork with Notchcroft revealed some of the nuances of the multiple CCG organisational accountability relationships, both internal and external. Committees, districts, and locales were all accountable to the governing body. The governing body were accountable to members, patients and the public, the local authority and HWB, Monitor, local Healthwatch, NHS England area team and, ultimately, the DH and Secretary of State. Discussions amongst the governing core about the nature and

implications of such relationships were a frequent feature of meetings that I attended at all organisational levels. However, the details of how the accountability relationships with some of these groups would operate in practice was not spelled out in detail in policy and predicated on, for example, transparency or democratic processes (i.e. the CCG governing body were accountable to the voting members largely through the election process itself), which reflects Checkland et al.'s (2013) findings.

One accountability relationship that is specified in detail in the HSCA12 is that between a CCG and their NHS England area team. The nature of this relationship for Notchcroft is discussed in detail in previous chapters. Of particular relevance here is the account in Chapter 11 (Section 11.2) of the assurance processes that the area team required of the urgent care team in order for them to fulfil their assurance obligations. These were perceived by the urgent care team as unnecessarily burdensome and interfering with the team's capacity to actually do the work. At the same time, there were concerns amongst the urgent care team that the area team were attempting to establish themselves as the de-facto legitimate force in regional urgent care commissioning management.

There were a number of other broader factors that impacted on the ability of the CCG to exert control and autonomy in the shaping of their local health service. The extent of funding cuts to the local authority and the challenges faced by third sector organisations to remain viable meant that there was considerable uncertainty in Notchcroft's local organisational field. These were factors that the CCG had no control over but impacted on their ability to commission services. In some cases, the CCG were required to gamble on whether certain organisations would still be operational over the course of a service contract. Another issue was the requirements placed on CCG commissioners to demonstrate to NHS England that they were offering their patients choice by putting out contracts to AQP. This shaped commissioning processes and outcomes and was a source of concern for some of those in the governing core who felt that it would confuse patients and fragment service provision, which would prevent the CCG from enjoying a sufficient degree of control over care pathways for certain conditions, thereby compromising their ability to commission care to the best of their clinical ability.

NHS 111 was a national level policy handed to the CCG to implement and with associated penalties for perceived failures to do so. Not only did NHS 111 impact on the clinical practice of all GPs in Notchcroft (e.g. changing their telephone answer messages, and monitoring an NHS.net email account for “post event messages” when their patients called the service) but it also had uncertain and potentially significant implications for the services that the CCG commissioned, such as emergency care, and out of hours care. Furthermore, as discussed in detail in Chapter 10, the governing body of the CCG were ultimately responsible for the “mobilisation” of a service they had little influence on or desire for. This aligned the governing body, and indeed the broader governing core, of the CCG with the state and threatened to negatively impact on their efforts to elicit the investment of the broader membership in the organisation.

In conclusion, aspects of the problematised policy did match up with the enacted policy in Notchcroft in a general sense: the high concentration of managers in PCTs was diluted, and commissioning responsibilities and decision-making were devolved to the CCG. However, as highlighted above, there are a number of important caveats and conditions to this statement that became clear during fieldwork with Notchcroft CCG. The policy goals of increased autonomy and accountability for the CCG, and GPs in particular, sometimes existed in a state of tension. The ability of the governing core of the CCG to exert control over local healthcare provision was constrained by financial and political insecurities in the broader organisational field, complying with legal obligations to facilitate service competition in the name of patient choice, and having imposed upon them responsibility for locally launching a nationally defined service that had significant implications for the work of the CCG and local GP practices. In terms of CCGs’ status as membership organisations, in Notchcroft there was considerable variety in terms of how engaged GPs, and others in GP practices, were with the CCG and its responsibilities under the HSCA12. This issue is explored in the following section in relation to the concept of the governing core.

12.6: The governing core and the membership organisation

In Chapter 7, I introduced and explained the concept of the governing core, which I developed as a result of observing the governance processes of CCG meetings at a variety

of organisational levels. Both “the membership” and “the governing body” were defined as entities within the policy and comprehensively specified, although (as discussed in Chapter 3) the finer details of who was and who was not a member were ambiguous. However, I found this dichotomy insufficient to describe what was taking place, and so the governing core concept was born from a practical need for a term that would describe all of those involved in the governance of the CCG, although not necessarily part of the governing body. Considering the policy again now, there is an acknowledgement in the Towards Establishment document (NHS Commissioning Board 2012a) that, in order to function, CCGs would require an additional group (aside from the governing body and membership) as part of their intra-organisational make up:

The member practices are then likely to identify a relatively small number of individuals who will take on key leadership roles in the CCG, including those who will sit on the CCG’s governing body alongside its other clinical members (at least one nurse and one doctor who is a secondary care specialist) and its lay members. (NHS Commissioning Board 2012a, p.7)

...

All GPs and their GP practice colleagues will need a broad understanding of how the CCG works. There will be a smaller group of GPs and other healthcare professionals involved in the leadership of the CCG who will need a much deeper understanding of the CCG’s duties as a statutory NHS body and the requirements of good governance. (NHS Commissioning Board 2012a, p.7)

These extracts hint at the necessity of some kind of governing core, although they suggest that this group will be composed specifically of health professionals. My observations revealed that many of those involved in CCG governance and leadership were not health professionals, and not all of them were CCG employees or affiliated with CCG member GP practices. Furthermore, the governing core was broader and more diffuse than the above extracts suggest. In this section, I will consider the governing core concept in relation to the enactment of the HSCA12 and, in particular, explore its relevance in understanding the CCG as a membership organisation.

The governing core describes all of those people, including but not limited to the governing body, involved in CCG governance processes at any of the organisational levels above GP practices. This is a broad cast of health professionals, managers, and others largely from inside the CCG but also from external organisations. The governing body

possessed legal responsibility for organisational decision making at the highest level of the organisation, but the broader elements of the governing core provided advice, shaped discussions, and influenced the development of consensus perspectives. This had clear implications for decisions taken by the governing body. Furthermore, at organisational levels below the governing body, the governing core was directly involved and officially responsible for some decision-making processes. This was particularly so at the district level where each district had their own approaches to GP practice communication and engagement, and organised some of their own events for their locales to attend.

That the broader governing core should influence the governing body is not objectionable – Notchcroft CCG governing body, like that of any CCG, was composed of a relatively small number of people (largely GPs) who had a particular range of experiences, expertise, and opinions. It is important that they were able to call on the knowledge of other people from a range of roles in the interests of informing judgement. However, fieldwork revealed the governing core, not just the governing body, to be an important feature of the CCG and the way it functioned; the lack of attention to it in the HSCA12 and related policy documents belies this. Perhaps this can be understood as a consequence of the stated policy ambition to devolve decision making to the local level. While governing body composition and some committees were prescribed much was left up to CCGs to determine. The governing core is a particularly important focus of attention because it is not specified in policy, is likely to vary widely between CCGs, and because it is integral to the CCG and the way it operates.

The existence of a governing core in an NHS commissioning organisation is not a new phenomenon relevant only to CCGs. For example, PCTs also had a certain amount of leeway to develop their own internal structures and governance processes and so varied locally (Walshe et al. 2004). A suggestion for future research contrasting the governing core of a CCG with that of a PCT is made in Section 12.11. It is also relevant to note that, as originally conceived, PCTs were presented as being more devolved and locally attuned organisations than the Health Authorities that they superseded, and this was the basis of their value. However, the governing core is particularly significant in relation to CCGs

because of CCGs' officially intended status as membership organisations. There are two main dimensions to this, which I shall discuss in turn.

Firstly, being part of the governing core frequently carried with it some element of monitoring of GP practices' (i.e. of the CCG members') performance. This was particularly the case for locales, districts, and certain committees. This kind of intra-professional oversight has been a key feature of all primary care led commissioning initiatives (Coleman et al. 2009; Miller et al. 2012), but the HSCA12 has taken it further than ever because of its comprehensiveness (i.e. all GP practices were legally obligated to become a CCG member) and the CCG having a statutory duty to assist NHS England in 'securing continuous improvement in the quality of primary medical services' (Department of Health 2012, p.6). A GP at a locality meeting described the nature of this tension or "lever" (Chapter 9, Section 9.2):

The CCG is a membership organisation but it has a role in ensuring continuous improvement—which is the task of the NHS England—of its members...
[LocB_M1_Mar13]

The tension arises from the fact that "the CCG" and "the membership" cannot be the same thing because the former must monitor the latter in some way. In practice, "the CCG" cannot, in this context, be reduced to the governing body because the governing body had little direct involvement in this process. Instead it involved a broad cross-section of the governing core at multiple organisational levels, particularly district and committee. Although accountability for this statutory duty ultimately rested with the governing body, it was these elements of the governing core—who varied in terms of their roles and level of accountability to the broader membership—that carried out the social practices associated with it. Many of those involved in this process were GPs who had essentially been co-opted into a position of peer assessor, some of whom expressed discomfort at the identity dissonance associated with this. This can be understood as a further policy driven reconfiguration of the relationship between GPs as a professional group and the state, part of the same historical process that can be traced back to the introduction of GPFH in the early 1990s (Chapter 3, Section 3.4). As a result of the HSCA12, groups of GPs in Notchcroft became more aligned with the aims of the state, which increased the basis on which GPs in Notchcroft could be delineated.

Secondly, the governing core frequently discussed how best to raise awareness amongst the broader membership that, because the CCG was a membership organisation, it meant that “the CCG” was everyone, i.e. the membership as a whole. As one governing body GP remarked at a district wide planning and engagement event: *‘The CCG is not the governing body, it is all of us’* [CCG5yr_M1_Jan13]. The governing core essentially took on responsibility for promoting the key tenets of the HSCA12 narrative and the vision of the CCG as a membership organisation. As such, they had an active role in mediating what it meant to be a CCG member, of transmitting the policy message of *how* a membership organisation should be to those legally classified as “the membership” by that same policy. They were simultaneous agents and targets of the HSCA12. All of this was associated with a broader campaign by the governing core to protect and enhance the legitimacy, credibility, and reputation of “the CCG.” However, these efforts cannot be understood apart from attempts to legitimate their own roles within the organisation as part of the apparatus of governance.

The nature of the connection between the governing core and the CCG as a membership organisation speaks to an unresolved confusion about the identity of “the CCG” and exactly *who* it was (i.e. who are the members) which was a feature of the policy itself as well as its enactment. This uncertainty perhaps explains the difficulties that the governing core identified in crafting and disseminating “a little story” about who “the CCG” was as an organisation. When interviewees outside of the governing core spoke about “the CCG” the term was used exclusively to refer to “all of those that govern”, i.e. they did not include themselves. However, when “the CCG” term was used by the governing core it sometimes referred to “all of us that are members” (although exactly who constituted a member was never articulated in detail) and sometimes to refer to “all of us that govern” (i.e. not the broader membership). The point being that at times GP practices, i.e. the members, were folded into the definition of what constitutes the CCG and at others they exist outside of it and were the targets of some of its actions. Through the reporting of the results in this thesis, I have tried to use “the CCG” and “the membership” as terms in a way that tracks their use in extracts by those in the organisation. While this reflects the data it has also reproduced some of the confusion around the terms found in both policy and practice. The governing core concept has been useful in helping to conceptualise and

articulate the nature of these ambiguities through the social practices observed in Notchcroft. Finally and crucially, the governing core was not a fixed entity—it represented a spectrum of involvement in CCG governance and is most meaningful when considered in relation to particular contexts and circumstances (i.e. the governing core as it relates to a particular committee is different to the governing core as it relates to one of the districts).

12.7: Researcher reflections

Qualitative research of this kind does not make assumptions that the researcher is a neutral and objective collector of unambiguous social data. It is instead recognised as an inherently personal endeavour, shaped by the researcher in immeasurable, potentially subtle, ways. As such, it is important for the researcher to operate with a reflexive awareness in order to provide some insights into the dynamic between the researcher and researched. This is something that I have consciously tried to sustain throughout the entire research process. In this section I will present some of my reflections on how I interacted with people in Notchcroft and offer insights into (my interpretations of) how some people perceived me and my presence, i.e. how I was “situated” (Walt et al. 2008). However, before this I will briefly note some of my physical characteristics as they are relevant to understanding my presence within the CCG. I also recommend returning to the beginning of this thesis and reading the section entitled *The author*. At the time of starting this study I was in my late 20s. I am approximately six feet tall and of a slim build. When attending any CCG events I would dress in a way that I considered smart but not overly formal, i.e. suit type trousers and formal shoes, usually with a shirt (but never a tie) or thin jumper.

The first meeting that I attended was a public governing body meeting. When I arrived, I introduced myself to the Chair, with whom I had been in email contact. When we finished speaking I realised that I was not sure where to sit. Most people, including the Chair, were sitting around a large rectangular table in the centre of the room. I was quite early so only around a third of the seats were filled. People sat looking and tapping at iPad screens or talking to each other. There were numerous other chairs arranged against the wall around the room. After a moment’s hesitation I decided to sit at the table:

Not sure where to sit. Move to the other side of the table. Start getting stuff out of my bag/fiddling. Sit down at the table. Woman [later identified as the Chair's PA and meeting minute taker] asks me if I'm a member of the public. 'Yes, I'm also doing a PhD.' She asks for my name, details. Tells me that the table is just for board members but I realise what she's going to say and pre-empt her. 'Shall I sit over there?' (a chair against the wall to one side of the room, closest to the big screen). 'Yes.' [She's friendly and it's not particularly embarrassing!]

A woman sits down on the chair next to me. Eating sandwiches. 'Are you a member of the public?' – 'I'm doing a PhD.' – 'So are you not a member of the public?'. I joke about them not being mutually exclusive. [Realise I'm unsure as to what my status is – where do I stand?] [GB_M1_Oct12]

This extract illustrates how the simple situation of deciding where to sit, and the social interactions around this, exposed my uncertainty about my position in relation to the governing core of the CCG. I realised that I instinctively expected my status as a researcher to somehow separate me from other members of the public, despite the fact that I was also there in an observational capacity. As noted in Chapter 6 (Section 6.2), observer participation can be understood as a continuum. Gold (1958) conceives of this with two extremes of "complete participant" and "complete observer", with "participant-as-observer" and "observer-as-participant" in between. My official role was that of a "complete observer," the same as any other member of the public. However, upon reflection I have come to understand my position as distinct from "just" a member of the public on the basis of permission and intent. That is, I explicitly obtained permission to attend CCG meetings, from those in the CCG but also through other legitimating processes such as university and NHS ethics boards. My intentions were likely different from other members of the public in that my objective was to create a record of the content and process of meetings and consider this in relation to national level policy. I also found that in practice my position on the continuum lay somewhere between "complete observer" and "observer-as-participant," and, crucially, this position was not fixed—it varied between meetings and over time.

During the early stages of fieldwork, particularly when establishing permission to attend meetings and when most of the governing core did not know me, I felt quite self-conscious and uncertain about my status. I would usually be asked by the chair to

introduce myself and explain my work to the meeting attendees at the start of the meeting. Upon reflection during the writing up of my field notes, I realised that I would use particular phrasings when doing this that lent additional legitimacy to my presence. For example, the following extract illustrates how I consciously used the phrase “working *with* the CCG” as I explained my research to a locality meeting that I was attending for the first time in order to encourage the acceptance of attendees:

...asked me if I would like to speak next and I thanked her. I introduced myself again and explained that I’d been “working with” the CCG since (I remember considering whether that phrasing was accurate and appropriate before I started speaking and then decided to use it – I realised that it does perhaps confer a certain legitimacy to my presence) October last year.
[LocC_M1_Jul13]

As the fieldwork period continued, I came to feel that I was treated quite differently in the various meetings that I attended. This was particularly so in district meetings, which reflected the differences in personality between them, to a degree (Chapter 8, Section 8.5). While I spent the vast majority of my time in meetings as a silent observer, in one district’s meetings I was encouraged to ask questions and, occasionally, explicitly asked to give my opinion on issues. In other meetings I felt utterly invisible and was barely even acknowledged by anyone. When meeting attendees did engage with me it offered insights into how they perceived me and my objectives as an observer. The following extract shows how an attendee associated my work with the DH, at least superficially, which was something I felt compelled to emphasise was not the case:

GP4 said to me “if you ever get a job in the DH then make sure you don’t let any daft ideas like this come in.” (NHS 111) – I said “it’s not in my career plan.” There was a bit of laughter at this exchange. [Dis1_M1_Dec12]

One of the governing core asked me on a number of occasions whether I could attend GP practice meetings, assess the extent of their understanding of “the CCG” and report back to the governing body:

Oth6 said he had thought of one thing that I might do (I started to write notes in my journal as he spoke so that I could capture it) is to go to various meetings at practice level and ask people questions that I know the answers to and then I could feedback to the board information about what percentage of people don't actually know about X. He said that with such a big organisation there is a risk that messages don't get through.
[CCG5yr_M1_Jan13]

I felt uncomfortable with the idea of performing a reconnaissance mission and considered it inappropriate as my observations of the CCG were on a non-participatory basis. I tried to explain that I felt I did not want to align myself with particular groups within the organisation. On reflection, I found the request itself interesting because it represented an attempt to co-opt me into the service of the governing core, and speaks to the challenge the governing core faced of trying to understanding the knowledge and perspectives of the broader membership within a CCG with multiple tiers below the committee level (i.e. districts and locales). This section illustrates how my “positionality” (Walt et al. 2008) as a researcher in relation to the governing core of the CCG was a negotiated, dynamic process that varied between contexts. Reflecting on the ways that the governing core of the CCG treated me and interacted with me provided an additional source of data only obtainable through observational qualitative work of this kind and represents one of its strengths.

12.8: Strengths and limitations of the study

This study has a number of strengths and limitations. Some of its strengths are directly related to particular limitations, like two sides of a coin, so I shall discuss these together.

Conducting research during times of upheaval and transformation within an organisational field is important because these periods ‘...are characterized by conditions of heightened uncertainty, under which novel practices can emerge, actors can make new kinds of claims, organizational forms can emerge and die, status orders can be restructured, and rules of engagement can be redefined’ (Lounsbury 2002, p.263). This assessment certainly rings true for the emergence of Notchcroft CCG. I was fortunate that this study coincided with the introduction of the HSCA12 and the establishment of CCGs. However, my fieldwork period of 13 months only spanned a relatively short period of

time before and after Notchcroft CCG became a statutory body. During those months events developed at quite a pace and, given that, it seems likely that organisational context has changed considerably since. What I was able to capture only represents a partial snapshot of this specific period. Against the charge that such a period of transformation is undesirable to research because it does not represent business as usual, I argue that major change programmes and organisational restructuring have become so normal in the NHS that finding “stability” to research may be considered challenging if not impossible.

A key conceptual tool in this study has been the “governing core” term, explained in Chapter 7 and considered in greater detail in this chapter (Section 12.6). It has provided a way to explain individual member involvement in CCG governance as a spectrum and thereby differentiate between members on the basis of their involvement. However, ascribing the governing core label to an individual does not describe a fixed characteristic of that individual. The allocation of the term is always relational and context dependent—individuals can move in and out of the governing core depending on the situation and the social practices occurring. In this sense, the term is similar to a given institutional logic when applied to an individual. It would not have been possible to address the research questions in a meaningful way without the governing core term, and it might prove useful for future research in a similar vein.

My interest in studying the enactment of the HSCA12 in Notchcroft justified gravitation towards observing the activities of the governing core. This perspective proved useful in that I was able to explore the interface between the CCG and other players in the organisational field, such as the area team. However, I was also interested in exploring the broader memberships’ views on the CCG as part of my focus on the implications of the CCG as a membership organisation. This process was conducted exclusively through a number of interviews. These provided rich data but recruiting GPs proved challenging and the interviews that I conducted relied on snowballing. Ideally, I would have been able to interview more of those outside the governing core, or even arrange a focus group, but time and resource constraints did not permit this.

I decided to focus my fieldwork on a single CCG because I was motivated to explore the organisational enactment of the HSCA12 in as much depth as possible. This has allowed me to create a contextually rich account that calls on a range of stories from the CCG organisation relating to a variety of areas of its work. However, a central guiding principle of this work is the preservation of the organisation's anonymity and this is made more complex by electing to study a single organisational case. During analysis I decided that I would omit whole series of events from my results in order to preserve Notchcroft CCG's anonymity. This measure was frustrating, at times, but necessary.

Case studies are often subject to criticism on the grounds that they possess limited generalisability. However, the idea that generalisation is not possible from case studies is unfounded (Stake 1995; Yin 2003; Flyvbjerg 2006), and the extent to which one may wish to generalise from a case study depends on the type of case study that one conducts. In an intrinsic case study such as this the aim is not to produce an objective and transportable "truth" that can be applied to other settings—it is to enhance understanding of the particular case, i.e. the CCG and the health policy that it is bound up with. The CCG is recognised as being one of 211 similar organisations, but few assumptions are made about the nature of this similarity and the claims that may be made about the others on the basis of studying this one. Nonetheless, an intrinsic case study may still contribute to the development of theory or 'analytic generalization' (Yin 2013, p.68).

Flyvbjerg (2006, p.224) argues that the idea that generating 'predictive theories and universals' is a more valuable aim for social scientists than developing 'concrete, context-dependent knowledge' is erroneous. He argues that generalisation is 'overvalued as a source of scientific development, whereas 'the force of example' is underestimated' (Flyvbjerg 2006, p.228). Furthermore, claims about the ability to produce generalised laws in studies of the social world have consistently been shown to be unfounded. I argue that this is the case in policy analysis and that attempts to characterise the effect of a national policy, without requisite caveats, are misleading and misguided. However, Scott et al. (2000) identified that, although their study was focused on the healthcare system of a specific city-region of the USA, the effects of the prominent organisational field level institutional logics that they identified were of relevance to other regions. In this study,

the assessment of the HSCA12 in terms of the institutional logics it embodies holds relevance, and locally mediated repercussions, for all CCGs.

12.9: Policy implications

In this section I will consider the implications of this study's findings to the development and instantiation of healthcare system policy. Engineering large-scale changes in an organisational field such as the NHS creates uncertainty, and organisations may feel the need to assert their relevance within the new and evolving configuration. As such, even when efforts are made to specify clearly the respective responsibilities of organisations, struggles for legitimate control over domains of activity can occur. There are two possible messages that policy planners could take from this. One, policies could spell out in greater detail the responsibilities and basis of relationships for new and reformed organisations within the field. However, this is unlikely to be successful because, as identified above, contextually specific local dynamics have a bearing on how policy is enacted and expecting to create a policy that accounts for these myriad variations is unrealistic. Two, policy changes could be made in a more incremental way so that, when certain organisations change or are created, they are within an organisational field with a cast of established organisations that are relatively assured of their role and legitimacy in carrying out their activities.

The story of NHS 111 has clear implications for the design and implementation of health policy. The HSCA12 caused profound disruption to the organisational field of English healthcare. At the time that CCGs were becoming established and preoccupied with fulfilling authorisation requirements they were given responsibility for launching NHS 111. CCGs had to hastily establish working relationships with other local CCGs in order to launch the service at a regional level. In Notchcroft, the task of overseeing the launch served to undermine the core ideological principles associated with the HSCA12 and had a negative impact on the efforts of the governing core to generate ideological "buy in" amongst the membership. In the future, major health service reorganisations and national service reconfigurations should not be planned so that they directly coincide. Furthermore, policies that aim to engender subscription to particular institutional logics

are likely to be more successful if other policy driven changes are ideologically harmonious or, at least, are sufficiently sensitive to them to avoid undermining them.

The governing core concept has the potential to better inform policy design because it provides a conceptual tool for thinking about localised governance processes.

Acknowledging and understanding that organisational governance in organisations such as CCGs will vary on the basis of, for instance, local history and ideological alliances better equips policy makers in the development of realistic expectations and the development of policy tools. It is not a realistic aim to make policy so specific as to account for these myriad contexts, but being aware of various tendencies amongst governing cores in different local contexts might assist in making more informed design decisions. It might help to answer the questions about ‘what works, for whom, in what circumstances?’ (Pawson and Tilley 1997, p.161). For organisations themselves, particularly those that are established as membership organisations or similar such models, a reflexive awareness of the composition and influence of the governing core beyond just the most formal and stable elements, such as governing body type structures, could be useful. By cultivating greater organisational self-awareness, the ability of the organisation to understand its governance processes, adapt to change, and hone its own initiatives could all be enhanced.

One the most significant recent policy developments relating to CCGs is the move towards giving CCGs a greater role in the commissioning of primary care (something which was ruled out during the passage of the Bill because of concerns about conflicts of interest) under co-commissioning arrangements with NHS England (NHS England 2014d). This can be understood as part of a drive by NHS England to reduce its size and costs (Lind 2014). Under the plans, CCGs will choose to adopt one of three co-commissioning models: ‘greater involvement in primary care decision making; joint commissioning arrangements; delegated commissioning arrangements’ (NHS England 2014d, p.13). Under delegated commissioning arrangements, CCGs will take on responsibility for managing GP practice contracts (i.e. GMS, PMS) and exercise control over, for instance, the creation and merging of GP practices. This represents a considerable extension of CCG responsibilities into a domain of management that was explicitly delineated in the HSCA12 as the purview of NHS England. Such arrangements will likely impact on the

dynamic between a CCG's governing core and their broader membership because they entail an even greater alignment between governing elements of the CCG and the state, and a greater division within the GP profession between those involved in such governance processes and those subject to the effects of them. Co-commissioning arrangements are likely to make it more challenging for CCG governing cores to get their broader memberships to "buy in" to the idea of being a member because they suggest a greater delineation between those within the organisation, between assessor and assessed. Consequently, the notion of the CCG as a mutually constructed project of local GPs "all in it together" becomes more distant, as does this aspect of the membership organisation concept itself. Furthermore, it is possible that this extension of CCG responsibilities will bring with it a more wide-ranging or formal role for the governing core. CCGs are being encouraged to set up committees to take responsibility for co-commissioning activities and it is likely that some committee members will be governing body members. However, there are serious concerns about conflicts of interest arising as CCGs make decisions about funding and contracts which will affect their member practices and, potentially, governing body GPs themselves. It is therefore acknowledged that, for many decisions, GP members of these new committees will need to recuse themselves from the decision-making process, suggesting that non-GP governing core members may find themselves taking a more significant (decision-making) role.

12.10: Practical implications

This section considers the practical implications of this study's findings to CCGs in general and Notchcroft CCG in particular. For Notchcroft, the central implication relates to the CCG's organisational sub-structure of districts and locales; a number of other implications correspond to this. I will discuss these issues, offer some suggestions and highlight particular matters that the governing core of the CCG might consider.

The governing core of the CCG was keen to get the broader membership to "buy in" to the organisation, to perceive it as something that they had a stake in and could contribute to. However, for most of those in Notchcroft affiliated with member GP practices, the main fora for engaging with "the CCG" were locale meetings. Having the organisational layer of districts above them, rather than the committees and governing body, created a

number of issues. Relaying information through an additional organisational layer created greater possibilities for miscommunication. It was also labour intensive as those in the governing core that traversed and facilitated all levels faced particular pressure in terms of time commitments and the challenging logistics of attending so many meetings. However, each district and locale were defined organisational sub-groups, some of which possessed particularly strong identities and sets of interests. When encouraging people within the organisation at large to “buy in” to “the CCG” it seems sensible to reduce to a minimum the number of intra-organisational groups that individuals can identify themselves with ahead of the CCG itself. It was the multiplicity of organisational “memberships” that some of the governing core held and operated within on a regular basis that contributed to the feelings of identity dissonance that they expressed.

If a beneficial course of action is to reduce Notchcroft’s organisational tiers from three to two, then the question of whether it is districts or locales that should make way arises. One factor that should play into this decision is a clear understanding of exactly what the governing core think being a CCG member means, which would then enable a clearer picture to be provided to people in terms of what they are being asked to “buy” into. The problematisation of the policy in Chapter 3 revealed that the membership organisation status of CCGs was a means of establishing an organisational model where GPs could feed their local knowledge of patients into the organisation in order to represent the health interests of those patients (Section 3.4). This locally attuned operation is certainly something that the governing core recognised as an important quality of Notchcroft CCG. However, if they were to adopt this as a key feature of membership and shape the CCG accordingly, then a structure and operating model that fosters more direct communication between the locally embedded elements of the organisation with the committees and governing body seems logical. From this perspective, locales seem like the organisational tier most important to maintain: they are organised around geographical areas and resources including health centres and other buildings, and they are focused on the needs of patient populations that reside in particular areas of Notchcroft. Districts are larger and generally not geographical and so rely on locales to provide them with local intelligence. Furthermore, I have already noted that locales are considered by the governing core to be important in the delivery of the CCG’s vision, as

well as a feature of the Primary Care LES and its remuneration of GP practices (Section 12.4).

It seems likely that any proposal to abolish districts would face resistance given that their incorporation into the CCG was partly the result of a negotiation not to have three separate CCGs. The fact that districts represented strong identities and sets of interests was an important factor in this, and they can be understood as a force that renders the process of establishing a cohesive, overarching organisational identity for the CCG more challenging. This is something that would have to be considered carefully by the governing core for any proposed organisational redesign. Furthermore, a manager suggested that districts were needed because locales were at very different states of maturity and required support in order to function effectively [Int_Mng5_Aug13]. However, it might be more effective for the CCG to establish one large management team to support all locales rather than splitting this function across three districts, which fieldwork revealed involved considerable clinical input. In a reorganised CCG with locales and no districts, the remit of locales and the basis of their interaction with the other levels of the organisation would need to be carefully considered. Logistically, it would be challenging to hold governing body meetings attended by representatives from all of the locales in Notchcroft at once. If a representative from each were to attend a governing body meeting then the attendance of such meetings might become unproductively large. These are issues that would need to be worked through and would, once again, be influenced by the precise role that locales were expected to play in the organisation, and how much ownership they would have over decision-making processes.

These issues around the nature of membership (exactly who are the members and what does being a member really mean?) and the degree of power devolution to locale-type organisational sub-units are important issues for all CCGs to consider. Checkland et al. (2012b) found that emerging CCGs tended to use localities as the main forum for membership discussion and engagement but there was variation in how they operated: one delegated considerable funds and decision-making powers to its localities but found it necessary to merge management support functions due to cost constraints; another had aspirations for being locally led but governance processes gravitated to the centre and the governing body. These matters speak to a tension between local empowerment

and central control within CCGs (i.e. between localities and the governing body), which parallels tensions between the local empowerment of CCGs and national level control by NHS England. For CCGs, it is important to be cognisant of these issues if the operation of the organisation is to align with expectations about what it is and *how* it should be from those that have some stake in it. An internal consistency between the two is likely to increase the stability of a CCG and make its identity clearer to everyone, particularly the broader membership.

Finally, CCGs' relationships with their NHS England area teams are likely to continue to evolve, particularly in the light of a recent decision to halve the number of area teams and reduce the number of senior staff associated with them (Lind 2014). NHS England employees have occupied particularly uncertain positions as a result of the HSCA12 because their purpose has been associated with a managerialist logic that the policy framed as undesirable (Section 12.4). For the governing core of CCGs, reflecting on this uncertainty, and considering it a factor in interactions with their area team, might help to reduce friction.

12.11: Future research

This study employed the institutional logics approach but its application was additive rather than foundational to the study design. In other words, the approach was enlisted as a sensitising device once the form and focus of the study had already been determined. It was used as a lens to cast over, and think about the interactions between, the four concentric circles of the study (Figure 1, Chapter 1, p.16). Through this process I have identified other ways that it might be employed in future studies of health policy. For example, the institutional logics approach posits that the more diverse an organisational field becomes—and healthcare is particularly diverse—the greater the scope for contextually specific combinations of logics to be adopted at a multitude of levels. As these combinations of logics become embedded—*institutionalised*—it becomes harder to achieve policy driven change across an organisational field because of the vested interests and identities associated with these logics. This study highlighted how such configurations of logics manifest and endure at the intra-organisational level. Future research might consider this particular issue at a broader scale. The organisational field

itself is too broad to address in such a way, but a particular medical specialism or professional group might make an interesting focus for such research.

A more richly resourced study than this one might explore the implications of the HSCA12 in a particular geographical area rather than focusing primarily on a CCG. There are a whole cast of local organisations, in addition to the CCG, that would be relevant in such an analysis, including: the HWB, local authority, service providers, NHS England area team, local Healthwatch, patient participation groups etc. Such a study might choose to focus on a specific healthcare area, such as mental health or older people, in order to establish a focus and guide the research. It could then devote particular attention to the social practices of interaction and negotiation between the organisational players.

Future research may explore the nature and implications of CCG governing cores in more detail. This study illustrates how the operation of a CCG necessitates a certain internal division of roles and responsibilities. In Notchcroft, some of the governing core found it hard to reconcile the requirements of different roles and their identity as both part of GP member practice and part of the governance apparatus of the CCG. This research has only touched on the relevance of identity theory to such phenomena and there is potential to build on this considerably. Identity dissonance amongst the governing core was often identifiable through the language individuals employed. Consequently, discourse analysis that focuses on the “identity work” taking place during member interaction could be a valuable approach in such a study (Benwell and Stokoe 2006).

A future study may wish to examine the governing core concept in relation to previous commissioning policy. One possibility would be a historical comparison of a PCT governing core with CCG governing core. Research suggests that within some PCTs the organisational levels below the board (i.e. the governing body equivalent) were disconnected from the decision making processes at board level and, as a consequence, time was spent designing plans and strategies but they were effectively “paralysed” until the board had met to sign off plans (Checkland et al. 2011). Fieldwork in Notchcroft CCG suggested a much closer relationship between the governing body and the rest of the governing core at other organisational levels. It may be that, generally speaking, in CCGs there are more avenues for a broader range of the governing core to influence the

organisation than was the case in PCTs. The membership organisation model may be a contributory factor in this, creating a greater feeling of legitimacy amongst the governing core at all levels. Any such studies would have to be designed carefully in order to account for the inherent limitations in studying historical organisational structures and experiences.

The dynamic between the CCG governing body and the NHS England area team was one of the most fascinating aspects of fieldwork because it was so multifaceted. Future research may explore the inter-organisational dynamics of CCGs and area teams in more detail and conduct meeting observations and interviews with members in both organisations. It might be valuable to focus on one particular domain of work where the activities of the area team and the CCG overlap, such as urgent and emergency care commissioning and local service redesign. This would make an excellent focus for future research because it offers the potential to explore the evolving dynamic between the policy representation of CCGs and their commissioning practices. It would also shed light on the efficacy of CCGs as localised decision makers within an area of the NHS that has multiple overlapping sets of governance boundaries and organisational interests.

In Chapter 2 (Section 2.1.1), I identified that, despite the recession being the most dominant election issue and the need to reduce the UK's budget deficit being identified by David Cameron as the Government's single most important task, this was not reflected in the major aims presented as guiding the Government's NHS reforms. Instead, the aims were remarkably similar to those of previous NHS reforms from successive governments (Chapter 2, Section 2.3.8). There were elements of the HSCA12 that (often implicitly) dealt with economic constraints—i.e. the potential for CCGs to make the NHS more efficient. However, the Government's drive to realise £20 billion of "efficiency savings" by 2014-2015 was treated entirely separately from the HSCA12 (Helm and Campbell 2012). This raises a number of questions: why was such a major contextual factor (i.e. the recession and austerity drive) not presented as part of the problem that the HSCA12 sought to address? Why does the HSCA12 instead identify a different problem (notably similar to numerous previous reforms)? Is the explicit presentation of health service budget cuts in the framing of a policy problem perceived by governments as off limits

because it represents too great a threat to political capital? If so, what is the history of this line of thinking and how can it be traced back through previous policies?

An ideal approach to addressing these questions would be Bacchi's (2012) "what's the problem represented to be?" or "WPR" approach (introduced in Chapter 3). Bacchi (2010, pp.64–65) advocates asking a number of questions of any policy, including: What assumptions underlie the "problem"? How has this representation come about? What is left unproblematic? What are the implications? What alternatives are there? She suggests that studying policy texts in order to establish problem representations creates the prospect for "working backwards" and tracing the evolution of a problem over time. The essential premise of the WPR approach is that 'since every policy endorses change of some sort, every policy contains an implicit representation of what is seen to be problematic' (Bacchi 2010, p.63). Problematising policy in this way involves trying to identify the problem and read between the lines in order to identify the assumptions it is predicated on, usually through a close examination of historical documents to identify patterns in problem narratives.

12.12: Chapter summary

In this chapter I employ three master themes (*"Buying in" to the membership organisation; Protecting responsibilities; Organisational structure*), which incorporate insights drawn from the data presented in the results chapters, in order to answer research questions one and two in more depth. This revealed that the governing core generally perceived the co-existence of districts and locales as self-explanatory, although the structure was seemingly inefficient and their purposes conflated. The embedding of districts and locales into the structure of the CCG can be explained because they both had clear functions and institutional logics pre-CCG, and districts were containers for different identities and interests—they were sufficiently taken for granted to be institutionalised. I also address research question three and highlight the utility of the institutional logics approach in enhancing analytical understanding in this study. I also reflect that some aspects of the approach appear challenging to realise in empirical practice, at least in a study such as this.

In this chapter I consider the experiences of Notchcroft CCG compared to the problematised understanding of the policy. While commissioning responsibilities were devolved to the more local level of clinically orientated CCGs, in practice only a sub-set of GPs and others were actively involved in governance processes: the governing core. The autonomy that the policy promised to CCGs was compromised by a number of factors, some of which were associated with different institutional logics, for instance: having to comply with legal obligations to facilitate service competition in the name of patient choice, and having responsibility for locally launching a nationally defined service (NHS 111) that had significant implications for the work of the CCG and local GP practices.

I discuss the explicit relevance of the governing core concept to understanding the membership organisation status of CCGs: the governing core (many of whom were GPs) were involved in performance monitoring of GP practices, aligning sub-sections of the membership with the managerial objectives of the state and creating identity dissonance for some of those involved; the governing core also took on the role of transmitting the normative policy ideas about what being a CCG member meant and, through this process, revealed the ambiguity about exactly who “the CCG” was. I also present the policy and practice implications of these findings and make some suggestions for future research. Finally, I highlight a number of developments that have occurred in the healthcare system since the start of the study, which illustrates the inexorable change of the NHS policy landscape.

12.13: Conclusion

The HSCA12 represents one of the more dramatic reforms in the history of the English NHS in terms of both its scope and pace. CCGs, the flagship of the policy (and the GPs that constituted them), were presented as an emancipatory force—they would save the NHS from ineffectual managers that lacked clinical and local knowledge about what patients needed. The HSCA12 created leeway for localised variation in the organisational development of CCGs. In Notchcroft, the form and function of the CCG was shaped in particular by local, historically embedded groupings of GP practices, which exhibited divergent interests and identities and manifested particularly in the organisational structure of districts and locales. These structural characteristics of the organisation, and

the social practices associated with them, underpinned by combinations of institutional logics, were themselves partial responses to previous national health policy reforms—this illustrates how the development of organisational elements in an organisational field like healthcare, which is subject to frequent and extensive policy reform, are contingent upon the local responses to previous reforms. The concept of sedimentation is useful in conceptualising this process (Cooper et al. 1996).

This study has sought to illuminate the emergent negotiation between governmental policy representation and local meanings and actions in an organisational setting. To this end, the membership organisation concept has been a key focus. The HSCA12 married normative content about what it meant to be a good member and a good membership organisation with a range of assessments and sanctions, primarily overseen by NHS England. Ambiguity about exactly who or what was a member in the policy was echoed with Notchcroft CCG. The governing core concept proved useful in articulating the nature of this ambiguity.

In terms of its relevance to the body of research exploring primary care led commissioning initiatives, this study resonates with previous findings that identify legitimacy as an important factor shaping the work of commissioning organisations (Bravo Vergel and Ferguson 2006; Coleman et al. 2009; Miller et al. 2012). It builds on such work by exploring the concerns and efforts of the CCG governing core to maintain and enhance the legitimacy of the organisation. This study also illustrates some of the tensions around the intra-professional assessment of clinicians (particularly GPs) that has been a feature of all such policies (Coleman et al. 2009; Miller et al. 2012) but is particularly extensive in CCGs.

Previous research has shown how local history and socio-cultural dynamics, particularly in relation to previous primary care led commissioning initiatives, are important factors in determining how new commissioning policies are realised and operate at a local level (Peretz and Bright 2007; Coleman et al. 2009; Coleman et al. 2010). The findings of this study illustrate how these factors are also relevant to the establishment and operation of CCGs. This study also develops Checkland et al.'s (2013) work on CCG accountability

relationships by exploring the implications of managing such relationships for those at the intra-organisational level of the CCG.

As I come to the end of the process of writing this thesis and reflect on the study in its entirety, it is remarkable just how much the landscape of the NHS and NHS policy has changed. I have identified some of the most recent and relevant developments earlier in this chapter, they include: a planned restructuring of NHS England to halve the number of area teams and reduce the number of senior managers (Lind 2014); a movement towards CCGs having a greater role in commissioning primary care under co-commissioning arrangements with NHS England (NHS England 2014d); a number of CCGs planning to merge, and others exploring the possibility of it, for cost saving reasons (Bostock 2014). These last two points are particularly interesting because they suggest a gravitation towards a PCT commissioning model, although with a more explicit clinical element. All of these developments hold potential for valuable future research.

The “Five Year Forward View”, a document overseen by Simon Stevens (the now Chief Executive of NHS England) and published in October 2014, proposes a greater multiplicity of care models including the introduction of “multispecialty care providers”, which would be single organisations containing primary care services, certain specialised services and professionals, such as pharmacists, that could identify and pro-actively engage with their most at risk patients (NHS England 2014e). A Private Members Bill (National Health Service (Amended Duties and Powers Bill)) sponsored by Labour MP Clive Efford, has just completed its second reading in the House of Commons. The Bill advocates the removal of what is presented as damaging market-based elements of the HSCA12. In particular, it proposes the reinstatement of the Secretary of State’s legal duty to provide a comprehensive national health service in England, and to repeal the HSCA12’s section 75 regulations, which relate to competition, choice, and procurement. The next general election takes place in May 2015 and it is hard to predict what developments the next parliamentary term may bring. What is more certain is that the highly political nature of healthcare provision, and the political incentives for political parties and politicians to make their mark on the NHS, means that NHS policy making is likely to continue to unfold at the same considerable pace in the foreseeable future.

I feel very privileged to have had the opportunity to spend the last three years immersed in the complex world of NHS policy and organisations—it has been a hugely rewarding and challenging endeavour. This thesis represents an inevitably partial and personal view of events in Notchcroft CCG over the fieldwork period. I hope to engage further with this data, elaborate on some of the stories that I have introduced, and produce a number of papers in the coming months. Finally, I would like to reiterate my sincere thanks to everyone involved with Notchcroft CCG. I am particularly grateful to those people that took part in interviews, answered my questions, and facilitated my access to meetings.

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Appendices

Appendix 1: Literature search keywords

NHS primary care led commissioning (Chapter 2, Section 2.3)	
<i>General and MeSH terms:</i>	<i>Commissioning policies:</i>
Community Health Planning/organization & administration	General practice/GP fundholding
England	Total purchasing
Evaluation	General practice/GP commissioning
General practice	Primary care groups
Organizational development	Primary care trusts
Organizational innovation	Practice-based commissioning
Health care rationing/methods	
Health care reform	
Health planning	
NHS	
Patient-Centered Care/organization & administration	
Policy making	
Primary health care	
Primary Health Care/organization & administration	
Program evaluation	
State medicine/organization & administration	
UK	

NHS policy analysis (Chapter 4)		
Case study	Healthcare reform	Policy ethnography
England	Implementation	Policy making
Ethnographies of policy	Institution	Public policy
Ethnography	NHS	Public sector
General practice	Observation	Reform
Great Britain	Organizational case studies	
Health policy	Organizational change	
Health services	Policy analysis	

Appendix 2: Participant information sheet

Participant info sheet:
Oct2012 / v.4



Participant information sheet

Title of research project:

Health policy, the politics of governance and change:
The introduction of Clinical Commissioning Groups in context

Introduction

You are invited to take part in a doctoral research project that is interested in exploring how health policy is transformed into practice. The focus of the project will be the Health and Social Care Act 2012 and the creation of a Clinical Commissioning Group. My name is Jonathan Hammond and I am the research student that is carrying out the study. I am part of the Health Policy, Politics and Organisation (HiPPO; <http://www.medicine.manchester.ac.uk/primarycare/research/hippo/>) research group at The University of Manchester. The purpose of this document is to give you clear information about what would be involved should you agree to take part. Please take your time reading this information, and feel free to show it to your colleagues and ask their opinions.

What is the purpose of the study?

The purpose of this study is to explore how healthcare policy in England is transformed from words to actions between the national level and the local level. The focus of the study is the Health and Social Care Act 2012 and, specifically, the introduction of Clinical Commissioning Groups. I am interested in working closely with one CCG to try and better understand how policy messages are made sense of and how the implementation process works in practice. I would like to compare the experience 'on the ground' with the way the policy is presented by the Government, as well as theoretical ideas about how policy is implemented.

Why am I being asked to participate?

You have been asked to take part because of your involvement with and/or knowledge of a particular Clinical Commissioning Group.

What will I have to do if I choose to take part in the research?

A major part of this research involves working closely with a Clinical Commissioning Group and finding out how national policy is turned into action at the local level. This involves seeing how decisions are made in reality, set in a local context, and then thinking about how this relates to the policy as it presented by the Government.

The main research methods used in this study will be qualitative observation and interviewing. In practice, this means that I would like to sit in on meetings, observe what happens, collect relevant meeting documents (minutes, agendas etc, electronically where possible), and write notes. I would also like to interview (approximately 15) people that are either members of / working with the Clinical Commissioning Group or have knowledge of primary care provision in the local area. The interviews will be a maximum of around 60 minutes in length. In some cases, I would like to interview the same people more than once after a period of several months.

To make it easier to keep track of the conversation, the interview will be audio recorded. This audio recording will then be used to produce an anonymised transcript of the interview. The meeting notes and documents, and the interview transcripts, will then be used as a source of insight into the process of making policy driven changes work in practice.

Every precaution will be taken to preserve the anonymity of site and participants.

Participant information sheet

Title of research project:

Health policy, the politics of governance and change:
The introduction of Clinical Commissioning Groups in context

Introduction

You are invited to take part in a doctoral research project that is interested in exploring how health policy is transformed into practice. The focus of the project will be the Health and Social Care Act 2012 and the creation of a Clinical Commissioning Group. My name is Jonathan Hammond and I am the research student that is carrying out the study. I am part of the Health Policy, Politics and Organisation (HiPPO; <http://www.medicine.manchester.ac.uk/primarycare/research/hippo/>) research group at The University of Manchester. The purpose of this document is to give you clear information about what would be involved should you agree to take part. Please take your time reading this information, and feel free to show it to your colleagues and ask their opinions.

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Every precaution will be taken to preserve the anonymity of site and participants.

Appendix 3: Interview consent form

Consent Form Interview:
Oct2012 / v2



Contact:
Jon Hammond
Tel: 0161 275 2000
Email: jonathan.hammond@postgrad.manchester.ac.uk

Consent Form: Interview

Project title: Health policy, the politics of governance and change:
The introduction of Clinical Commissioning Groups in context

Name of principal researcher: Jon Hammond

**Please tick the box if you
agree with the statement**

- | | |
|---|--------------------------|
| 1) I confirm that I have read and understood the Participant Information Sheet Oct2012 / v.4 and have had an opportunity to ask questions. | <input type="checkbox"/> |
| 2) I understand that my participation is entirely voluntary and that I am free to withdraw at any time without negative consequence to myself or my organisation. | <input type="checkbox"/> |
| 3) I give my permission for this interview to be audio recorded. | <input type="checkbox"/> |
| 4) I agree that an anonymised written record of this interview will be produced and anonymised quotations will be used in research reports, a PhD thesis, journal articles and presentations. | <input type="checkbox"/> |
| 5) I agree to take part in the above study. | <input type="checkbox"/> |

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Please complete both copies of the consent form (keeping one for your own records)

Appendix 4: CCG meeting and event observation details

Meeting/ event #	Meeting/event	Meeting/event code and #	Month and year	Duration (hours)
1	Governing body	GB_M1	Oct 2012	2
2	Governing body	GB_M2	Nov 2012	2
3	Committee 5	Com5_M1	Dec 2012	2
4	Governing body	GB_M3	Dec 2012	3
5	District 2	Dis2_M1	Dec 2012	2
6	District 1	Dis1_M1	Dec 2012	3
7	Governing body	GB_M4	Jan 2013	3.5
8	Committee 7	Com7_M1	Jan 2013	3
9	District 1	Dis1_M2	Jan 2013	3.5
10	District 3	Dis3_M1	Jan 2013	3
11	Urgent care team	UCT_M1	Jan 2013	3
12	Committee 4	Com4_M1	Jan 2013	2
13	CCG wide five year planning event	CCG5yr_M1	Jan 2013	2.5
14	CCG management staff meeting	CCGstaff_M1	Jan 2013	0.5
15	Committee 6	Com6_M1	Jan 2013	2.5
16	Committee 5	Com5_M2	Feb 2013	1.5
17	Governing body	GB_M5	Mar 2013	2.5
18	District 1	Dis1_M3	Mar 2013	3.5
19	Locale B	LocB_M1	Mar 2013	1
20	Committee 6	Com6_M2	Mar 2013	2
21	Committee 5	Com5_M3	Apr 2013	2.5
22	Governing body	GB_M6	Apr 2013	2
23	District 2	Dis2_M2	Apr 2013	2
24	District 3	Dis3_M1	Apr 2013	3
25	Care integration	CI_M1	Apr 2013	2
26	Committee 3	Com3_M1	Apr 2013	2
27	District 1 public event	Dis1Pub_M1	May 2013	3.5
28	Urgent care team	UCT_M2	May 2013	3
29	Governing body	GB_M7	May 2013	2
30	Locale A	LocA	May 2013	1.5
31	Committee 3	Com3_M2	May 2013	2
32	Urgent care team	UCT_M3	May 2013	2.5
33	Committee 6	Com6_M2	May 2013	2
34	Urgent care team	UCT_M4	May 2013	2
35	Governing body	GB_M8	Jun 2013	1
36	Locale C	LocC_M1	Jul 2013	1.5
37	Locale D	LocD_M1	Jul 2013	1.5
38	District 1	Dis1_M4	Nov 2013	2.5
Total				86.5

Appendix 5: Interview details

Interview #	Interviewee code	Month (2013)	Duration (hours)
1	Mng3	January	1
2	Mng7	April	1
3	Mng4	April	1
4	Mng1	April	1
5	GP6	May	1.25
6	Mng5	August	1
7	GP10	August	1
8	Oth3	November	1
9	GP11	November	0.75
10	Oth4	November	0.75
11	GP12	November	0.75
12	GP13	November	1.25
13	Oth5	December	0.75
14	GP14	December	0.5
15	GP15	December	0.5
16	GP16	December	0.5
Total			14

Appendix 6: Coding database extract

_accountability & responsibility

111 – failure fault ‘squarely with provider’

membership org. means multiple accountabilities

_assessments internal

finding the right story to tell practices about performance plan
need

_commissioning support

‘not a mature market’

_membership org.

elected to make decisions

different in practice than on paper

how far reaching is ccg vision amongst membership

_reputation, credibility, legitimacy

good pr a factor to consider in healthcare spending

quality premium – ‘reputational risk’